

Guide to the Standards of Proficiency for Social Care Workers

Guide to the Standards of Proficiency for Social Care Workers

written by social care workers for social care workers

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Contents

Welcome to the eBook	1

Front Matter

Acknowledgements	5
Foreword	8
Overview of the eBook Publication	12
Introduction	14

Domain 1 - Professional Autonomy and Accountability

Domain 1: List of Contributors	19
Chapter 1 – Denise Lyons (D1SOP1)	25
Chapter 2 – John Byrne (D1SOP2)	38
Chapter 3 – Laura Doyle (D1SOP3)	47
Chapter 4 – Imelda Rea (D1SOP4)	56
Chapter 5 – Catherine Carty (D1SOP5)	63
Chapter 6 – Lisa Hanlon (D1SOP6)	77
Chapter 7 – Charlotte Burke (D1SOP7)	87
Chapter 8 – Hazel Finlay (D1SOP8)	114
Chapter 9 – Deirdre Connolly (D1SOP9)	121
Chapter 10 – Anthony Corcoran (D1SOP10)	133
Chapter 11 – Noelle Reilly (D1SOP11)	145
Chapter 12 – Maria Ronan (D1SOP12)	151
Chapter 13 – Sarah Joyce (D1SOP13)	160
Chapter 14 – Teresa Brown and Margaret Fingleton (D1SOP14)	169
Chapter 15 – Janine Zube (D1SOP15)	182
Chapter 16 – Moira O'Neill (D1SOP16)	193

Chapter 17 – Lauren Bacon (D1SOP17)	205
Chapter 18 – Iseult Paul (D1SOP18)	217
Chapter 19 – Mark Smith (D1SOP19)	234
Chapter 20 – Karen Mahon (D1SOP20)	245
Chapter 21 – Jennifer Mc Garr (D1SOP21)	254
Chapter 22 – Danielle Douglas (D1SOP22)	269
Chapter 23 – Lynn Leggett (D1SOP23)	281

Domain 2 - Communication, Collaborative Practice and Teamworking

Domain 2: List of Contributors	295
Chapter 24 – Evonne Mushonga (D2SOP1)	300
Chapter 25 – Shauna O'Regan (D2SOP2)	310
Chapter 26 – Vicki Anderson (D2SOP3)	321
Chapter 27 – Eleanor Lyons (D2SOP4)	330
Chapter 28 – Deirdre Berry (D2SOP5)	339
Chapter 29 – Paul Hogan (D2SOP6)	350
Chapter 30 – Ailish Jameson (D2SOP7)	361
Chapter 31 – Garreth McCarthy (D2SOP8)	372
Chapter 32 – Maeve Dempsey and Collie Patton (D2SOP9)	385
Chapter 33 – Bernie Breen (D2SOP10)	398
Chapter 34 – Gillian Larkin and Marian Connell (D2SOP11)	410
Chapter 35 – Natasha Davis-Dolan (D2SOP12)	431
Chapter 36 – Des Mooney (D2SOP13)	444
Chapter 37 – Gráinne Powell (D2SOP14)	456
Chapter 38 – Des Mooney (D2SOP15)	465
Chapter 39 – Marian Connell (D2SOP16)	482
Chapter 40 – Tanya Turley and Diane Devine (D2SOP17)	495

Domain 3 - Safety and Quality

Domain 3: List of Contributors	517

Chapter 41 – Audrey Moore (D3SOP1)	522
Chapter 42 – Noel Howard (D3SOP2)	533
Chapter 43 – Lorna O'Reilly and Jamie Grennan (D3SOP3)	542
Chapter 44 – Victoria Mc Donagh (D3SOP4)	553
Chapter 45 – John Balfe (D3SOP5)	563
Chapter 46 – Grainne Ridge (D3SOP6)	573
Chapter 47 – Orla Dowling (D3SOP7)	582
Chapter 48 – Jacqui McCann (D3SOP8)	594
Chapter 49 – Sheena O'Neill and Caroline Costello (D3SOP9)	619
Chapter 50 – Claire Barry (D3SOP10)	632
Chapter 51 – Michael McCarthy (D3SOP11)	647
Chapter 52 – Grace O'Flynn (D3SOP12)	666
Chapter 53 – Dawn Murtagh (D3SOP13)	681
Chapter 54 – Marie Nolan (D3SOP14)	693
Chapter 55 – Deborah Brady and Fiona Brannelly (D3SOP15)	705

Domain 4 - Professional Development

Domain 4: List of Contributors	719
Chapter 56 – Cathy Murphy (D4SOP1)	721
Chapter 57 – Adrian McKenna (D4SOP2)	734
Chapter 58 – Delores Crerar (D4SOP3)	743
Chapter 59 – Caroline Coyle and Imelda Rea (D4SOP4)	758
Chapter 60 – Adrian McKenna (D4SOP5)	775
Chapter 61 – Francis Gahan (D4SOP6)	783

Domain 5 - Professional Knowledge and Skills

Domain 5: List of Contributors	799
Chapter 62 – Sarah Joyce (D5SOP1)	804
Chapter 63 – Juliane Reinheimer (D5SOP2)	813
Chapter 64 – Laura Doyle (D5SOP2)	825
Chapter 65 – Antonia Kenny (D5SOP4)	838

Chapter 66 – Helena Doody (D5SOP5)	846
Chapter 67 – Noelle Reilly and Denise Lyons (D5SOP6)	857
Chapter 68 – Lindsay Malone (D5SOP7)	876
Chapter 69 – Denise Lyons and Sharon Claffey (D5SOP8)	895
Chapter 70 – Teresa Brown (D5SOP9)	911
Chapter 71 – Padraig Ruane (D5SOP10)	929
Chapter 72 – Denise Lyons (D5SOP11)	940
Chapter 73 – Paul Creaven (D5SOP12)	955
Chapter 74 – Victoria Mc Donagh (D5SOP13)	971
Chapter 75 – Teresa Brown and David Power (D5SOP14)	978
Chapter 76 – Niamh Delany (D5SOP15)	1003
Chapter 77 – Denise Lyons (D5SOP16)	1014
Chapter 78 – Francis Gahan (D5SOP17)	1028
Chapter 79 – Gillian Larkin (D5SOP18)	1037
Chapter 80 – Christina Sieber (D5SOP19)	1054
Updated Revisions from PDF Booklets	1063

Welcome to the eBook

We are delighted to welcome you to this interactive eBook, created to support learning, reflection, and professional growth within the field of social care.

This publication brings together contributions from educators, practitioners, and students, each offering insight into the **CORU Standards of Proficiency for Social Care Workers**. Originally developed across five separate PDF booklets, this version unites them into one accessible, searchable, and easy-to-navigate digital format.

Originally published in 2021 as a series of books hosted on [Social Care Ireland's website](#).

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FRONT MATTER

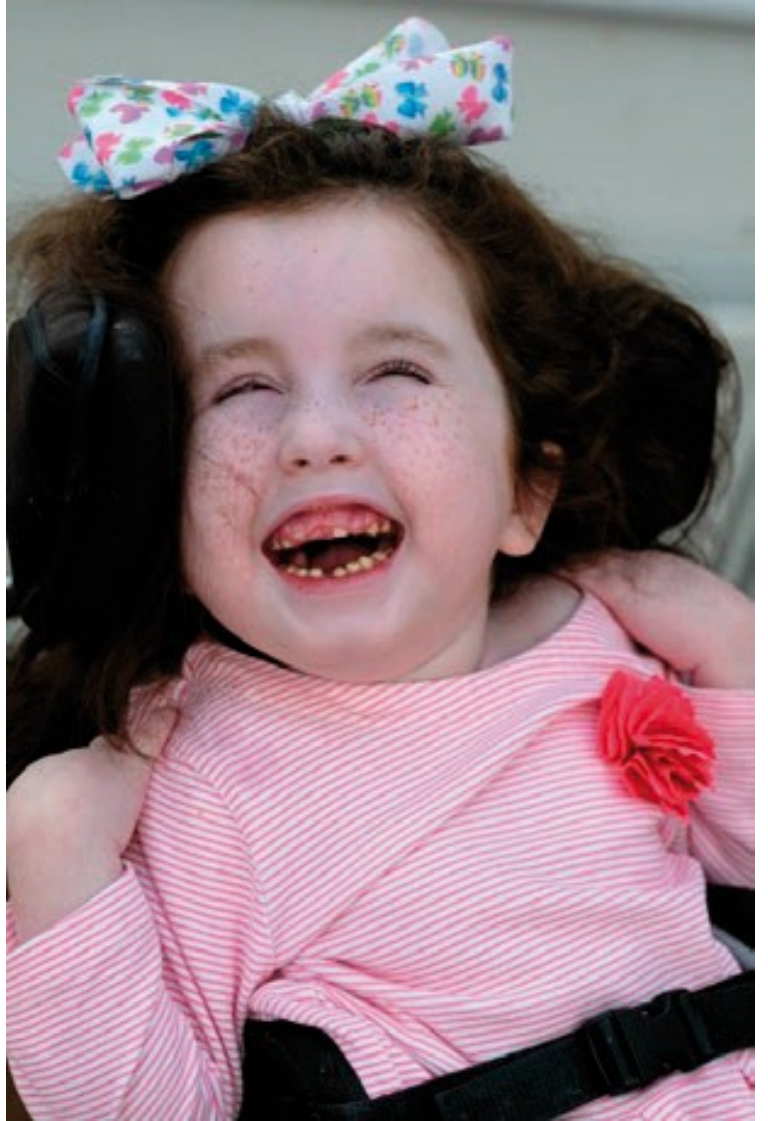
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Although comprising individually written chapters, this e-book is a team effort creating a collective voice of social care practice. We are eternally grateful to the social care workers, in different stages of their writing and practice journeys, who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

We would like to thank Jane Rogers for the attention to detail in copy editing that shaped this work into a publishable text. Jane, your kindness and patience made this publication possible. As this is a royalty-free e-book, we would like to thank HIQA (FREDA), Alan Chapman (Johari Window), and Stuart Mulholland (Welltree Model) for permission to use their original infographics in this publication. We would like to acknowledge the generosity of our donors who provided the funds necessary to develop this eBook as a free resource.

- The Irish Association of Social Care Educators IASCE.
- National Health and Social Care Professionals H&SCP Office, HSE
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- The Strategic Alignment of Teaching and Learning Enhancement Fund 2019, by the National Forum for the Enhancement of Teaching and Learning through IT Carlow.
- The Irish Association of Social Care Managers IASCM.

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



All rights reserved: Hollie Brown Quail (March 2011 – May 2020) Adam Lyons
(February 2010 – June 2020)

Foreword

One of the most beautiful gifts in the world is the gift of encouragement. When someone encourages you, that person helps you over a threshold you might otherwise never have crossed on your own (John O' Donohue 1956-2008). We were very privileged to receive many gifts of encouragement for this project and we are delighted to include their voices as the foreword to this e-book.

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

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

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

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

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

There is no way I could do justice to this 2021 publication 'Guide to the Standards of Proficiency for Social Care Workers'. It contains eighty contributions from highly qualified and experienced authors. The range of knowledge, research, qualifications, experience and education/training is quite stunning. This guide is a huge compendium, starting with the key term: Social care is ... a profession that

requires an in-depth understanding of and interest in people. Practice is centred within the relationship between you and another person. Social care work places an onus on the worker to constantly reflect on her/his attitudes, physical and mental health and ongoing ability to focus on and be present with the service user(s). The work is emotionally and physically challenging because you use your self as the 'tool' (Lyons 2013). Every possible aspect of the work of social care is essayed with added examples, key terms, cases, tasks, tips for educators, references and biographies. All the time rooted in best practice, in accordance with legal and statutory requirements, underpinned by social justice and human rights. The emphasis is on human relationships with clear and principled explorations of what can be a fraught area of endeavour and task. In the long run, education and training are central, enabling students to move through knowledge to wisdom so that they do not work 'to the book', but to the reality and the needs of their clients. The main tool being the 'Self. It is an astonishing, comprehensive articulation of the work. It will surely remain the fundamental text with regard to social care for many years to come. This then should give all those in anyway involved in social care great confidence in themselves and in their profession. It must also give substantial standing within the whole welter of professions concerned and involved with the citizens and agencies of this State. An outstanding achievement, heartiest congratulations to all concerned (Pat Brennan, Kilkenny 2021).

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

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

failure as well as the uplifting light of the small steps of success. The editors and contributors are to be congratulated and thank you for the touching dedication.

Overview of the eBook Publication

This eBook is a consolidated from **five original PDF booklets published on the Social Care Ireland website** ([Click here for details](#)), brought together into a **single, accessible digital resource**. While the core content remains faithful to the original publications, some **revisions and updates** (see [Updated Revisions from PDF Booklets](#)) have been made to improve clarity, consistency, and navigation for readers.

Structure and Organisation

The eBook is structured according to the **five CORU domains of proficiency for Social Care Workers**. Each domain forms a **main section or chapter grouping**, and within each, you'll find contributions from different authors who reflect on or explore a specific **standard of proficiency**. Each main section begins with a List of Contributors, outlining the authors linked to that domain. You can jump directly to these sections using the following links [Domain 1](#), [Domain 2](#), [Domain 3](#), [Domain 4](#), and [Domain 5](#).

Each chapter is labelled using a shorthand code for easy reference. For example:

- **DISOP3** refers to **Domain 1, Standard of Proficiency 3**
- **D3SOP7** refers to **Domain 3, Standard of Proficiency 7**

Each chapter clearly states:

- The **author(s)** of the contribution
 - The **domain and standard** being addressed
 - Reflective insights, examples from practice, and interpretations of the standard's application
-

Using the eBook – Navigation & Search

To help you find what you need, the eBook includes:

-  **Clickable Table of Contents:** Navigate through domains and individual standards quickly by clicking on the chapter titles in the menu.
-  **Search Function:** Use the search bar at the top of the page to enter keywords, codes (e.g. “D2SOP5”), author names, or topics. This will show you all chapters where your search term appears.
-  **Chapter Navigation Buttons:** At the bottom of each chapter, use the “Previous” and “Next” buttons to browse sequentially through the book.

This eBook has been designed to support **student learning**, **professional development**, and **reflective practice**. It invites readers to engage with CORU’s standards of proficiency through diverse lenses and lived experience, fostering critical thought and deeper understanding.

Introduction

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

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

The standards of proficiency are portrayed as a threshold framework for creative and informed practice that views service users as central to social care work. Here the worlds of practice, policy, research and regulation are brought into much closer proximity, presented as an integrated practice- informed body of knowledge with the relationship at the core. The keywords and language of the proficiency are explored and considered through a social care lens anchored in practice. A unique section of each chapter is called 'Social Care is ...', in which the author explains what social care practice means to them, based on their knowledge and experience. The aim here is to provide as many perspectives as possible on what this evolving profession means to social care workers. Reflections of practice are drawn upon from the 'coal-face' using fictional case studies to maximise students' engagement with the proficiency. The final section of each chapter contains 'Tips for Practice Educators' with a focus on

how they might teach the proficiency as practice educators, using practical exercises, reflective questions, quotes and points to consider. The social care workers involved have given their time and expertise to help strengthen the profession and their contributions are a testament to their competence, generosity, passion and pride in social care work.

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

DOMAIN 1 - PROFESSIONAL AUTONOMY AND ACCOUNTABILITY

Social care workers must act ethically, safely, and within the boundaries of the law and professional guidelines. They are expected to respect the dignity, rights, and preferences of service users while maintaining confidentiality and professional boundaries. Workers must demonstrate informed decision-making, personal responsibility, cultural sensitivity, and self-awareness in practice.

Domain 1: List of Contributors

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

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

Lauren Bacon is a social care leader in an adult hub day service for individuals with intellectual disability. Lauren has a special interest in person-centred planning, relationships and sexuality. She has also practised in the area of disability residential services, including children's services, young adults and older adults. Lauren has experience of working in special educational support in Canada and Ireland. In 2014 she completed an MA in Sexuality Studies in DCU; the focus of her thesis was on organisational supports provided to individuals with intellectual disability in relation to relationships and sexuality in Ireland.

Charlotte Burke is a professional qualified social care worker with a master's in Child, Family and Community Studies. She has been involved in social care for over twenty years as a social care worker, social care leader (person in charge) and trainer. Since 2017, she has been the Continuing Professional Development (CPD) Co-ordinator with Social Care Ireland. Part of that role involves speaking to social care practitioners and students on understanding the CORU process, CPD, statutory registration, mapping the standards of proficiency and the implications for future practice.

John Byrne is a lecturer in social care at the Waterford Institute of Technology. He is also an accredited humanistic/integrative psychotherapist. He has been involved in Irish social care since 1993 and has extensive practice experience in residential childcare, adult homelessness, and addiction. He was the first paid co-ordinator of the Irish Association of Social Care Workers (IASCW) and has contributed to several publications and conferences, both national and international, on issues related to professional development and therapeutic social care work. His current research interest is the role of the prison officer in the care and rehabilitation of people in prison.

Catherine Carty began working as a social care worker in 1984, qualifying from Dublin Institute of Technology's in-service programme in 1988. Since then, she has worked in a variety of social care settings prior to taking up her current post in Limerick Institute of Technology in 2013 where she teaches on both the BA and MA Social Care programmes and is the current Programme Lead for Social Care, Ennis. She is currently completing her PhD with the National University of Ireland Galway. Catherine has been a member of the Social Care Workers Registration Board with CORU since 2015, having held the post of Chair from 2019 to 2021.

Deirdre Connolly is a project lead with the Health Information and Quality Authority (HIQA) developing evidence-based national standards and guidance for health and social care services, as well as tools to support frontline staff to put the standards into practice. She has been involved in social care since 1993, working in services supporting people with intellectual disabilities, third-level education access services, and has extensive experience in housing and homeless services, with a particular focus on quality improvement through stakeholder engagement. Deirdre holds a master's in Social Care Leadership and Management from Technological University Dublin.

Anthony Corcoran is a supervisor and social care worker currently working for a homecare and day service disability provider. Anthony has a focused interest in the autism field along with areas of mental health. He has worked specifically in the area of disabilities services, including working with children, young people and older adults. Anthony has begun conducting research in the autism field with the aim of producing published research in this area.

Danielle Douglas is a lecturer in social care at Waterford Institute of Technology. Prior to becoming a lecturer in 2008, Danielle worked with marginalised young people in a variety of educational settings. In 2012, she

achieved an MA by research on the topic of resilience, outcomes and foster care. Her interest in foster care stems from her multiple experiences as a care leaver, relative foster carer, and researcher of foster care systems. She was elected President of the International Foster Care Organisation (IFCO) in 2017 and was co-host of its 2014 international conference. She is also a core group member of Power4Youth, a European peer support network for care leavers. She is a member of Tusla's Research Advisory Group. Danielle is currently undertaking a PhD in Children and Youth Studies in University College Dublin and her chosen topic is identity construction in foster care.

Laura Doyle, who is a social care manager employed in a service for adults with intellectual disabilities, graduated with a BA (Hons) in Applied Social Studies in Social Care in 2012 from Waterford Institute of Technology and worked as a social care worker for a number of years supporting adults with disabilities. Laura currently supports a team of social care workers in the provision of high-quality services and supports in a day service setting. Laura is also a PhD student in Waterford Institute of Technology, undertaking a research project on 'Moving towards a human rights-based approach in disability services: An analysis of social care workers' skills and competencies, which explores how policy manifests into social care practice.

Margaret Fingleton is a lecturer and tutor in the School of Law, Languages and Social Sciences in Technological University Dublin, City Campus. Margaret has worked in the statutory and voluntary sector over many years, has experience in residential and community care, youth and disability services and was owner and manager of Finwey Farm, which provided animal-assisted therapy/activities and forest school education. Margaret has co-authored a paper on an integrated framework for social care and is currently working on the development of this framework for educators, students and professionals.

Hazel Finlay is a social care lecturer in the Department of Applied Arts and the Programme Leader for the BA (Hons) in Social Care Practice at Waterford Institute of Technology. She holds a BA (Hons) in Applied Social Studies in Social Care and an MA (Research) on the topic of Human Security and Nurse Migration. Hazel has eight years professional experience working in residential care with adults with intellectual disabilities and young people in care. For the past eleven years, Hazel has been lecturing at Waterford Institute of Technology with a special interest in social policy, migration, disability and social care practice.

Lisa Hanlon is Healthy Campus Co-ordinator at Athlone Institute of Technology,

where she also lectures on the part-time and full-time social care programmes. Lisa holds a BA in Social Care Practice and a master's in Advanced Social Care Practice. She has worked as a social care practitioner in youth work, residential care, community-based care and day services. Her career spans over seventeen years working in the area of intellectual disability, mental health and health promotion.

Sarah Joyce currently works full time in frontline homeless services. She has extensive experience in numerous challenging environments from homeless services, education centres and direct provision centres to addiction services, dealing with people from a person-centred perspective. She holds a BA (Hons) in Social Care from Technological University Dublin.

Lynn Leggett is a social care worker currently working in a day service for people with intellectual disabilities. Lynn completed her BA in Applied Social Studies in the Institute of Technology Sligo in 2007 and her BA (Hons) in Applied Social Studies (Disability) at the Open Training College in 2015. Lynn was awarded the Gerry Clarke Memorial Award in Recognition of Outstanding Application of Learning to Practice by the Open Training College in 2015.

Karen Mahon qualified from Technological University Dublin Blanchardstown in 2008. Since graduating she has worked in a variety of settings with young people and their families. Karen began her journey as a youth worker in disadvantaged communities and working with ethnic minorities, and went on to work as a social care leader in various specialist residential services ranging from high support to semi-independent living units. Karen has been working in child and adolescent mental health for the last eight years and completed specialist training in child, adolescent and family mental health in Trinity College Dublin. She is an active member of the CAMHS Special Interest Group and has been the conference lead for the past three years.

Jennifer McGarr is a social care worker and senior lecturer in the Department of Humanities, TU Dublin Tallaght Campus, where she lectures on the Applied Social Care programme. Jennifer has a diverse range of experiences within social care, having worked for fifteen years across a variety of residential and community contexts. Jennifer is a PhD candidate, currently researching African women's experiences of integration in Ireland. She is an active member of the Irish Association of Social Care Educators (IASCE) and Social Care Ireland (SCI), and sits on the SCI Education Advisory Group.

Moira O'Neill graduated from Technological University Dublin, Tallaght Campus with a first class honours in Applied Social Care having been accepted as an advanced entry student from Ballyfermot College of Further Education. She has social care experience in the areas of special needs, homeless services and youth mental health.

Iseult Paul graduated from the Institute of Technology Blanchardstown in 2007 with a first class honours degree in Social Care. Since 2005 she has been working in the intellectual disability sector, supporting men and women with mild to moderate intellectual disabilities. She is the author of Chapter 10, 'The Stranger in the Mirror: Dealing with Dementia in the Intellectual Disability Sector', in *Social Care: Learning from Practice*, edited by Noel Howard and Denise Lyons. Since graduating Iseult has acted as a practice placement educator, supervising social care students from the Institute of Technology, Blanchardstown. Iseult is a practice educator and believes that having students on placement is a valuable opportunity not only for the student but for the men and women in the service to have a role and voice in shaping the future practice of social care workers.

Imelda Rea divides her work in Technological University of the Shannon: Midlands Midwest (formally AIT) between lecturing in Social Care degree programmes and working as a community connector with the College Connect project, connecting with people who experience multiple marginalisation, supporting them on their journey into higher education, and beyond, as a student support worker. Imelda has worked in residential care, youth training initiatives and is a volunteer in community radio. She has an MA in Child and Youth Care and degrees in both Social Studies and Community Development.

Noelle Reilly is a social care worker currently working as social care placement co-ordinator and associate lecturer in Institute of Technology Carlow. Noelle has extensive experience as a social care worker in Ireland and has worked in residential care and in the disability sector. Noelle is currently a member of Social Care Ireland and is an active member of the Irish Association of Social Care Workers and a member of the Social Care Workers Registration Board.

Maria Ronan is a graduate of Waterford Institute of Technology's (WIT) Applied Social Studies in Social Care degree programme. She lectures in WIT's School of Humanities and also supports social care students during their practice placements. Maria does relief work in both day and residential services for adults with intellectual disabilities and thus continues to enjoy the rewarding aspects of social care work in addition to keeping her skills up to date. Maria has undertaken

voluntary work for many years with a number of organisations in Ireland and abroad including St Vincent de Paul and the Citizens' Information Centre and has fundraised for cancer research, Guide Dogs for the Blind and Amnesty International. Maria is a PhD candidate in WIT; the subject of her research is the impact of state apologies for institutional abuse.

Mark Smith is the Director of Crannóg Nua Special Care Service and has been in this role for the last ten years. Mark has worked in special care and high support since 2002 in a number of different roles including Deputy Director, Director and Interim National Manager for Special Care. Prior to this he worked since 1993 for the Los Angeles Society (now called Home Again) as the Director and Residential Manager. Mark first qualified from Dublin Institute of Technology in 1988 and has postgraduate qualifications in Child Protection and Health Care Management. Mark is currently studying for a MA in Social Care Leadership in Technological University Dublin. He has been a member of the executive of the Irish Association of Social Care Workers and has represented this organisation in the initial discussions on registration; he also represents social care workers on the Expert Working Group looking at issues in social care.

Janine Zube has twenty years' experience as a social care worker in services supporting people with intellectual and psychosocial disabilities and supporting families and young people accessing services in the community in Ireland and Germany. She holds a postgraduate qualification in Management and a Masters Degree in Human Resource Management (HRM). Janine is passionate about creating opportunities to access education and employment for people with disabilities. As a case manager Janine works with a diverse population promoting community inclusion and engaging with a variety of stakeholders. Janine is an active member of Social Care Ireland, a founding member of Disability Special Interest Group and a member of the Workers' Advisory Group.

Chapter 1 – Denise Lyons (D1SOP1)

Domain 1 Standard of Proficiency 1

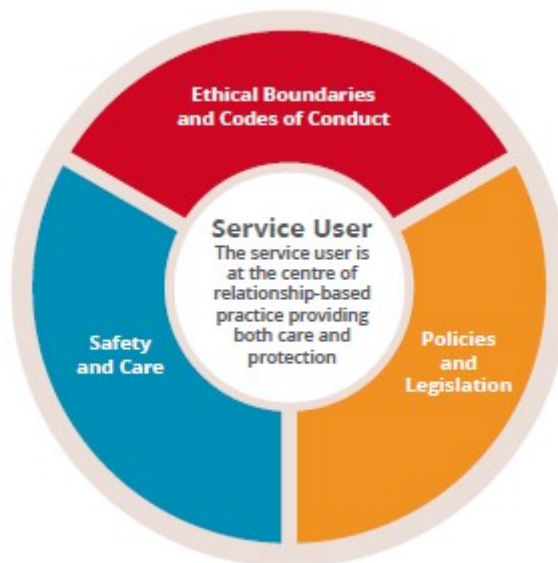
Be able to practise safely and effectively within the legal, ethical and practice boundaries of the profession.

KEY TERMS

Practice boundaries of the profession
Legal, ethical and practice boundaries
Zone of helpfulness
Shared duty to care
Professionalisation

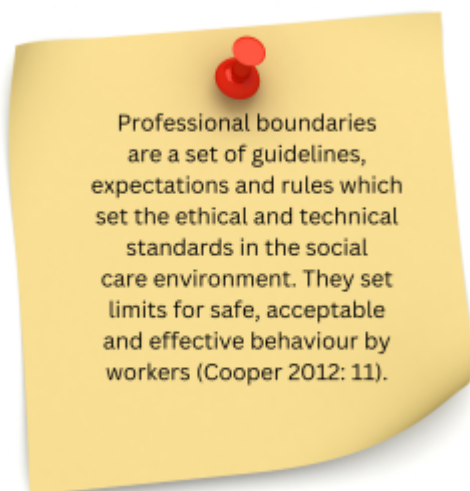
Social care is ... a profession that requires a relationship between you and another person. It involves understanding and responding to their attitudes, physical and mental health and emotionally and physically challenging behaviour.

Practice Boundaries of the Profession



Author-created diagram: Service User in relationship-based practice

The practice boundaries of social care support workers to provide safe, ethical and legal practice.



Professional boundaries are a set of guidelines, expectations and rules which set the ethical and technical standards in the social care environment. They set limits for safe, acceptable and effective behaviour by workers (Cooper 2012: 11). Professional boundaries are one of the defining characteristics that separates unskilled labour from a profession (Eraut 1994). According to Hashimoto (2006), the word 'profession' means to profess or declare that, as a professional, you will fulfil your duty in society, using expert

knowledge, and are regulated, autonomous and accountable. A key characteristic of any professional body is its ability to make independent decisions about, and to have self-governance on, the definition, role, scope and duties of its members. **Autonomy** is derived from a Greek word meaning self-governance, and on a personal level, it relates to the ability to be in control of and

make decisions about your own life (Rendtorff 2008). Professional autonomy relates to the ability to make decisions and judgements within the work environment, which are not absolute, but shaped and limited by guidelines or codes of ethics established by the profession (Hashimoto 2006). The eighty standards of proficiency, presented as individual chapters in this book, outline all the skills and knowledge needed to practise safely and effectively within the boundaries of our profession. These standards of proficiency are supported by a Code of Professional Conduct and Ethics and 'each year registrants will be asked to pledge that they comply' (SCWRB 2019: 1). The 27 'responsibilities' in the Code of Professional Conduct and Ethics (2019) are categorised under three subheadings; Conduct, Performance and Ethics. Chapter 7 provides an overview of this document and looks specifically at the codes of conduct that are not already included in the eighty standards of proficiency. **Accountability** is being able to explain the decisions or actions you have made, or not taken, to the people who are directly affected by them (De Lissovoy 2013). Accountability is an important part of professionalisation and when people can stand over their decisions, practice becomes more transparent and safe. Regulation is about accountability to the service user, requiring discipline and adherence to the codes of ethics and conduct, and being answerable for our actions through a sense of individual responsibility. Regulation and accountability are part of a quality assurance process, which begins by setting standards, providing training and then implementing the standards and codes of conduct. This is a cyclical process and 'as the profession develops, the Social Care Workers Registration Board is committed to continually reviewing these standards, in doing so, ensuring that they remain both relevant and comprehensive' (SCWRB 2019: 2).

The Quality Assurance Cycle of Social Care Work (Adapted from Ellis & Whittington 1998)



Author-created diagram: Four-step process related to professional standards and continuous improvement.

Social care work is in a constant state of flux and we, as active participants of the quality assurance process, are always learning more about how to practise in a safe way. The quality assurance process begins on the first day of your social care education, as colleges prepare students to practise safely and effectively within the legal, ethical and practice boundaries of the profession. The inclusion of social care work in the 2005 Health and Social Care Professionals Act (DoHC 2005) was the catalyst for a series of changes in the education of social care

workers, beginning with the redesign of programmes to ensure that the 80 standards of proficiency are the threshold learning outcomes for students. Social care educators will have to meet the standards outlined by SCWRB (2017a) in order to receive approval to continue educating social care workers. The Social Care Registration Board has ultimate power over the educational institutes, which require documentary evidence of a 'high standard of professional education', as indicated in sections 7, 27 and 38 of the 2005 Act. Educators will have to prove that they have suitably trained the designated professional to be a 'fit and proper person, able to engage in the practice of the profession, with knowledge of the language necessary for practice' (DoHC 2005: 11-28). The Social Care Registration Board has outlined that only educators eligible to register on the social care register (social care workers) will be permitted to teach or supervise the practice elements of the social care course. The protection of the title 'social care work' within the Health and Social Care Professionals Act 2005, the statutory registration of social care and the inclusion of workers as social care lecturers in the revised programmes, are all indicators of the professionalisation of social care work.

Legal, Ethical and Practice Boundaries

As well as being a characteristic of a profession that is regulated, autonomous and accountable, professional boundaries are important, because as a worker you have formal authority, and thus the potential to misuse your power and influence over service users. The focus of this chapter reflects the main aim of CORU, to ensure that the vulnerable public are protected by directing the worker on what he or she must do to keep people safe within legal, ethical and practice boundaries. Together, these professional boundaries reflect the values of social care and are influenced by changing ideas about how professionals should help others and what is safe practice (O'Leary *et al.* 2013).

To begin our discussion on professional boundaries in social care work, it is important to understand that the relationship is the core of your practice with others, not viewed as a tool (Lyons 2013; CORU 2017b), but as 'the centre of it all' (Ormond 2014: 252). Through spending time together, knowledge is gained on: the service user's likes and dislikes; how to interpret communication cues; how to meet needs quickly and effectively; how to provide support appropriately; and being an advocate by communicating accurate information to others. Professional boundaries are integral to this relationship because there is a power imbalance (O'Leary *et al.* 2013) and as such, the potential to use actions,

inactions or information to cause harm and abuse. The social care work relationship is a genuine connection between the service user and the worker, which is based on feelings of safety and trust (Smith 2009; *Smith et al.* 2013). This relationship is described by social care workers as needing focus and time, as being a difficult thing to establish, and experienced as personal as well as professional (Lyons 2017). Ensuring that professional boundaries reflect these values of practice, they must not become a barrier that separates the worker from the service user (O’Leary *et al.* 2013), but one that maintains a relationship-based approach that is safe and genuine. This chapter continues with the boundaries that reflect laws and legislation, and codes of ethics and conduct. They are structured in the form of codes, rules and policies that can provide clear directions on what you ‘must’ and ‘must not’ do (SCWRB 2019), with the aim of helping workers to make safe decisions.

Legal Boundaries

Acting in the best interest of service users is the foundation of professional boundaries and as such, as a social care worker you are ‘always accountable for what you do, what you fail to do, and for your behaviour’ (SCWRB 2019: 14). Being able to practise safely within the legal boundaries of the social care profession begins with an awareness and understanding of all the relevant legislation (Cooper 2012). The Standards of Proficiency for Social Care Workers (SCWRB 2017b: 3) require workers to be aware of all ‘new and emerging legislation’ that is ‘relevant to the profession’. This statement (in standard D1 SOP13) allows for the inclusion of new or amended legislation that will be enacted during the social care worker’s long career. The Social Care Workers Registration Board (SCWRB 2017b) noted the importance of specific legal boundaries within the standards, which are illustrated in the table on the following page. Workers need to understand the boundaries of confidentiality and how this can sometimes be in conflict with whistleblowing, can risk assess, gain informed consent, and know the current legislation on data protection and the freedom of information. These are separate standards of proficiency and will be addressed in more detail in the corresponding chapters in this e-book. The table gives you some examples of the specific legal statutes that you must comply with in your duty of care to service user(s). A duty of care is central to social care practice, it is a commitment to reduce the risk of harm to the service user, other professionals and yourself. You can learn more about your professional duty to care in Chapter six.

Boundary from Standards of Proficiency	Relevant Proficiency	Chapter in e-book	Example of R Understand
Data protection	D1 SOP 13	13	Data Protection
Freedom of information	D1 SOP 13	13	Freedom of In
Confidentiality	D1 SOP 14	14	Freedom of In 2014 Data Protec
Whistleblowing	D1 SOP 14	14	Protected Dis
Informed consent and capacity	D1 SOP 14 D1 SOP 15	15, 16	Assisted Deci
Risk assessments	D3 SOP 12	52	Safety, Health

From the date a Bill is signed into law by the President, the legislation is enforceable and as such social care workers need to know what the legislation states and how it can impact on their practice with others (Kenneally & Tully 2013). It is also important to know the current policies that are provided as a guide for health and social care professionals on how to comply with the legislation, for example Tusla's *Protected Disclosures Policy and Procedure: A Guide for Whistleblowing on Alleged Wrongdoing* (2016). Complying with the relevant legislation and the policy guidelines will underpin safe social care practice in each setting.

Ethical and Practice Boundaries

Current legislation and relevant policies, professional codes of conduct and ethics, taken together, will provide clear guidelines on what workers must and must not do. However, it is not always possible to have a rule or code to follow for every situation and experience in social care work and sometimes workers need to decide which 'right' or 'code' needs to take precedence. In these situations, professional boundaries appear liminal (Turner 1969), existing within the 'grey zones' of effective social care practice. The liminal grey zone exists because individual workers base their ethical decision-making on multiple factors including past experiences with the service user, and their own socialisation,

upbringing, cultural influences, norms and values. These practice decisions and/or ethical dilemmas need careful thought and reflection and sometimes adjustment, to ensure they remain ethical, legal and in the best interest of the service user (Cooper 2012). Read the discussion topics below and write down your own answer before you have a discussion with your peers.

TASK 1

You are on placement in a day service for adults with an intellectual disability and on your day off you meet a service user (Tom) on the bus. What are your boundaries for the following dilemmas? Please provide a rationale for your decision.

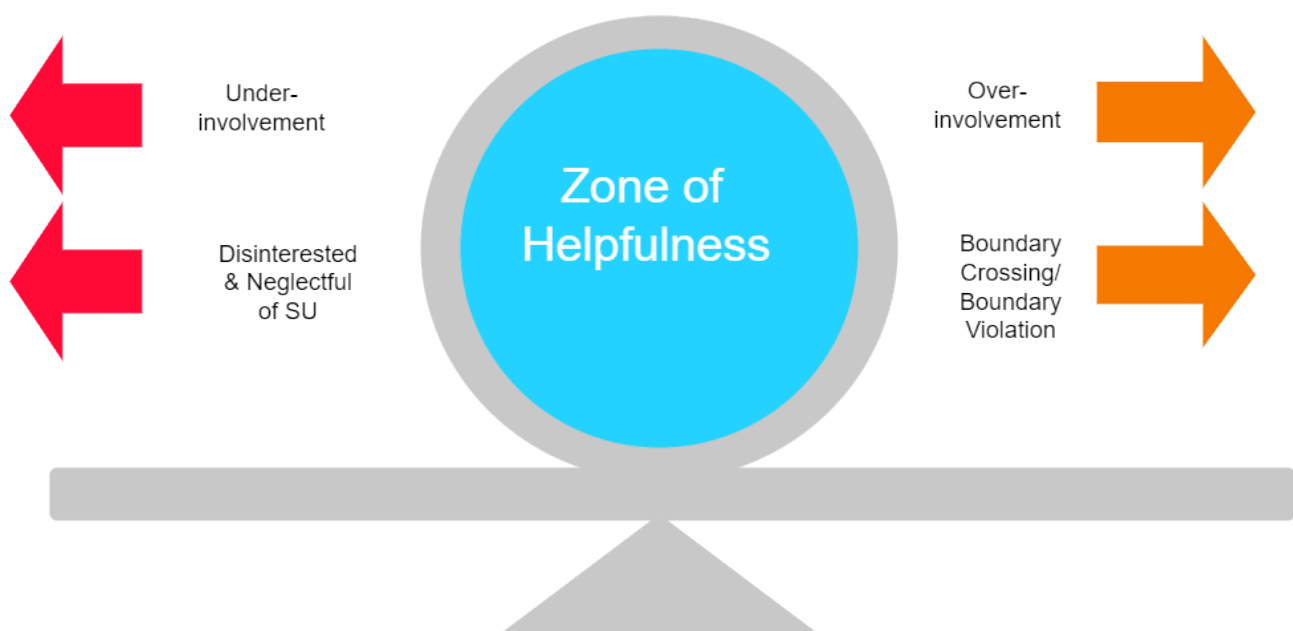
- (a) Tom gestures for you to sit beside him on the bus. Do you comply?
- (b) Tom knows the area and asks you questions about where you live. Do you answer truthfully?
- (c) You are both going shopping, and Tom asks if he can accompany you. Do you say yes?

Navigating the Grey Zone of Boundaries: the Zone of Helpfulness

The discussion topics above are examples of some of the first boundaries students need to navigate on their practice placement. Some practice educators will have clear guidelines to help students know how to respond to common ethical dilemmas, responses which will be caring and also protect the service user from harm. Care is not simply dyadic – within the relationship between the worker and the other person – but is ‘the concern of living, active humans engaged in the processes of everyday living’, a daily practice that is ‘aimed at maintaining and continuing our world’ and the world of others (Tronto 1993: 104). Biestek (1961) argues that a care ethic includes the values of acceptance, self-determination, confidentiality, individualisation and a non-judgemental attitude. These values are supported by two principles, a purposeful expression of feelings and controlled emotional involvement, which together form the seven principles

of practice, and guide the worker towards developing a relationship based on care and protection.

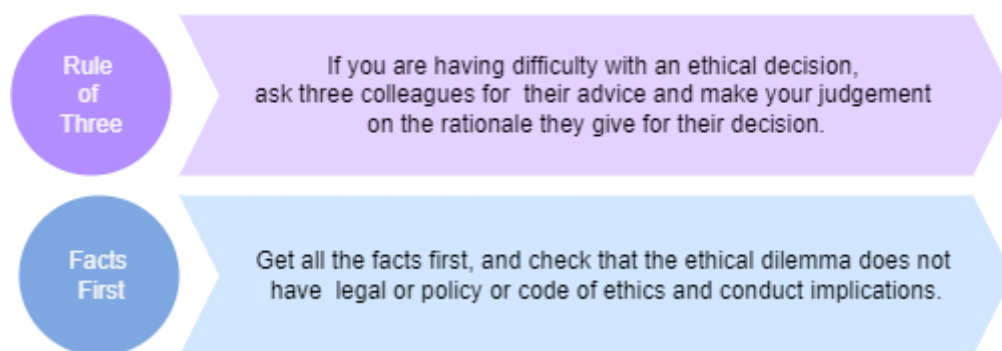
The continuum of professional behaviour is a framework designed originally to support nurses develop professional boundaries to navigate the grey zone of professional boundaries, and protect while providing care (NCSBN 1996). An adapted version of the *zone of helpfulness* framework is presented here as a guide for social care workers. This interpretation is different from the original; here the relationship is presented as central to our understanding of professional boundaries. The framework describes boundaries as existing within a continuum and the aim is to stay within the centre – the **zone of helpfulness** – where the boundaries are focused on what is best for the service user. The ‘healthy boundaries’ in the centre of the continuum (the zone of helpfulness), are consistent with a relationship-based approach, and provide protection within the experience of care. If the worker focuses too much ‘on what the boundary is, rather than why it is needed and how it is created’ (O’Leary *et al.* 2013: 135), they become **under-involved**. Alternatively, if they abuse their power, don’t comply with the codes of ethics and conduct or break the law, they are **over-involved**.



Autor-created diagram: Zone of Helpfulness

The zone of helpfulness is the space within the relationship between the social care worker and other, experienced when the service user feels heard, has personal autonomy, feels respected and understands how they are being protected by staff and the service. There is a clear understanding of what boundaries are in place to protect the service user and how and why they help.

Chapter 21 provides more information on the role of the relationship in shaping our professional boundaries and provides advice on how to navigate those difficult 'grey zones' through the use of the Davidson model, which will also help you to stay in the helpful zone. **Over-involvement** can happen when the worker is not aware of their power and influence in the relationship and also does not comply with the boundaries of safe practice. The Code of Professional Conduct and Ethics (2019) provides clear guidelines on what workers must not do or they will be in breach of their duty of care. Over-involvement can also include experiences when the worker is trying to meet their own needs through their relationship with the service user. The only way to develop good practice boundaries is to maintain an openness to continuing professional development, through a process of ongoing learning about yourself and your practice with others. Ormond (2014) conceptualises social care practice as an openness to learn by a worker who is constantly questioning the internal and external influences and limits on practice and self. 'Having an openness to learning is a prerequisite' to social care practice, 'the good enough worker never really reaches the point where they can say that they have arrived' (Ormond 2014: 262). As a lived experience, social care is about learning through relationships, and the magic that can happen within a social care relationship based on trust, safety and genuine care. It also about people, who they are, and how their life journey has influenced them in how they present themselves today. The following practices will keep you rooted within the zone of helpfulness.



Author-created diagram: Practices rooted within the zone of helpfulness.

Under-involvement happens when the worker, in trying to adhere to practice boundaries, has become emotionally distant from the service user. The worker can appear uninterested in the service user and not relationship-focused, can act with an extreme focus on rules, can appear inconsistent, detached and superficial. Social care work requires more cognitive engagement in the

'technologies of care' (Smith 2009: 9), and in indirect practices (Fulcher & Ainsworth 2012), including paperwork, risk assessments, behaviour plans and reports. An increased level of report writing is viewed as the main culprit for taking social care workers away from spending time with service users in children's residential care, and this may be an issue also faced by workers in different contexts (Mooney 2014). If time spent with the service users is not valued within the workplace, the worker may feel out of balance, distanced and separate from the service user, and incongruous to their care ethic. The responsibility to ensure that professional boundaries remain beneficial to the service user does not lie solely with the worker, but also includes the service, the regulators and policy-makers, as a shared duty to care. Social care workers need to talk to their line managers if they feel they are not able to spend quality time with service users to adequately meet their needs. The final sentence of the Code of Professional Conduct and Ethics (SCWRB 2019: 28) reminds social care workers to remember that we are accountable as autonomous practitioners, for what we do and fail to do. We also ask you to remember that as well as practising safely and effectively within the legal, ethical and practice boundaries, you will keep the relationship between you and the service user at the centre of your practice.



Tips for Practice Educators

Students learn about professional boundaries within the placement setting by the practice educator.

- Give the student specific legislation and policies to read and ask them to indicate how these laws and policies protect the service users in this setting.
- Give the student an ethical dilemma from your setting and advise them on what are the best responses to give.
- If you do not already have guidelines on typical practice boundaries, set this as a task for the student and ask your colleagues to become involved.

Learning to navigate the grey zone of professional boundaries:

According to social care workers in different services (Lyons 2017), it takes years of practice before they began to feel more comfortable and confident in their acquired skills and knowledge and feel they are doing 'effective practice' using their professional boundaries. Workers described these 'years of experience' as a rite of passage (Turner 1969), through which social care practice is 'learned', and the social care worker identity claimed. Think about your own daily practice and how you stay in the zone of helpfulness. What are the biggest challenges for you to maintain a relationship based approach in your practice?

Task for the practice educator:

What are the important practice boundaries you have learned that have helped you navigate the grey zone in your service?

Primarily, workers use their relationships with others as a gauge of their ability as a worker and of their identity. This includes one-to-one relationship feedback with service users, team meetings, peer feedback and regular supervision. People judge themselves based on how they feel others are judging them, especially if the 'others' are of value (Erikson 1968). As an experienced worker, in the role of practice educator, what you say, and how you say it, will have an impact on the emerging professional identity of the student or newly qualified member of your team. Think about the feedback you are about to give the student and ask yourself what important message you learned about professional boundaries from your own practice placement and early work experiences.

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Chapter 2 – John Byrne (DISOP2)

Domain 1 Standard of Proficiency 2

Be able to identify the limits of their practice and know when to seek advice and additional expertise or refer to another professional.

KEY TERMS

Practice
Relationship
Competence
Empowerment
Boundary
Duty of care

Social care is ... about positive change. It is using relationships to promote equality of opportunity. More importantly though, it is about confidently and selflessly using your knowledge and skills to help people to make choices and then to take as much responsibility as possible for themselves.

TASK 1

Take a moment to consider the following questions:

What exactly is social care 'practice'?

What skills and knowledge has your professional training/education given you?

Is there an overlap between social care and other professional disciplines? If yes, how do you decide where your role ends and theirs begins?

This proficiency is about knowledge, skills and competence. It is about knowing the boundaries of our practice and professional ability. Before we go further, it is important to have a clear understanding of what our 'practice' is. According to CORU (2019), social care is 'a relationship-based approach to the purposeful planning and provision of care, protection, psychosocial support and advocacy

in partnership with vulnerable individuals and groups who experience marginalisation, disadvantage or special needs’.

Relationship

In social care work, the relationship between worker and client is the foundation of everything (O’Connor *et al.* 2003). Its purpose is to help the client to assume as much control over their own life as possible and move toward independence. In practice, the social care worker is responsible for the development of the ‘relationship’. S/he does that in a way that is not doing something ‘to’ or ‘for’ the client, but rather in ‘partnership with’ them. Everything the worker does, involves both consciously and unconsciously, empowerment and support of the client, enabling them to take responsibility for themselves (as far as is practicable). Depending on their age and cognitive ability, for some clients that will involve decisions around fully independent living; for others, it will involve making decisions about what clothes to wear, or what food to eat.

The work is not ad hoc or informal but the product of structured assessments and interventions based on theoretical knowledge, and designed specifically to address issues of marginalisation, disadvantage and social exclusion. Irrespective of the client group, the model of practice is the same. Assessments are carried out, the client’s needs are identified and prioritised, and interventions are designed and implemented to ensure that the client’s needs are met (O’Connor *et al.* 2003). In keeping with the principle of empowerment, social care workers will only meet a client’s needs for them when they cannot or could not be reasonably expected to do it for themselves.

The social care worker is highly skilled in the ‘craft of care’, or the ability to notice the dynamics that play out in that relationship. S/he will typically have completed at least three years of personal development work and will have a highly tuned awareness of his/her own values, prejudices and emotional responses to people and situations. S/he will be aware of the imbalance of power in the relationship and will be trained to mitigate that by adopting emancipatory or anti-oppressive practice (Dalrymple & Burke 2006) and conveying a position of ‘unconditional positive regard’ (Byrne 2009); ‘a deeply held belief that all human beings are fundamentally equal. S/he will have a comprehensive theoretical understanding of human behaviour and social structures, and a basic training in counselling skills (Moss 2008). S/he will be adaptable to new challenges and situations and will perceive all human behaviour, no matter how bizarre it seems, as a form of communication.

The Limits of Our Practice

Knowing the limits of our skills and competencies in social care is important for several reasons, not least of which is because it is linked to our duty of care. If a worker makes a decision that is outside the realms of their professional knowledge and competence and they get it wrong, they could be in significant difficulty.

In tort (civil disagreement) law, negligence is judged by the extent to which an accused meets the standard of a reasonable person, or professional, in their care of another (Atkins *et al.* 2020). Where a duty of care is established and a professional could have 'reasonably foreseen' an issue, s/he has a legal responsibility to take action to ensure that the client comes to no harm. If the professional's actions (or failures to act) fall below the standard of the reasonable person, or professional (and the client suffers as a direct result of those actions/omissions), the professional may be found negligent in their duty of care and be held liable for damages.

A social care worker's personal liability for their practice is made very clear in Section 21 of the CORU *Code of Professional Conduct and Ethics* (SCWRB 2019), which states that workers must 'ensure that you maintain adequate professional indemnity cover for any assessment, intervention, treatment or service you provide or have provided'. That essentially means that if you make a decision and get it wrong, you could be sued, so you must have insurance to cover the potential liability. This is further re-enforced by Section 9(f), which states that workers should 'be able to justify any decisions you make within your scope of practice. You are always accountable for what you do, what you fail to do, and for your behaviour.' The problem is that the scope of a social care worker's practice is not that easy to define. A social care worker could reasonably ask: When does facilitating a client's daily exercise become physio or occupational therapy? When does providing psychosocial support become counselling? So how do we know when our practice has gone beyond our professional competence? According to Moss (2008), all human service workers provide a level of counselling on a continuum from soft to hard. At the softer end of the scale, teachers (for example) provide emotional support to anxious students at exam time; at the harder end of the scale, psychotherapists facilitate clients to explore deep emotional trauma. The challenge for the teacher is to know where one discipline ends and the other begins. In social care, we work with a wide range of people who present with complex emotional and psychological issues, so the boundary of our practice is even more difficult to define.

Case Study 1

John is fourteen years old and lives in residential care. After a violent outburst, he becomes very upset and tells social care staff how sad he is that his dad forgot his birthday again. He explains how conflicted he feels with his dad, as he loves and hates him at the same time. Staff listen carefully, conveying compassion and empathy, but wonder if this is beyond their competence and whether it is psychosocial support or counselling.

Every day social care workers make decisions that could be considered outside the realms of their professional competence. In the above example, if the worker does not provide the space for John to explore the issue, there is no learning for him. If s/he does, then s/he could be accused of exacerbating his sadness without the competence of a professional counsellor. If the boy harmed himself or absconded after that conversation, the worker might be asked to explain why they facilitated him to explore the issue. Of course, if we were to be overly concerned with that, we would not do the work, or our practice would be so restricted that it would be ineffective. In my 28 years in social care, I have never heard of a social care worker being sued for professional negligence, so do not panic. Just remember that your responsibility is to the client, but also to yourself and to your employer. If there is any doubt that your practice decision crosses into another professional discipline, you should seek (and take) advice from a qualified professional in that discipline before developing your style of practice or proceeding with an intervention.

Case Study 2

During the violent episode, John punched a wall, sustaining a minor laceration and bruising to his hand, which caused him some pain. The staff member was a former camogie player and had significant personal experience of such injuries. She thought John would be fine, but since she was not qualified to make that assessment, she brought him to the doctor. The doctor referred John to hospital for an X-ray, which determined that nothing was broken. Even though the social care worker's assessment was correct, the decision was outside her professional competence, so she was obliged to have it checked.

Case Study 3

Mary presented to a domestic violence refuge with her three young children having been violently assaulted by her partner. The social care staff had significant experience in this area and were very familiar with Mary's rights and entitlements. Having provided her with the relevant information, staff referred Mary to a solicitor for independent legal advice..

Case Study 4

Michael has Down syndrome. While he cannot live independently, he completes daily independent tasks as part of a community integration intervention. At a pedestrian crossing in the city one day, Michael waited for the green light but while crossing the road was knocked down and injured by a Garda car. Nobody had told Michael that emergency vehicles can go through red lights when their sirens are on.

We can see from the practice examples above that social care workers are constantly managing risk. In some areas, the boundaries of our knowledge, such as when the client requires medical or legal advice, are clearly defined; in other areas they are not.

Professional social care work is about risk assessment and management, not risk elimination. If we do not take any risk, our clients will never have new experiences and our practice will become oppressive and institutional. The challenge is to know exactly what you are qualified to do, and where the boundary lies between social care and another professional discipline.

The key is to trust your internal wisdom and make all decisions from a place of awareness and transparency. Make sure you are familiar with the practice within your agency and do not step outside that practice without consultation with a manager or senior staff. Having said that, you should also be aware that managers/agencies make mistakes too, and just because somebody else said a decision was okay does not mean that you are absolved of your personal liability.

Knowing when to seek advice

The first thing that comes to mind here is that you should not wait until you

are at the limit of your ability before you ask for advice. As a therapist, whenever I feel stuck, or think I 'need' advice about the work, I ask the client what they think would help. In my view, the most dangerous and unhelpful position the 'professional' human service provider can take is to assume that because of their training or education, they know more about the client than the client knows about themselves. Of course, that statement is dependent to some extent on the client's age and cognitive ability, but we should never underestimate the client's ability to know what they need.

I bring some knowledge and experience to my relationship with my clients in social care and psychotherapy. They do the same, and together we try to find solutions to issues that cause a barrier to their quality of life. Throughout that process I will remain open to advice and guidance in all its forms from a variety of sources. I will also use formal professional supervision and team discussion/reflection to its full potential.

Knowing when to seek additional expertise

As a humanistic/integrative therapist and social care worker, I have a bit of a reaction to the word 'expertise'. I do not see myself as an 'expert' on anything but myself. While I always value the input of people with additional knowledge, the suggestion that our clients' lives should be decided exclusively by those with 'expertise' does not always sit comfortably with me. Sometimes our clients need input from family, friends, community members and priests/spiritual advisers. Sometimes they need it from doctors, therapists and solicitors or experts in various other fields. Decisions on how/when to seek additional expertise should be made when there is either an impasse in the work that cannot be resolved internally, or when external input may bring a skillset to the intervention that is particularly useful. When seeking clinical input, it is important to remember, though, that another professional may provide a medical as opposed to a psychosocial response to a problem that may or may not be consistent with the ethos of your agency.

Case Study 5

John was a non-verbal 15-year-old with a moderate learning difficulty and retentive encopresis.

His bowel motions occurred once a week, causing him significant pain and discomfort, which manifested in aggressive challenging behaviour. Medical professionals recommended manual bowel evacuations and laxatives, but social care staff noticed that being in a swimming pool stimulated his bowel motions. Staff deferred acting on the medical advice and brought him swimming twice a week, which resolved the issue. They took a great deal of care to get him out of the water in time!

Knowing when to refer to another professional

As previously stated, social care work is about helping the client to take ownership of their own life: it is not about us. If we reach the stage with our client where we are not helpful, for any reason, then we owe it to them (and their family) to refer them to another worker/professional. It would be unreasonable to expect a social care worker to be 100% effective with all their clients all the time. The challenge is to have the awareness and maturity to know where your strengths lie, and not to let your ego get in the way of the work. If you are no longer helpful or need to pass a client on to somebody else, then it is your responsibility to do that. Controlled emotional involvement or over-enmeshment in the client's world can also be a reason for passing a client on. Carl Rogers said that in humanistic work the necessary elements of the helping relationship are genuineness, empathy and unconditional positive regard (Mearns & Cooper 2005). Empathy is viewing the client's world through their eyes as if it were your own, but without ever losing the 'as if' quality. Some social care workers believe that it is possible to finish work at the end of a shift and leave it all behind. I do not agree. When we care about, and work with, very vulnerable people, I have found that it is almost impossible to completely forget about them outside work. However, we should remember that a job is supposed to support your life; it is not supposed to be your life. When we become enmeshed in our client's world to the point where it begins to overshadow our private lives, or where workers have strong feelings for a client (love/hate/sexual attraction), we risk our judgement becoming impaired. If that happens and the issue cannot be resolved, we owe it to our client to pass them on to a staff member who can remain impartial.



Tips for Practice Educators

Many social care workers and students still struggle to articulate exactly what we do. This is partly why it has taken us so long to achieve public recognition and professional status. Now that we have a clear and concise definition for our work, it is important that our students learn and understand it, because they cannot know the limits of their practice, if they do not know exactly what their practice is. Students should be encouraged to:

1. Understand that professional social care work is far more complex than simply helping vulnerable people.
2. Deconstruct the term 'relationship-based work' and understand the importance of the dynamics in their relationships with their clients.
3. Understand their legal responsibility to their clients.
4. Understand that care, protection, psychosocial support and advocacy are the cornerstones of our practice.
5. Notice their position of power in the relationship with their clients and always aim to give the client as much control as possible over their own life.
6. Be very clear about when their practice could be perceived to cross into another discipline and use supervision and peer support wisely to take advice and guidance in that regard.
7. Understand that knowledge is an important prerequisite to professional practice, but a worker with compassion and little knowledge will be far more effective than a worker with knowledge and little compassion!

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Chapter 3 – Laura Doyle (DISOP3)

Domain 1 Standard of Proficiency 3

Be able to act in the best interest of service users at all times with due regard to their will and preference

KEY TERMS

Best interests

Will and preference

Rights-based practice

Human rights-based approach

Social care is ... the planning and provision of relationship-based care and supports to people who experience marginalisation and/or disadvantage in society. Relationships are at the core of what social care is and through the promotion of healthy relationships, human rights and advocacy, social care promotes and supports people to reach their full potential.

Best Interests

In social care we have the privilege of supporting a broad spectrum of vulnerable groups of people, from children and adolescents in residential services to people in direct provision, people with disabilities, people dealing with trauma, among many others. The people with whom we come into contact are deemed to be in need of support, and this support can manifest itself in many different ways. One of our main roles as social care workers is to help by asking what is in the best interests of the person who requires support. In social care we encounter the term 'best interests' quite frequently, but what exactly does it mean?

The term 'best interests' as a children's rights principle is derived from the UN Convention on the Rights of the Child, which states that 'the best interests of the child must be a primary consideration in all actions concerning children' (UN

1989). ‘Best interests’ is also used as a guiding principle in the Mental Health Act 2001: when making a decision under the Act, the best interests of the person shall be the main consideration. In the Irish context, there is no clear definition of ‘best interests’, which leaves the term open to different interpretations and applications. Walsh (2017) argues that in the legal landscape this has oftentimes led to the courts interpreting this principle in a paternalistic manner. There are many examples of paternalism embedded in Irish history, including the power that the Church held and its devastating impact on people who were placed in educational reform settings and Magdalene laundries ‘for their own good’; and the medicalisation of mental health and disability which led to people being put in institutional settings under the pretext of protecting them and protecting society, by limiting their own personal liberty and autonomy.

But how do we as social care workers determine what are the best interests of a person? Our own values and belief systems can at times influence our decision-making process in relation to care and support. Our own interpretations of best interests could be derived from our own values and beliefs. Our personal values and beliefs can influence our decision-making in many areas of our lives, including our career. Reflective practice can play a vital role in allowing practitioners the space to reflect on these important issues and to critically analyse the role that our values and beliefs might play in our practice. Determining the best interests of a person should not be done in isolation. Best practice would be to include as many people as possible who know the person well and have developed relationships with them. The person receiving support should be involved and included in the dialogue and understanding of what is in their best interests. They should be at the centre of this person-centred approach to their care.

Task 1

Think about your life and what changes would happen (if any) if someone supporting you were to act in your ‘best interests’?

Will and Preference

The proficiency states that as social care workers we need to have due regard to the will and preference of the service user. But what is meant by a person’s

‘will and preference’? Will and preference, like best interests, remains undefined. However, it can be interpreted as how a person wants to live their life and the preferences they have in relation to their personal life choices. These vary from person to person and often change over time. ‘Due regard’ means having the proper care or concern for something. In the context of the proficiency it means that, while working in the best interests of the person, we as practitioners need to properly consider and take into account the will and preference of the person receiving support and to ensure that as far as is practicable these are upheld and respected.

Will and preference, as a term, can be found in the UN Convention on the Rights of Persons with Disabilities (CRPD) (UN 2006). The adoption of the CRPD was a momentous occasion as it formally recognised disability as a human rights issue and reaffirmed that all people with disabilities should enjoy all human rights and freedoms. In Ireland, the introduction of the Assisted Decision-Making (Capacity) Act in 2015 was a monumental step towards recognising the right of all adult citizens to make decisions about their own lives. This Act, once fully enacted, will see the presumption of capacity afforded to all adult citizens regardless of mental health diagnosis, disability or other diagnosis. Under this Act we must presume that all adults have the capacity to make decisions, whether or not we feel they are the right decisions.

How do we as practitioners determine a person’s will and preference? Building relationships is key. Discovery is a process in person-centred planning whereby a person’s goals, wishes and dreams are established using a variety of tools that are individualised to suit the needs of the person. The discovery process is the starting point to building relationships and establishing trust with the person. What if the will and preference of a person is in conflict with what is in their best interests?

It is important that practitioners reflect on these scenarios and seek the appropriate support and guidance.

TASK 2

How would you support a person if their will and preference would impose a risk to that person’s safety or wellbeing?

Questions for a social care worker to reflection when looking at the best interests and will and preference of a person.

Best Interests

What are the person's best interests?

Are these best interests agreed upon by the person and/or others?

Are the rights of the person respected and upheld at all times?

Am I fulfilling my professional obligation to this person?

Will and Preference

What are the person's goals, wishes and dreams?

How does the person want to live their life and what is needed to support this?

Does the person's will and preference pose a risk? If so, what can be done to minimise this risk?

TASK 3

Please reflect on the questions (Best Interests) and (Will and Preference) and apply them to the case study below

Case Study 1

Marian is a 55-year-old woman who lives in a residential home for adults with intellectual disabilities. She smokes 20 cigarettes a day; she has smoked since she was 18 and has negatively responded when asked to stop. Marian continuously gets chest infections and other health complications relating to smoking. Marian's doctor has advised that she needs to quit smoking for the good of her health. It is in Marian's best interests to stop smoking; however, her will and preference is to continue. As Marian's social care worker, how would you support Marian in the context of the proficiency 'be able to act in the best interests of service users at all times with due regard to their will and preference'?

Human Rights-Based Approach

In recent times there has been an emphasis on a human rights-based approach to care in Ireland. The Health Information and Quality Authority (HIQA), in conjunction with Safeguarding Ireland, has developed a guidance document on a rights-based approach, *Guidance to Support a Human Rights- Based*

Approach in Health and Social Care Services, which was partly funded by the Irish Human Rights and Equality Commission (HIQA 2019). As practitioners, we operate within the legal parameters of service and support provision. It is imperative that we know, and are aware of the importance of knowing, the rights of the people we provided support to and to ensure that support and interventions are delivered in a way that is respectful of these rights.

According to Curtice and Exworthy (2010), in a human rights-based approach to care the clinical processes, organisational practices and culture of a service support and protect the human rights of people who use the service. It is 'the process by which human rights can be protected by adherence to underlying core values of fairness, respect, equality, dignity and autonomy, or FREDAs' (Curtice & Exworthy 2010: 150). It is important that we as social care workers understand these principles and are able to apply them to our practice.

While operating in a practice in which we must act in the person's best interests, with due regard to will and preference, we must, as practitioners, be cognisant of the rights of the person and ensure that we are not working in a manner that means these principles are not respected or promoted. Equally, we must be cognisant of our obligations to people who receive support to promote their safety, health and wellbeing at all times and take all reasonable actions to support these.

Figure 2: Awareness of our own values and beliefs play a vital part in supporting an HRBA and supporting the will and preference of a person.



Author-created diagram: Key components of ethical and rights-based decision-making.

TASK 4

How would you promote and support a rights-based approach in practice?

It is important as practitioners that we are aware of our value system and are cognisant of imposing that same value system on others. For example, if a social care worker values health and healthy eating they must be careful not to impose

their values on others who might not share similar values or beliefs. One of the ways we do this is through our reflective practice. Values are not stagnant – they can change over time – which is why it is important to continuously reflect on our own values and how they might influence our practice. Equally we must be aware of our own limitations in defining what is in the best interests of a person, the person themselves and the people who know the person well. Determining what is in a person's 'best interests' should not be done in isolation; it needs to be a collaborative approach with the person involved, as much as is practicable, and at the centre of all discussions.

Discovering the 'best interests' and the 'will and preference' of a person begins with establishing a relationship with the person in order to learn more about them. This process can take time and should be done at a pace that the person is comfortable with. This relationship needs to be genuine and built on trust in order for the person to respond positively to the process and to engage with you as a practitioner. As social care workers we will come across difficult cases, ones in which the will and preference of a person could be in direct conflict with what is deemed to be in their best interests. In these cases it is imperative that the dignity and rights of the person are upheld at all times and that the practitioner is aware of their own legal obligations.

TASK 5

Think about and reflect on your own values. What would you do if you were supporting someone whose value system was different from your own?



Tips for Practice Educators

Students will need to reflect on their own interpretations of what 'best interests' means to them. This can be done through the student reflecting on their own values and beliefs. One tool which can be useful to use is the coat of arms, a tool whereby the student reflects on what is important to them and puts this into their own coat of arms. The student should then be encouraged to think about situations in which they are supporting someone whose values and beliefs are in conflict

with their own: how would they respond? The importance of diversity should be highlighted to show how our values and beliefs are often in conflict with those of others and that as practitioners we need to be able to respond appropriately in these situations and be aware that we do not impose our own values and beliefs on others in the context of best interests.

A key requirement for understanding and applying this proficiency is the student's understanding of the role that relationships play when determining the best interests and will and preference of the person they are supporting. Students need to have a clear understanding of their own interpretations of best interests and how this can influence their decision-making. Reflective practice and a collaborative approach are key to implementing this proficiency in practice. Students need to have a thorough understanding of this and to be able to use these approaches in practice.

Relationships are also key to helping a practitioner discover the will and preference of a person. The discovery process can be used to support relationship-building and to help determine a person's will and preference. The discovery process for person-centred planning can be applied to a wide variety of settings and the various tools used to support the process can be applied in relationship building with the person. The coat of arms, the circle of support and my perfect day are just a sample of tools that can be adapted and individualised to suit each person. Students should have an understanding of person-centred planning and the various tools used in this approach to inform other areas of their work and to help support relationship-building.

Person-centred Planning Tools

Coat of Arms – A tool to support a person to think of what means the most to them in their life, what they truly value, and to design their own coat of arms around this. The person is supported to draw and reflect on their values and why they are important to them. Available from <https://www.nga.gov/content/dam/ngaweb/Education/learning-resources/lessons-activities/greco-roman-myths/coat-of-arms.pdf>.

Circle of Support – A tool which maps out all the people in the person's life. This tool can be also used as a great learning tool to support boundaries and different relationships. Available from <https://www.mentalhealth.org.uk/sites/default/files/a-guide-to-circles-of-support.pdf>

My Perfect Day – A tool used to facilitate a conversation about what constitutes a perfect day for the person. This helps the social care worker establish what is important for the person and also to identify some of the person's goals, wishes and dreams. <http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/>

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Chapter 4 – Imelda Rea (DISOP4)

Domain 1 Standard of Proficiency 4

Be aware of current guidelines and legislation relating to candour and disclosure.

KEY TERMS

Standard
Candour
Disclosure
Relating
Connecting
Being
Aware – Up
to date
guidelines
and
Legislation

Social care is ... a delicate balance of *holding on and letting go* when caring for the whole person, family, or group at any or all stages of life's continuum. When prevention or intervention is required, it is not just a *doing for others* process, but an *enabling of others* from a non-judgemental strengths-based perspective.

TASK 1

Describe a recent experience when you had to speak openly and honestly but the topic made you feel uncomfortable. Why was this conversation needed?

Standard

Before we consider how we can improve our awareness of guidelines and

legislation we should begin with a clear understanding of the meanings of key terms used to guide us in standard 4, specifically **candour** and **disclosure**.



The online Cambridge Dictionary defines candour as *the quality of being honest and telling the truth, especially about a difficult or embarrassing subject* and disclosure as *the act of making something known or the fact that is made known*. In my practice in social care, the term disclosure has come to be used most often in relation to a child or vulnerable adult revealing abuse perpetrated on them. In other words 'disclosure' is what others do, while we, the worker, receive the information. Given that specific circumstance, we would be correct in this thinking. However, when the social care professional is ready to report what has been entrusted to their care, how and to whom they disclose the information is of equal importance: their retelling of the information must be candid, accurate and honest, especially about something difficult or painful.

TASK 2

Consider a time when the most appropriate response to a situation is to withhold or provide inaccurate information. How can you justify this?

Candour and Disclosure

Candour in social care is a more general term. It helps to provide the full picture of the event and an opportunity to evaluate and learn from this. Candour should be ever-present in the culture of the organisation. It is important for social care workers to examine the culture of their service to ensure that they do not find

themselves in a negative workplace where blame and defensive tactics are the standard response to an incident. Historically, this was common in many workplaces and the lack of candour in documentation left its own scars. The current requirement of transparency, and supportive practices such as professional supervision, enable openness and honesty to thrive and barriers to be broken down. Considered together, candour and disclosure are tools to help us focus on and improve the culture in social care organisations and to build stronger and more equal relationships with people who use social care services.

Case Study 1

It is the last hour of the final day of a week-long summer camp for inner-city pre-teens. Youth worker Jane (pseudonym) is beginning to pack away sports equipment when Seamus (pseudonym), who had said he was tired today and did not want to take part in the physical activities, begins to help Jane with the packing.

When they are both at one side of the sports hall, they sit down for a short break. It is then that Seamus discloses information about a serious physical assault by his mother the previous day. He raises his sleeves to reveal fresh bruises along the length of both arms. Seamus begins to cry when he states that his mother will collect him at the end of today's camp.

Jane reassures Seamus that she can help him and begins to implement the protocol for child protection, when Seamus's mother arrives. Jane tells her that Seamus is part of the 'clean- up team' and they have not finished yet, so she should wait outside – this is not true, but it provides the time needed for additional support to arrive.

Jane was not comfortable with telling this lie, but felt it was acceptable under the circumstances.

Registering with CORU and adhering to the Code of Professional Conduct and Ethics requires you to maintain high standards of conduct and to act in the best interest of the service user. Those on the register are required to *'do everything, insofar as within your control, to enhance the health, safety or welfare of a service user ... protect service users if you believe they are or may be at risk from another professional's conduct, performance or health'*.

Relating/Connecting

Mistakes can happen in any place of work. In social care, if a mistake occurs, by accident or through an act or omission, it is the social care worker's professional

duty of care to report it. Policies in the organisation should both facilitate and prevent obstruction of such reporting.

The value of candour is significant. Even in well-managed services things can go wrong, e.g., losing an individual's belongings, providing incorrect information, misuse of equipment or not acting quickly enough on concerns raised by an individual. Actions or inactions may result in consequences, ranging from minor to more serious, with possible long-term implications for those concerned.

Candour links with our duty of care; we demonstrate respect to our service users by being honest, open and transparent when something goes wrong. When we inform others of our failures or wrongdoings, despite the negative impact an accident, omission or incident may have on the individual, their family and others, an honest, open disclosure and acknowledgement of the error can enable a better resolution and faster rebuilding of confidence in the service and staff, while also providing valuable learning to ensure that similar events do not occur in the future.

Being Aware – Up to Date

Being aware of current information relating to this standard of proficiency is difficult at this time. Much has been achieved by CORU in professionalising the role of the social care worker, but legislation in relation to candour and disclosure has yet to proceed beyond the medical healthcare arena, e.g., the **Civil Liability (Amendment) Act 2017** provides a legal framework for voluntary open disclosure of all patient safety incidents, including near misses and no-harm events. It provides for an open and consistent approach to communicating with patients and their families and offering an apology, as appropriate, when things go wrong in healthcare. In 2018, the government approved the general scheme of the **Patient Safety Bill**, for **mandatory** open disclosure and external notification of patient safety incidents; clinical audit guidance; and extending the remit of the Health Information and Quality Authority (HIQA) to private hospitals.

In the medical healthcare professional setting, the much-publicised cases of misdiagnosed cervical smears, and the subsequent delay in informing those affected, shone an intense light on the lack of candour and disclosure for those affected. The lack of timely information limited, for many women, the option to act earlier to attempt to mitigate their situation, proving life-changing for many, and in some cases life-ending.

Social care professionals must consciously embrace the ethos of candour and disclosure in their practice to ensure that their clients, service users, co-workers and others are not negatively affected in any way by the absence of candour and disclosure in the culture of the organisation and must be prepared to engage in open and honest dialogue if a mistake should happen.

Guidelines and Legislation

Similarities between how the United Kingdom and Ireland have progressed in this area are clear. Presently, however, there is no social care-specific legislation in Ireland on this topic. Students would be well advised to look towards the UK and European legislation to gain an insight into how Irish legislators may be guided when legislation of this kind is considered for enactment in the Republic of Ireland. The UK has legislated for candour and disclosure in both medical healthcare and social care. The duty of candour is specified in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and applies to any organisation carrying out healthcare and/or social care activities that are regulated by the Care Quality Commission.

While there is currently (as of 2021) no Irish legislation on the topic of candour and disclosure in social care specifically, there are a number of guidance and legislative documents that require and promote candid disclosure of information. These include (but are not limited to):

- Safeguarding Vulnerable Persons at Risk of Abuse
- Children First Act 2015
- Children First Guidance 2017
- Protection for Persons Reporting Child Abuse Act 1998
- National Vetting Bureau Acts 2012 and 2016
- Freedom of Information Act 2014
- Data Protection Act 2018
- Safety, Health and Welfare at Work Act 2005
- Accident and incident internal/external reports
- Specific organisational reports.

With reference to information students may be required to make available to placement providers, employers or for professional registration, at no time should students misrepresent their qualifications or abilities. On completion of

the appropriate degree and subsequent registration, much consideration should be given to the personal accountability the acquisition of professional status will have on the individual and those in their care.



Tips for Practice Educators

As the student progresses through their educational journey, it is important to stress at all stages of your interaction with them that today's guidelines and legislation (requiring learning and assessment and exam recall) will be updated and added to. They will change with the times. What will not change will be the requirement to be aware of such changes.

The long-awaited professionalisation of social care rests on their shoulders – they must uphold the standards of proficiency in their chosen field – and on ours, as tutors and lecturers, to help guide the student to reach their best professional self.

Students' ability to understand that it is they who will be the 'professional' in the care sector on completion of their degree, should be tested formally and informally in a safe space to allow them to make mistakes and learn from them. The lecture hall/college and placement are the learning spaces in which to firmly grasp the concept of their co-responsibility in upholding these standards. However, once in the workplace the student's understanding of the requirement for candour and disclosure should be almost innate.

One important term in Domain 1 Standard 4 is to be 'aware'; this awareness is required throughout the lifetime of your practice. Continuing professional development should run in tandem with continuing personal development. Students will benefit from a fuller understanding of where they are in terms of standards of proficiency and year of study. Supervision preparation further emphasises accountability of their role, whatever the entry level into the workplace. As the majority of guidelines, codes of ethics and conduct and legislative information can now be accessed online, encouraging students to sign up to newsletters/emails from reputable sources, e.g., the Health and Social Care Professionals Council (CORU), the Health Information and Quality Authority (HIQA), the Health Service Executive (HSE), etc. will go some way to keeping the student informed of significant changes and the impact changes have on candour and disclosure in their work area.

Promoting, in IT classes, the correct archiving systems for such documents can help students to easily access and update them when required.

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Chapter 5 – Catherine Carty (DISOP5)

Domain 1 Standard of Proficiency 5

Respect and uphold the rights, dignity and autonomy of every service user including their role in the diagnostic, therapeutic and social care process.

KEY TERMS

Human rights-based
Approach
Respect
Rights
Dignity
Autonomy
Participati
on

Social care is ... about supporting the children and families we work with to bring about changes in their lives. It is about working with them to identify areas for change, in order that their lives can be the best they can be. As a social care worker, it is not about being their friend or their confidante, it is about being the person they can trust to hear them, to acknowledge their ability to be self-directional in their own lives, to empower them to participate in decisions which affect them and finally to work with them (and others) to find solutions.

Introduction

Social care workers work in many different settings – with children and young people, families, children and adults with disabilities, adults in homeless or addiction services, in day, residential or community-based support services. Regardless of the sector, or setting, we have a professional responsibility to respect and uphold the rights, dignity and autonomy of every person we are working with. This is particularly important with regard to involving those we are supporting in their assessment of need and subsequent diagnosis or work plan. It also relates to facilitating the meaningful participation of our clients in the therapeutic interventions we engage in as part of a professional social care

process. This Standard of Proficiency dovetails with others in this publication, but specifically Domain 5 Standard 3 (Chapter 64) and Domain 5 Standard 13 (Chapter 74). You might find it useful to read this chapter in conjunction with Chapters 64 and 74. In exploring this Standard of Proficiency, this chapter will draw on the Health Information and Quality Authority (HIQA) 2019 publication *Guidance on a Human Rights-based Approach in Health and Social Care Services*. Additional support material will be included and will be supplemented by case examples and tasks for practice.

TASK 1

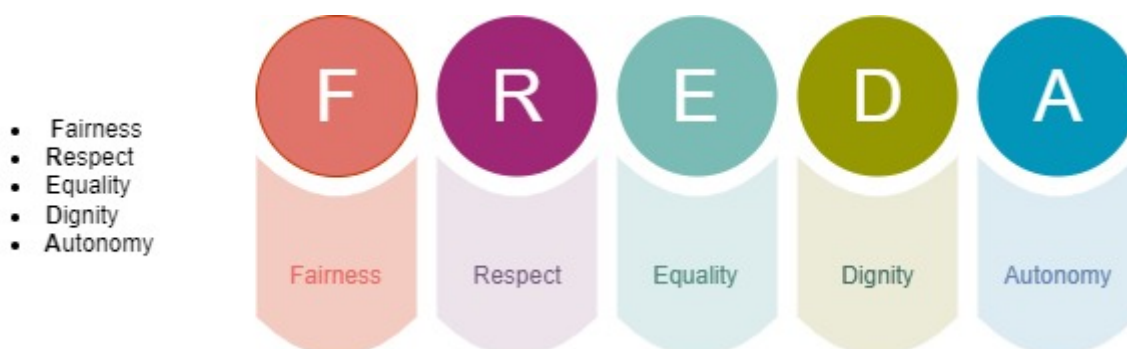
Read the journal article Fitzgerald et al. (2020) 'Translating a human rights-based approach into health and social care practice' in the Journal of Social Care, available at <https://arrow.tudublin.ie/jsoc/vol3/iss1/>

Throughout my career, starting as a social care worker in the 1980s to being employed on the Social Care Programme with Limerick Institute of Technology, I have experienced enormous change in the professional landscape of social care practice. I began working at a time when young people were still cared for in industrial schools, where adults with disabilities were cared for in large, congregated settings, and when there was scant involvement with children and families within their own communities. Giving young people, families and others we worked with a voice in decisions that affected them was the exception rather than the norm. Today, we have moved to a place where the rights and autonomy of those we are supporting is underwritten by legislation and where staff and advocacy organisations facilitate their voice to be at the centre of their care and support. Through increased regulation and the impending registration of the social care profession, this standard of quality practice is now a requirement and, through its delivery, will aim to ensure better outcomes in the lives of those we are working with.

Human Rights-Based Approach

A human rights-based approach is the cornerstone of inclusive practice. 'Human rights are about people being treated with fairness, respect, equality and dignity; having a say over their lives and participating as fully as possible in decisions

about their care and support' (HIQA 2019: 7). While there has been an increased focus on the importance of working from a rights-based approach, it is perhaps more of a challenge to understand and apply this approach in practice. There are many justifications for practising with an inclusive rights-based approach. First, it supports person-centred care and support, which ensures those receiving services are at the centre of the decision-making process.



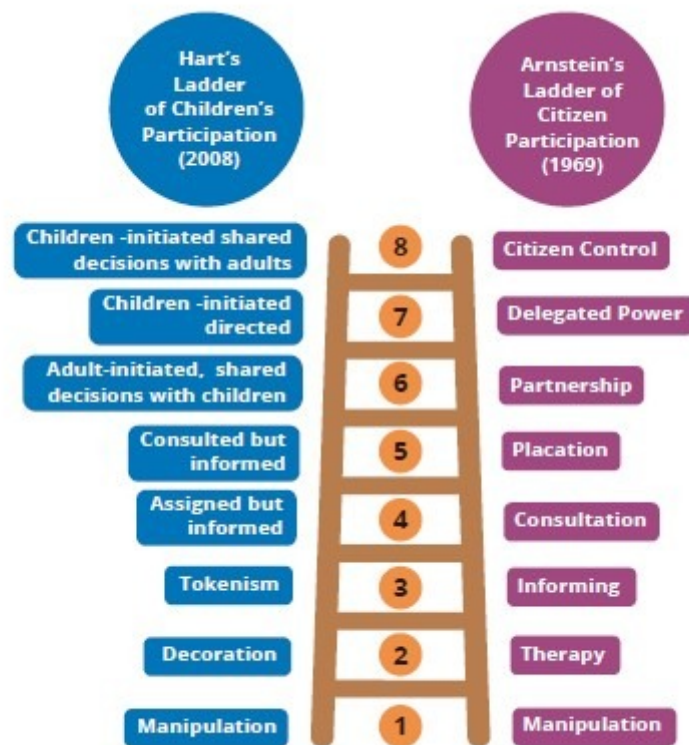
Author created diagram: FRED A principles

Second, it is a professional requirement of the Social Care Workers' Code of Professional Conduct and Ethics, a code all social care workers will be bound by following registration of the profession (SCWRB 2019). Third, it is enshrined in law. The legal frameworks informing and underpinning policy directives in the state place a responsibility on organisations and individuals to 'uphold the human rights of people using their services' (HIQA 2019: 9). A useful framework for exploring how a human rights-based approach can be used in practice is to apply the five FRED A principles (Curtice & Exworthy 2010).

Fairness

Fairness, in the context of a rights-based approach to practice, relates to ensuring that the person receiving the service is at the centre of all decisions made regarding their care and support. Fairness reinforces the core beliefs of equality and autonomy, making sure that the decision-making process is just and free from discrimination. Fairness in our practice can be promoted by providing relevant information. Not everyone can access and understand information relevant to their care and support. Therefore, it is incumbent on us in our practice to provide information that is easily accessible to the people we are supporting. They may need help in understanding the information, the processes or

procedures, or the context in which the information is shared. Providing all the relevant information in a way that is accessible to those we are working with will support their ability to provide informed consent to participate in the service we are offering them. People we are supporting have a right to access information about their care and support. To facilitate this, systems should be in place, within services, for service users to access their personal information.



Author created diagram: A comparative visual representation of Hart's Ladder of Children's Participation (2008) and Arnstein's Ladder of Citizen Participation (1969).

This is particularly the case for those clients who are hard to reach or engage. Examples include, but are not limited to, young people with offending behaviour, people in active addiction, members of ethnic minority communities, etc. We must be creative in how we share information with everyone we are supporting, in a way that is easily accessed and understood. This also goes for gaining their consent to participate in social care processes or exercising their autonomy to not engage. Because someone is hard to reach, or not engaging in support services, this does not negate our responsibility to find ways to fully involve them

when decisions are being made about their care and support. All information shared with us should only be used for the purpose it was given, as per current GDPR regulations. In following these regulations, we are obliged to seek permission from those we are supporting, if we are required to share that information with others. People using social care services should never hear from a third party that their information has been shared without their permission.

Fairness, underpinning the way we work with service users, also includes facilitating them to give feedback on the service they have received, which is invaluable to an organisation. Depending on the experience, however, it may be challenging to hear. We need to be mindful to build in mechanisms to our work with service users that enable them to give feedback without feeling that it will negatively impact on their re-engagement with the service. A cornerstone of a rights-based approach is the participation of those we are working with in all decisions regarding their care and support. It is incumbent on us, as social care workers, to seek out opportunities to facilitate the involvement of those we are supporting. One tool to support you to apply this in practice is Hart's ladder of participation (Hart 1992).

Sherry Arnstein initially devised the ladder of participation in relation to citizen engagement and public participation in the USA. Roger Hart later adapted the ladder to make it applicable to children's participation and published a seminal text in 1992, which was published by UNICEF. (There is a link to this text in the following practice task.) There are some differences between the two ladders, as you would expect, given that one was aimed at the participation of the general population and the other was aimed at children and young people's participation. The main differences between the two approaches are: Arnstein identifies steps 1 and 2 as non-participation, while Hart proposes that steps 1-3 are not meaningful participation. Hart's steps 4-8 refer to different degrees of participation, while Arnstein suggests that his Steps 3-5 are tokenistic involvement with citizen power represented in steps 6-8. The ladder of participation is a useful tool for appraising the levels of service user participation within the organisation you are working in (Arnstein 1969; Hart 1992).

Case Study 1

Where Fairness was practised Liz has an intellectual disability and lived at home with her father until his death. As there were concerns that Liz might not be able to live independently, she was placed in a residential centre. Liz was unhappy in the residential centre and expressed her wish to live independently in the community. Her support team worked with her to put a support plan in place. Liz took part in all discussions about her options and managing risks. She was provided with all the relevant information and training she needed to ensure she understood the choices available to her and could actively participate in the decision-making process regarding her care. After extensive work with Liz, she was supported by staff to move back into the community 12 months later. She now lives independently and receives six hours of support per week. (For other case examples, please see HIQA 2019: 21).

Task 2

To demonstrate fairness in your practice

- Look again at Hart's ladder of participation. You can read more about the different stages of participation here: <https://www.unicef-irc.org/publications/100-childrens-participation-from-tokenism-to-citizenship.html>
- Think about someone you are working with on placement (or in practice).
- Can you identify where the involvement of that person is on the ladder?
- Can you think of a situation where they could be more actively involved in decisions about their care?
- Record what steps you could take to rectify this.
- When completing your practice intervention on placement, consider including an evaluation sheet for your participants, in order to encourage feedback on your piece of work.

Respect

HIQA suggests that 'respect is shown in the actions towards a person by others and can be demonstrated by communicating in a courteous manner', which helps those we are working with to 'feel valued through taking time to get to know them as a person and not as a number or a "condition"' (HIQA 2019: 25). Showing respect for the people we are supporting is central to providing care and support and is demonstrated in an objective and unbiased way having regard for the person's rights, values and beliefs. Demonstrating respect for those we are working with can be shown in the way we communicate with them. This begins from the first time we meet them, and continues in introducing ourselves and sharing what our role is in the organisation. In our communication

with service users, we respectfully check and re-check their understanding of what is being said, without using jargon or technical language. Cooper says that the social care sector is 'full of initials, shortenings, technical terms and language that enables professionals to talk about service users and issues quickly and easily' (2012: 59). However, while we may be familiar with the technical terms or abbreviations, using them with service users when these are not part of their everyday language only serves to alienate them and perhaps make them feel inferior.

Demonstrating respect in practice takes account of the person's wishes, will and preference for the way they want to live their lives. Gaining knowledge of these entails 'being present' while listening to the person we are supporting, and not following our agenda of how we want them to engage with the service. While being mindful of the person's personal safety and that of others, it is incumbent upon us to support the service user to achieve their personal goals, through the way they want to live their lives, and the relationships they want with those who are important to them.

Where respect was practised

Liam is a new resident in a residential centre for older people, where he has chosen to live. When he meets a new member of staff, they introduce themselves to him. The staff learn about Liam's background, including his love of painting. When staff speak to Liam, they always address him by his first name, as he has requested. They ask Liam if there is anything else that would help him settle into the centre. Liam asks for photos of his family and for his paintings to be displayed around his room. The staff support Liam in picking out and displaying the photos and paintings he would like to keep in his room. Staff have taken the time to get to know Liam and his preferences and have respected his request for access to his possessions. (For other case examples, please see HIQA 2019).

TASK 3

To demonstrate respect in your practice

- Think about how you greet service users you are working with on placement.
- Do you greet them using their name?
- Do you introduce yourself to them and tell them what your role in the organisation is?
- Do you tell them what will happen when they are in the service?
- Do you offer them refreshments – tea, coffee – when they arrive?

- Think about how you can change the way you greet service users, while being more respectful of them as people.
- Make a list of the steps you could take and try them out when next meeting a service user.

Equality

HIQA describes equality as ‘people having equal opportunities and being treated no less favourably than other people on the grounds set out in legislation’ (HIQA 2019: 32). In the Irish context, these grounds are: age; civil status; disability; family status; gender; membership of the Traveller community; race, colour or nationality; religion; sexual orientation. Therefore, when we ensure we are mindful of equality for all in our practice, we ensure that no one is discriminated against because of their status or characteristics. Some may need additional support to access services in order to achieve the best possible outcomes from the care they receive.

This is achieved through communicating clearly with those we are supporting, in a way that they can understand, regardless of who they are or their communication ability. This may entail adapting our communication style or that of our organisation to be inclusive of everyone. It may mean using different media, besides written material, to provide information to service users. It may also mean adapting policies and other formal material to include graphics and/or making them available in different languages, depending on who may be accessing them.

Being equitable in our practice also means adapting where, when, and how we meet with service users, in order that they are not disadvantaged on the basis of accessibility to, or participation in, services. In doing this, we must be mindful of their ability to make decisions which are right for them, regardless of their age, sexual orientation, race, colour or nationality, status, disability or membership of an ethnic minority. It is our responsibility to remember that discrimination occurs when someone is treated in a different way from someone else in a similar situation, or where people in very different situations are treated the same.

Case Example: Where equality was not practised

English is not Nadia's first language, and she often chooses to bring her friend, who speaks fluent English, with her to healthcare appointments to interpret and ensure she does not miss any important details. On one occasion, Nadia had a hospital outpatient appointment. However, her friend was not available to attend the appointment with her. Nadia phoned ahead to ask for an interpreter for the appointment but was told by the clinic secretary that this would not be possible. Nadia felt discriminated against and that no attempt was made to access an interpreter for her. As a result of not having an interpreter, Nadia did not understand everything that was discussed with her and her ability to make an informed decision was compromised. (For other case examples, please see HIQA 2019: 37).

TASK 4

Practice Task: To demonstrate equality in your practice

- Think about how someone whose first language is not English might access your service (or your placement site).
- Unless English is not your first language, this is a difficult task, so try to imagine that Polish is your first language and that you understand very little English.
- When trying this task, go out of the front door of your building and enter it again.
- Look around you to see if you can read anything or see a graphic for anything that makes sense to you. (Remember that you understand very little English.)
- Is there a welcome sign in Polish?
- Are there any graphics that indicate you are welcome in the building?
- Make a list of the pieces of information that you would need to be able to access this service if you were a service user with very little English.
- Try to action some of those thoughts in order to not disadvantage anyone from accessing your service.
- Consider who are the people who use your service.
- Do some have literacy issues?
- If so, perhaps think about working with them to adapt critical policy documents in order to make them more accessible to everyone, including graphics where appropriate. These could then be left in the service for others to use.
- Also think about signs or graphics for the entrance and throughout the building. These could be in different languages, laminated and easy to change as needs be.

Dignity

According to HIQA, dignity means 'treating people with compassion and in a

way that values them as human beings and supports their self-respect, even if their wishes are not known at the time' (HIQA 2019: 38). Dignity is fundamental to upholding people's human rights and all human rights are connected to human dignity. When people are treated with dignity and respect, it helps them to trust the people working with them and feel safe. When service users feel safe within a service, the likelihood is that the working relationships can be improved, potentially resulting in better outcomes. When there is a lack of dignity in how we work with those we are supporting, this can result in feelings of insecurity, guilt, shame, worthlessness, anger, frustration, lack of confidence, inadequacy and reduced motivation. These feelings can also be replicated in the staff team. Therefore, showing people dignity in how we work with them is imperative to them feeling valued and respected.

This is achieved through meeting their basic needs of, for example, food, clothing, and personal care. For those who are coming to the service for the first time, this would include showing them where the bathrooms are and where they can get a cup of tea (if possible). When working with people with disabilities, or those who may need assistance with their personal care, it is imperative that this is carried out while always respecting the privacy of the service user. It also means not discussing a service user's personal history or information within earshot of others, even if those others are colleagues. Private matters should be discussed in private spaces. This requires some planning. When meeting with a service user, make sure a private space is available. When walking to the private space, try to engage in chit-chat rather than beginning the business of the visit, and wait until you are in the private space to discuss private issues.

When speaking with service users, it is crucial that we use the person's name and gender pronoun when engaging with them, or participating in a meeting with colleagues about them, whether they are present or not. To really demonstrate dignity when working with service users, it is important that we give them the time to share some of their life with us. In fact, it is a privilege if they do. By giving time, we can find out who are the significant relationships in their lives and aspects of their culture or heritage that are important to them. If someone we are supporting is non-verbal, we should work hard to learn from others, including family members, as to their preferences, communicating with them directly, and striving to learn from them what their likes and dislikes are. Through this knowledge, we can adapt the way we support them, so they feel safer, more included and are more able to participate and direct their care.

Case Study 4

Case Example: Where dignity was practised

Fiona is pregnant and has started to experience depression. She has been referred to a midwife with mental health expertise in her local maternity hospital. Fiona does not want others finding out about her depression. The mental health midwife ensures that her privacy is respected at all times. When Fiona is called for her appointment, although the room is a few minutes' walk from the waiting area, the midwife ensures they are in the consultation room and cannot be overheard before they begin talking. (For other case examples, please see HIQA 2019: 43).

TASK 5

Practice Task: To demonstrate dignity in your practice

- Watch the video in the following link: <https://www.scie.org.uk/dignity/care/videos/choice-control> (NOT WORKING)
- Make a note of what you learned from watching the video.
- Think about the service users in the service you are working in, or are on placement in.
- How can you adapt your practice in order to transfer some of your learning from the video to your work with the people you are supporting?
- Prepare some notes from your learning to bring to your next supervision session.

Autonomy

Autonomy refers to 'the ability of a person to direct how they live on a day-to-day basis according to personal values, beliefs and preferences'; in a health and social care setting, 'autonomy involves the person using a service making informed decisions about their care, support or treatment' (HIQA 2019: 46). Cooper advises that 'clients have a basic right to decide on and consent to their treatment and how to live their life' and may choose to 'behave in dangerous, unhealthy or unsafe ways' (Cooper 2012: 44). This may be a challenging path to navigate for staff and students alike. Therefore, while we can try to use our skills to persuade them to take a different path, we cannot force them to do things they do not want to do. The exception to this is if service users are in danger of hurting themselves or others.

For us to facilitate our service users in demonstrating autonomy in relation to their own care, they may require different levels of support to assert their

autonomy and make their own decisions. Key to this is providing, through meaningful communication, all the information they require to make a fully informed decision. It then becomes our duty to accept their decision, whether or not we agree with it, believing that our service users have the right to make a decision that may appear to us to be unwise. If we have provided all the supports necessary to help them make an informed decision about their care and treatment, we then have to take a step back and support their choice, respecting the person ‘as the expert on their own life’ (HIQA 2019: 26).

Case Study 5

Case Example: Where autonomy was facilitated

Jane has a physical disability and had been living in a residential centre. However, she wished to live at home. Following discussion and assessment, her support team in the residential centre felt that this was not ideal, as she was considered to be a person with high needs. Jane and the team discussed this, and she understood and agreed that she would not receive the same level of care at home that she would have in the residential centre. Jane’s wishes were respected, and she was supported to take a measured risk. This was not about discharging Jane from the service, but about supporting her to transition from the residential centre and continuing to provide her with care in a different setting. Staff supported Jane in exercising her autonomy by understanding and respecting her will and preferences and supporting her to live independently. Staff communicate with Jane on a regular basis to make sure that her new living situation is working well for her and identify any additional supports that she may need. (For other case examples, please see HIQA 2019: 52).

TASK 6

Practice Task: To facilitate autonomy in your practice

Think of a situation in practice, where your view would be different from your service user’s, in relation to their best interests. Consider what are the risks and benefits for the service users if their wishes are supported. Think about whether there are risks for the organisation if the service user is supported with their decision. Weigh up the risk and benefits to the service users. In supervision, explore this dilemma with your supervisor (practice educator) to see how best the service user could have their needs met through being supported with their decision.

Summary

This proficiency explores how you respect and uphold the rights, dignity and

autonomy of every service user, including their role in the diagnostic, therapeutic and social care process. This can be achieved through keeping those we are supporting at the centre of their care, while providing them with all the information required to help them make decisions in relation to their care and treatment. This should be done with respect, dignity and acknowledgement that individual people are best placed to make these decisions about their lives.



Tips for Practice Educators

Throughout this chapter there are tasks and activities to help students engage with this proficiency. Ask students to relate the tasks to your service



Tips for Social Care Educators

To support your teaching and discussion of this Standard of Proficiency with your students, perhaps review HIQA's dedicated online resource (HIQA 2019), where you will find an academic slide deck that you can download and use with your students. The guidance document that was used as the framework for this chapter is included there and contains additional exercises and reflections for students to engage in. You can also find a link to a human rights-based approach training programme, delivered by HSE LanD, which your students might find helpful. The link to the training is available at HIQA (2019).

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Chapter 6 – Lisa Hanlon (DISOP6)

Domain 1 Standard of Proficiency 6

Be able to exercise a professional duty of care

KEY TERMS

Duty
of care
Code
of
conduct
Learni
ng to
care
Self-
care

Social care is ... about the everyday moments. We are there with people, sometimes every day, not just at times of crisis. An activity which may appear mundane to someone else can be a significant piece of work for someone we work with, from preparing a meal to going to a medical appointment or making a phone call. Sometimes just being there and being present when 'nothing' is happening is the time when the 'magic' happens!

Defining Duty of Care

In CORU's *Standards of Proficiency for Social Care Workers* (SCWRB 2017) there is an expectation, under Professional Autonomy and Accountability, that graduates will exercise a professional duty of care. Legally, this means that you should not harm those to whom you owe a duty of care by your acts or omissions. Failure to do this could mean you are liable due to negligence (Hinds n.d.). As a professional you owe a duty of care to the people you support, your colleagues, your employer, yourself and the public interest. Kline and Khan (2013) describe this as the interconnected duties of care, which include the employer's duty of care to patients, the employer's duty of care to staff, the staff duty of care to themselves and to each other and the staff duty of care to patients. The staff duty of care to themselves is expanded on further in the section on self-care below.

One way to ensure quality in how you care for others is to be aware of the standards of your profession. This may involve attending relevant training and keeping your skills open to direction and supervision. According to the Code of Professional Conduct and Ethics, hereinafter referred to as the Code (SCWRB 2019), you must ensure that your knowledge, skills and performance are of a high standard. Your skills must be kept up to date and you should also participate in continuing professional development (CPD). High standards have become the norm in many social care settings as we have become accustomed to HIQA inspections.

Safeguarding is a common element in our work. According to the Code, you must risk assess and 'take any steps needed to minimise, reduce or eliminate the risks you identify' (SCWRB 2019: 21). It can be challenging to maintain the balance between, on the one hand, keeping people safe and, on the other, protecting their freedom of choice and opportunities to live a rewarding life. This can be particularly difficult if we feel we know best. We should be aware of paternalistic tendencies, and according to the Code, unless we know otherwise, we must assume that service users have the capacity to make their own decisions, even when we doubt that their decision is the best choice (SCWRB 2019). Gallagher and Edmondson (2015) caution against an overly managerial approach with over-regulation and over-recording, which could impede 'wise' social care. Wise social care, rather than best practice, prioritises sustaining warm relationships, flexible judgement and compassion. Standards are upheld, but not at the expense of core values and ethical considerations. A further standpoint to consider is the 'dignity of risk'. Perscke (1972) coined the phrase in relation to the benefits of risk taking and its consequential learning and development, as opposed to detrimental overprotection. Discussing risk with those you care encourages skilled conversations, shared decisions and the acknowledgment of individual differences (Marsh & Kelly 2018).

Professional experience: I was working with a lady who lived alone. She had severe epilepsy and had also spent long periods of her life in a large mental institution. I worked as part of a community support team and we made twice daily visits to support her with daily tasks. One day, when she was at home alone, she fell during a seizure, causing a head injury when she banged her head off the edge of the washing machine. The injury required staples but she was otherwise okay. My first reaction was to make adjustments to her home to make it safer as I was concerned about hard edges and corners. She was later offered the option to have foam padding added to edges of furniture and surfaces. She declined the padding because, following her years of institutional care, she was very house-proud. She acknowledged that she could have further falls, but she chose to live

with a certain amount of risk. We supported her choice to have her home look as she wished.

TASK 1

Reflect on how you would feel if someone you work with chose a course of action that you feel unsure about rather than one you feel is better and safer for them. How would you deal with this?

My response to the task:

Assuming that the person has the capacity to make the decision put before them, support them to understand the options. Be creative in supporting them to view the situation from various perspectives. When their decision is made, respect it and support them. It is our role to support the person to understand the risks and possible consequences rather than remove or limit the choices. There is risk to things we all do every day; sometimes things do not go well and we deal with the consequences. People will not get the chance to learn and develop if they do not get to try new things. What are we protecting them from here? Serious dangers? Or are we trying to protect them from making mistakes, learning from their mistakes, experiencing hurt feelings and having regrets? Should they not feel these things? We are not alone in our work; there are other professionals we can talk to about our concerns. We can share our reservations with a colleague and make sure we are there to support the person if things do go wrong.

Overview of Code of Professional Conduct and Ethics

CORU's *Social Care Workers Registration Board Code of Professional Conduct and Ethics for Social Care Workers* (SCWRB 2019) specifies the standards of ethics, conduct and performance expected of registered social care workers. It is part of our duty of care to read and understand the Code, which outlines what is expected of us as professionals. Misconduct or poor performance could result in professional misconduct or disciplinary action under a fitness to practice investigation. Breaches of the Code can happen through things you do or things

you neglect to do (omissions). This places a greater onus on us as professionals to be aware of professional standards: ignorance is not an acceptable defence. The responsibilities outlined in the code are grouped into three categories: conduct, performance and ethics.

TASK 2

Read the Code of Professional Conduct and Ethics (www.coru.ie/files-codes-of-conduct/scwrb-code-of-professional-conduct-and-ethics-for-social-care-workers.pdf). (NOT WORKING) Pay attention to the twenty-seven responsibilities specific to social care workers under the headings Conduct, Performance, Ethics and Responsibilities.

Learning to Care

We can learn about caring by observing others. It is useful to have positive role models in your place of work. Look for experienced staff who have a good rapport with the people you work with. Try to observe the interactions they have with others and later have conversations with them about why they acted or reacted in a particular way. It helps to be self-aware and take time to examine how you have reacted to situations on placement or in work. It is an advantage to keep an open, questioning mind. This is relevant in terms of duty of care because it benefits the service user, the people with work with and ourselves. No matter how much experience or expertise we gain, we will never know it all, people will always surprise us and will always have something to teach us. We are not, and should not aim to be, all-knowing beings. We need to have a curious mind along with an appetite to keep learning. A mindset that is open to new ideas and ways of working helps us work well with others and avoid getting stuck in a rut.

TASK 3

Think about a time you may have reacted strongly to something while on placement or at work. Why does this situation still come to mind? Thinking of a colleague you admire, how do you think they might have reacted in that same situation? How does this differ from your reaction? What can you learn from this for the future?

TASK 4

Suggest incorporating an exercise into team meetings to promote questioning minds. Every month, ask a different team member to tell the team about an article they read, documentary they came across, podcast they heard about a novel approach relevant to your setting.

Our duty of care can sometimes be evident in the everyday attention to detail in our work. Even though we often spend time on daily tasks that may seem mundane, they present opportunities for purposeful practice. This ensures that there is a therapeutic element to what we are doing. This approach supports positive change for those we are working with. Garfat and Fulcher (2013) identified these everyday moments as opportunities for interventions as we get to observe the ways people can get stuck in ways that perpetuate their struggles. By being there and spending time with people as they live their lives we can support them to discover ways to act differently, which could free them from destructive ways.

Self-care

Our duty of care is not solely about safety. Care can also refer to kindness, to others and to ourselves. Regular self-care routines should become part of your practice and not just something you think of in times of crisis. To take care of other people, you have to take care of yourself; otherwise you start running on empty. As your own wellbeing grows, the more able and likely you are to be patient, supportive, empathetic and loving. This is not just something nice to do; it is expected of us as professionals. The Code states, with respect to addressing health issues related to your fitness to practise, that you must look after your physical, emotional and psychological health.

Taking care of yourself influences others as we impact on each other in our interactions. Helping others helps you; helping yourself helps others. Similarly, harming others harms you; harming yourself harms others. Purposefully invest in self-care practice – take a break, do some exercise, take some time for yourself – and then notice how this affects your relationships. Notice how healthy boundaries in relationships help prevent you getting angry and eventually needing to withdraw. In a way this links to interconnected duties of care (Kline &

Khan 2013) referred to earlier, as staff teams that experience workplace violence, which leads to burnout and emotional exhaustion, have reported that these conditions lead to poorer service delivery (Keogh & Byrne 2017).

Minding yourself and being actively aware of how and when you participate in acts of self-care can be overlooked or dismissed. We need to prioritise ourselves and get into a routine of taking care of ourselves all the time, not just when we are feeling stressed. As trained professionals, we possess many skills but sometimes we can feel stuck, unsure of what to do next or as if things are just getting on top of us. It is important to know our own limits and to recognise when we need help. According to the Code of Professional Conduct you must 'act within the limits of your knowledge, skills, competence and experience' (SCWRB 2019). We often encourage help-seeking behaviour in those we work with, but do we practise this ourselves? Asking for help and advice should be viewed as a strength no matter what stage of your career you are at.

As well as incorporating useful exercises such as relaxation techniques into your life, it is important to look after yourself physically in terms of sleep, diet and exercise. Prevention of burnout is important enough that you need to take active steps to prevent it. Burnout is 'continuous and repetitive emotional pressure that takes place while workers try to maintain close relationships with people for long periods' (Choi & Kim 2015: 583). Burnout can be prevented and mitigated against when you do things such as acknowledge the emotional toll of your work, have self-awareness in relation to your emotional reactions, take responsibility for your wellbeing and develop protective strategies such as setting boundaries between the self and the professional role (Molloy 2019; Keogh & Byrne 2017).

A friend of mine who worked in quite a challenging environment would find it hard to get work out of her head when she got home. She decided to do something to clearly 'switch off work mode'. She began a new routine of changing out of her work clothes and having a shower while singing loudly to music. She sees this routine as shaking off work and becoming herself again, and she then finds it easier to push thoughts of work from her head. For other people it might be walking the dog, going for a swim or just sitting with a cup of tea. It should be something that you can do or access easily so that you can slot it into your routine easily. It also needs to be done with the intention of self-care and de-stressing.

Mindfulness and breathing techniques are useful skills. They can be used to calm your mind before an important meeting or event, or as a way to de-stress after work or quieten your mind when you are trying to sleep. There are numerous books, apps, courses and classes you can take to learn more. Here is an

example of a de-stressing breathing technique from Padraig O'Morain, an Irish mindfulness coach:

- Become aware of what your mind is saying, in other words of your thoughts at this moment.
- Breathe in through your nose while silently counting to four.
- Hold your breath for another count of four while imagining it is filling your head with calm and smoothing out any physical tension.
- Breathe out to a count of four while imagining the calm flowing through your body.

Self-care Tips

- Know your limits and know when to ask for help.
- Look after yourself physically, get enough sleep, eat as healthily as you can and do some physical activity at least three times a week.
- Find a relaxation exercise that suits you the best. They can all work equally well. Walking, petting or just spending time with your pets can be calming.
- Develop a routine to fit at least one technique into your day (at whatever time you prefer) to practise it.
- Use something in your environment as a reminder to fit relaxation into your day (e.g., when you wake up, after you finish shift handover, when you arrive home, before you go to sleep).
- Get outdoors: getting outside is great for exercise and fresh air. You can explore the idea of 'mindful walking'. Leave your phone on mute and go for a walk where you really take in and notice the sights, sounds and smells around you, focus on these things and keep pushing thoughts of work or negative thoughts out of your head.
- Stimulate your senses: different things work for different people. Maybe your way to relax is to light a nice candle and just sit for a few minutes taking in the aroma and watching it flicker. Try to do this, just concentrating on the candle. Avoid making to-do lists in your head.

These activities will not remove the problems from your life/work, but they do teach you to calm your thoughts and practice moments of relaxation or mindfulness, which can help with the anxiety caused by stressful experiences. Over time, as you use a relaxation exercise (e.g., breathing exercise, gentle stretching, mindfulness) every day, you can expect to get better at the skill.

TASK 5

Complete a self-care plan. You can design one yourself (or use the sample one at the end of this chapter). Try using headings to see where you need to focus most attention. Note down what stressors may be making you feel anxious or burnt out. Then look at the wellbeing activities you incorporate into your life. For example, under the heading Physical, you might list Eat healthily most of the time; Get enough sleep; and Take regular exercise. Next, what do you do to take care of yourself emotionally? Do you write a diary, paint, take time to be alone and think, use breathing techniques, spend time with your pet, practise mindfulness, have someone to talk to? What do you do socially? It is important to do things with other people and to nurture our relationships. Do you regularly phone or video chat with a friend, have date nights with your partner, visit family, be part of a club or group? If you are already doing these things, make sure that you prioritise them and recognise them as self-care. If you are not doing anything like this, ask yourself what is standing in your way and what you can do to make it happen. Be patient and kind with yourself, start off small and build up. If your self-care practice falls by the wayside a bit, just pick it backup again – don't abandon it.

My self-care plan

Stressors in my life:		
Things I do/will do to care for myself physically	Things I do/will do to care for myself emotionally	Things I do/will do to care for myself socially
What is preventing me from doing more self-care activities?		
What will I do to overcome these barriers?		



Tips for Practice Educators

A main requirement for achieving this proficiency is the student's understanding of their responsibilities in terms of their duty of care. Knowledge of the Code is important. Students need to be aware how and where to access this information and should be conversant with the contents.

Risk and risk assessment usually features in discussions on duty of care. Although this is a vital piece of work to cover, it should be balanced with the needs and rights of the person we are working with. We strive to keep people safe but also support people to develop and live as independently as possible. Interesting conversations could be had on duty of care versus dignity of risk/therapeutic risk.

Caring for others involves respecting them and this begins with the care and self-respect we show ourselves. We must not merely pay lip service to the notion of self-care but actively encourage it. Students should be self-aware and able to identify the stressors in their lives and the steps they routinely take to counteract them. Personal self-care plans are a useful tool for students to identify their own personal wellbeing story. This is an important step to have in place before students start on placement and should be something we check in with them about, perhaps as part of a checklist for preparedness for placement. Incorporating self-care into our practice is a good way to model for the people we work with. We are showing them how we actively care for ourselves even when we feel well and healthy, not as just a reaction to crisis or illness.

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[publication/](#)

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Chapter 7 – Charlotte Burke (DISOP7)

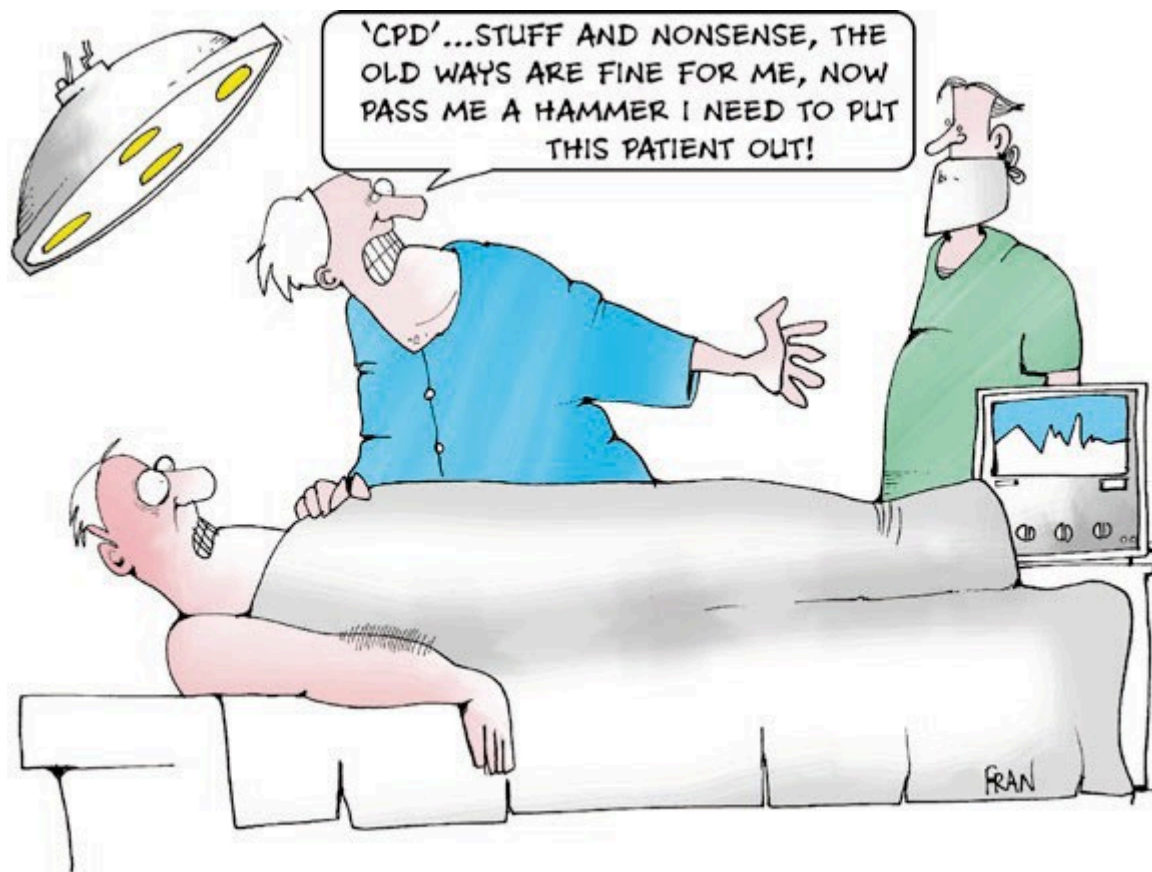
Domain 1 Standard of Proficiency 7

Understand what is required of them by the Registration Board and be familiar with the provisions of the current Code of Professional Conduct and Ethics for the profession issued by the Registration Board.

KEY TERMS

CORU
Registration
on National
Health And
Social Care
Professions Office
Fitness to
practise
Code of
professional
conduct and
ethics

Social care ... has many facets within our communities. Primarily, social care workers endeavour to support the most vulnerable persons in our society, to be active citizens and seek the right to adequate supports to live a life of their choosing. We need social care workers to build a trusting relationship; to really understand, what it is like to walk in someone else's shoes and to advocate for the right to a life, not just be satisfied as passive recipients of services. The principle of social justice is fundamental in social care work.



CartoonStock.com

Source: Cartoon by Fran, from CartoonStock. Used with permission.

After many years of striving for professional recognition, we as social care professionals are finally reaching our goal – registration. This is an exciting time for us and more importantly for our service users, as we navigate the journey. The Code of Professional Conduct and Ethics provides a safe framework for our practice, within which we, align our decision-making ability with high standards of service provision. Registration is part of our professional identity as social care workers and it strengthens our status and contributes to professional confidence. Continuing Professional development (CPD) should be embedded in our practice and we need to embrace it and be motivated to learn and upskill as professional social care workers.

CORU

CORU was established by the Health and Social Care Professionals Act 2005

(as amended), (HSCP Act) to protect the vulnerable public – by introducing statutory registration for health and social care professionals. The role of the Health Information and Quality Authority (HIQA), established under the Health Act 2007 – is to monitor the safety and quality of health and social care services. These two pieces of legislation have led to statutory registration and regulation of health and social care professionals and service providers. Both CORU and HIQA have a statutory obligation under each Act and are duty bound to act in line with the legislation.

CORU is Ireland's multi-profession health and social care regulator. All health and social care professionals who, are subject to registration by CORU, and once registered, you are subject to the Code of Professional Conduct and Ethics, which requires you to include your registration number on any official records.

The HSCP Act 2005 (as amended) established registration boards for the seventeen professions designated in the Act. These professions were originally: clinical biochemist; dietitian; medical scientist; occupational therapist; orthoptist; physiotherapist; podiatrist; psychologist; radiographer; social care worker; social worker; and speech and language therapist. Five professions were added later: optician and optometrist (added when the Optical Regulator was amalgamated into CORU as the Optical Registration Board); counsellor; psychotherapist; and radiation therapist.

TASK 1

Go to the CORU website www.coru.ie and look up the current social care registration board members. Who is the current chair? How many professions are currently registered by the designated board?

The registration boards are overseen by a council, which is responsible for governance and strategy; a representative of each of the seventeen professions sits on the council. The Social Care Workers Registration Board established on 27 March 2015 by the then Minister for Health – Leo Varadkar, is also subject to the HSCP Act 2005 (as amended). It is important to understand that standards set by the Registration Board must be taken into account for Social Care Workers' future practice. The board sets a threshold for safe practice, although most registrants will be practising well and above this standard.

The Social Care Workers Registration Board (SCWRB) is an autonomous body.

CORU's; Council, the Registration Boards and the Executive, together have the powers to make bye-law's, which must be legally enforceable and upheld by the High Court. The SCWRB had the final say, after a public consultation process, in the final Code of Professional Conduct and Ethics for Social Care Workers 2018. We will go into this in more detail later on.

What's In A Name?

The social care profession has evolved over many decades and has various identities, depending on where you work and what service you provide.

As a social care worker for nearly twenty years, this title was retained in the service I worked for, and it is my professional identity, however, this was not the case for everyone. In social work, for example, irrespective of the setting, the professional title of 'social worker' does not change. The social care profession began when industrial schools were phased out in the 1970's. Social care practice was born out of the need to address the serious deficiencies in these large children's centres (Lalor and Share 2013). The *Report on Reformatory and Industrial School's Systems* (1970), chaired by District Justice Eileen Kennedy (the Kennedy Report), recommended that staff engaged in childcare should be professionally trained. There was a shift to smaller, community-based residential settings and increased recognition of the need for training for those providing care and support to children.

As social care practice started to diversify, so did the professional representative body. Noel Howard speaks about a meeting of the Association of Workers with Children in Care (AWCC) in 1976, as a 'sea of black', such was the dominance of religious orders in the profession at the time (Howard & Lyons 2014). The AWCC became the Irish Association of Care Workers (IACW) as the field of childcare developed into community childcare throughout the 1970's. As social care began to emerge as a distinct profession involved in the wider provision of care, for example in the disability services, the IACW became the IASCW (Irish Association of Social Care Workers) (*Curam Magazine* 2012). In 2011, social care educators, managers and workers came together to form Social Care Ireland, officially launched by Minister Frances Fitzgerald, as the professional representative body for the social care profession in Ireland (Howard *et al.* 2014).

The Kennedy Report's recommendation to close large institutions in favour of smaller community- based settings, was pivotal in the evolution of the social care

profession. The roots of the title 'social care worker' as we know it today could be argued to have come about due to the industrial unrest of the 1990's and the subsequent Labour Court ruling that included new grades for childcare workers/ house parents. People working in the disability services also came to be known as social care workers. The title was coined by Damien McClelland in a Joint Committee and was adopted in 2001 following the Labour Court judgement that fixed pay grades, which led to significant pay increases, in some cases as much as 33% (Lalor *et al.* 2013).

There was increasing recognition of the value of professional training in delivery of care, and that employment of social care workers has expanded beyond traditional employment settings, such as children's residential settings, into community-based services. As these roles evolved within communities, so did a plethora of titles. Social Care Ireland conducted a study titled 'Registration Awareness Study' available on its website: (www.socialcareireland.ie). A mixed method approach was used with 726 participants completing an online survey, followed up by 16 semi-structured interviews. The report's findings revealed nearly 80 different titles; other than social care worker; but the only title protected by the HSCP Act is 'social care worker'.

TASK 2

Go to the Irish Times website (www.irishtimes.com) and find and read this article; 'Cork women to face criminal charges of falsely claiming to be therapists', Sunday, 9 February, 2020.

Registration Process

Once the register for social care workers is open, there is a two-year transitional period (known as grandparenting) during which you can apply to register. Only those who are registered may use the title of 'social care worker' when this transition period ends. To be eligible to apply to register, you must either hold an approved qualification, or qualify under the grandparenting (transitional) provisions within the Act. This means that you must be able to demonstrate two years' practice in the previous five years on the date the register opens. You must have a schedule 3 qualification listed in the Act; or a sufficiently relevant qualification; or successfully complete an assessment of professional competence (AOPC). The AOPC is an additional route for social care workers to

apply to register during the transitional period allowed for by the Act (Section 91 Subsection 2). The applicant must have two years' continuous practice on the date of application and must be, in the opinion of their employer, competent in the practice of the profession.

The registration process involves a number of stages and can take some time depending on the volume of applications. New graduates with an approved qualification tend to get on the register between eight and twelve weeks following receipt of all required documentation. Therefore, it is recommended that you start gathering this information and be prepared. You need to complete an online application and submit supporting documents. Then there is an e-vetting process. When all documents have been received and verified, the Board delegates authority to the register to put standard applicants on the register once verification is complete. The Board makes decisions on non-standard applicants. The Board must grant registration if the eligibility criteria set out in legislation are met.



*Author-created diagram: '8 Steps to CORU Registration' outlines the registration process. *Certified Copy Policy: To certify a photocopy of an original document, a Solicitor, Commissioner for Oaths, Notary Public or Peace Commissioner must sight the original document and the photocopy of the document at the same time. The certifier will provide a signature, stamp and date on the photocopy which confirms that the photocopy is a true copy of the original document. (CORU website 2020) <https://coru.ie/health-and-social-care-professionals/registration/how-do-i-apply-for-registration-/apply-for-registration/>*

It is your responsibility to apply to the Social Care Workers Registration Board, as the registrant, to engage and demonstrate that you meet the eligibility criteria to register with CORU. Most importantly, you cannot use the title of social care worker after the transitional period, unless you are on the register of the Social Care Workers Registration Board. CORU can take enforcement action where an individual is using a protected title and is not registered with the designated Board. As can be seen from the 'Irish Times' Article in the task box above, this is vital for public protection, to ensure that the public are using the services of appropriately qualified and competent health and social care professionals.

National Health and Social Care Profession's Office

Another important body for all social care professionals is the HSE's National Health and Social Care Profession's Office (HSCP's). This service was established under the 2005 Act to offer support, e-learning modules and access to conferences. It also provides an opportunity for interdisciplinary networking opportunities, where different professionals can share information and learn from each other. As a social care worker, and one of the designated professions in the 2005 Act, you have access to the supports offered.

TASK 3

Who is the current lead of the National Health and Social Care Professional's Office?

You can access more information on this resource on the HSCP hub on HSELand

(www.hseland.ie)

Why Is Registration Important

Registration of Health and Social Care Professionals (HSCP's) is important where there is a potential risk to the public that cannot be mitigated by any other action; except statutory regulation. The purpose of statutory registration is to protect the public. Professions that are designated by legislation to register; benefit from the protection of their professional title. Protecting the use of a title, means that when a member of the public uses the services of a registered/regulated professional, they know that a registrant's qualification has been

independently substantiated. Regulated professions are also subject to the Code of Professional Conduct and Ethics applicable to that profession.

Fitness to Practise

The primary aim of CORU is to protect the public. One way of doing this is having a fitness to practice system. This enables CORU to investigate complaints received about a registered professional relating to poor professional performance, misconduct and/or health concerns, which may result in a fitness to practice hearing. During a Fitness to Practice hearing, evidence will be heard from all sides involved. A determination will then be made as to whether a complaint is justified, whether a sanction should be imposed and an agreement to the nature of that sanction. In serious incidents, a professional may be struck from the register and will no longer be entitled to practice, or they may have other sanctions put in place, such as increased supervision or be temporarily suspended. Most importantly, it does not replace the existing complaints procedures that exists with your employer.

That is why it is imperative that you have read and understood the Code of Professional Conduct and Ethics. It formalises the boundaries of your practice as a social care worker. That is why it is so important for you to stay within its remit of accountability, confidentiality, and decision making. Basically, you need to be able to stand over your work and the Code gives you the parameters in which to do that.

Read the case studies in this chapter on your own and answer the questions. A sample answer to each question is provided at the end of each example.

Case Study 1

A panel from CORU's Professional Conduct Committee heard that a social care worker had posted comments regarding a current case on her Facebook page. These comments had become public and had received significant media attention. The social care worker fully accepted responsibility for her actions; however, she said that she believed these comments to have been private to her Facebook friends and that she had been experiencing a high caseload with a lack of support or supervision, which had impacted on her. The committee found that the facts proved amounted to misconduct in that her actions fell seriously below the standards to be expected of a registered social care worker. While her fitness to practice was remediable, the panel determined that she had

not taken actions to address this. Further, the panel concluded that she continued to apportion responsibility to others rather than accept full responsibility herself. The committee issued conditions of work practice, including supervision by a social care worker line manager registered by CORU; and required her to provide details of this supervisor to CORU and to inform the council immediately if leaving this position and/or further disciplinary procedures.

(Adapted from the Health and Care Professions Council, UK (www.hpc-uk.org/).)

Answer

The standard the registrant breached falls under confidentiality and subsequent failure to understand the nature of her action. This registrant did not act in the best interest of the service user or respect their confidentiality and privacy. Accountability for your decision-making is a fundamental principle that underpins all codes of professional conduct and ethics. You have to be able to stand over your decision-making and rationalise why you made such a decision. In this example the registrant partly accepted the responsibility but produced a number of excuses – her workload, lack of supervision. She did not accept full responsibility for breaching her code of professional conduct and ethics. Her ability to reflect on her poor decision-making is the key message from this example. Reflective learning is a great way of looking at your knowledge, values and assumptions, turning them over in your mind and giving your thought process serious consideration.

Code of Professional Conduct and Ethics

You have a **professional responsibility** to be familiar with the Code of Professional Conduct and Ethics for Social Care Workers. This document outlines the standards of ethical behaviour and conduct that the public expects from social care workers. When you complete your degree and fundamentally your placements, you will learn to understand how the Code distinguishes your role as a Social Care Worker from other professions. All the Codes will be the same across 17 professions, with only the last section being specific to the profession.

The Code of Professional Conduct and Ethics for Social Care Workers (2018) was set by the Social Care Workers Registration Board and the Council of CORU after a lengthy consultation process. It is tailored by the boards to include any profession specific requirements. Each year registrants will be asked to pledge that they comply with the Code of Professional Conduct and Ethics.

We will now go through the code section by section. The sections are grouped

into three categories; Conduct, Performance and Ethics. You will find it useful to have the code open in front of you as you read.

Conduct

You must always maintain a high standard of conduct.

TASK 4

Read **CONDUCT**, Section 1-5 of the Code of Professional Conduct and Ethics for Social Care Workers (pages 8-12).

Section 1 states that you must act in the best interest of service users. You must treat people with dignity and respect, uphold their right to privacy and autonomy, and respect diversity and different cultures and values. When working in teams it is important to conduct yourself in a professional manner; how you act and the advice you give can have a significant impact on a service user.

Section 2 emphasises the importance of keeping service user information securely and treating it confidentially, including guarding it against accidental disclosure. For best practice, it is advisable to follow confidentiality guidelines and GDPR legislation. Always inform service users (where possible) if you are sharing information about them and obtain their consent before discussing confidential information with their family, carers, friends or other professionals involved in their care.

Section 3 outlines how you must maintain high standards of personal conduct and behaviour. This means that you must uphold the rights and dignity of anyone using the service you work in. You must also, conduct yourself in a professional manner, including when working out in the community. Respecting the roles of other HSCP's is fundamental; you can use their expertise to enhance the service for the service user, and you will need to work in partnership. Included under this section is to not harm, abuse or neglect service users. Look up Tusla's Safeguarding Policies along with human resources (HR) policy and practices in your organisation. This is explained in more detail under Section 8.

Section 4 looks at using social media responsibly. You need to be very careful with this section and it reiterates all of the above sections, such as conducting yourself in a professional manner, in the best interest of the service user, and

abiding by boundaries of confidentiality. If you use social media, first of all think about what the impact will/might be on the service user if you post something on social media. Ask yourself; if it will be a breach of data, if it will be defamatory or if it will harm them in any way. We will go through this section in more detail in the next case study.

Section 5 explores your responsibility to register and to stay on the register. You must inform CORU, if, for instance, you receive a caution from An Garda Síochána or if you have been involved in a criminal offence. If you are suspended by your employer, you also need to inform CORU. You can only practise under the parameters set out in this code under the title social care worker. Any changes to your circumstances need to be followed up with CORU.

Case Study 2

You are on shift in a residential care home and the young person in your care has come back to the unit appearing – ‘intoxicated’- with slurred speech and with a smell of alcohol off their breath, after visiting their family. They are chatting openly with you and they seem relaxed, but this behaviour is unusual; they are usually much quieter. Eventually they fall asleep at the kitchen table and your colleague thinks it’s funny. They say, ‘This would be hilarious if we took a photo and sent it to all the staff on WhatsApp’

1. Do you think this is an issue under the Professional Code of Conduct and Ethics for Social Care Workers?
2. What sections of the Code do you think this relates to?
3. What do you do next?
4. How would you act in the best interest of this young person?
5. If you disagreed with your colleague’s conduct, what would you do?
6. What attitude do you feel is reflected in this case study?
7. How could you use social media responsibly?

Answer

Categorically, pictures of service users do not belong on your phone or on social media. You need to follow the confidentiality policy of your employer and the Code of Professional Conduct and Ethics. Respecting the confidentiality and privacy of the young person in your care is fundamental. You need to speak up and highlight that this action is disrespectful, that it is not a good idea and that it could result in disciplinary action for you both, not just the budding photographer. The young person has not given consent and they are also intoxicated. Your duty of care and your

decision-making process should focus on keeping this young person safe from further harm by getting them to bed, putting them in the recovery position, closely monitoring them during the rest of the night in case they vomit, and possibly seeking medical attention. You will also need to establish how they became intoxicated; this information will inform the incident report. It is important to remember that it is illegal to drink alcohol under the age of 18 years. However, since the young person is intoxicated, you may need to judge whether this is something to try resolve right now or at another appropriate time.

Performance

You must always maintain a high standard of performance in your professional practice.

TASK 5

Read **PERFORMANCE**, Sections 6-21 of the Code of Professional Conduct and Ethics for Social Care Workers (page 13-22).

Section 6 considers 'wellbeing'. It is your responsibility to look after your own wellbeing. It is also your duty to reveal any health issues/illnesses that may affect your ability to practise. It is worth mentioning that once you reveal this information you cannot be discriminated against. A note of caution, though; if you don't declare something and you are investigated this will not be taken lightly. You need to take responsibility if you have a health issue. Bear in mind that you also have the flexibility of taking yourself on and off the register. Seek advice from your line manager, GP or occupational health practitioner to avoid the risk of inflicting harm to service users, yourself and others.

You can find more information from your employer under the 'Dignity at Work' section in their human resources (HR) policies. The law reflected in this policy comes from the Safety, Health and Welfare at Work Act 2015.

Section 7 signifies the importance of familiarising yourself with relevant legislation that impacts on your practice. In college, you will become familiar with legislation such as the Child Care Act 1991 and its amendments. Tusla (the Child and Family Agency) has welcomed amendments to the 1991 Act; for example the; Early Years Services Amendments Regulations 2016; and Child Care Amendment Act 2015, which has led to a strengthening of the legislative basis

for the provision of aftercare services (www.tusla.ie). Depending on who your employer is, changes to legislation will be implemented into policies and procedure documents, which will impact on your practice and service provision.

Section 8 shows the significance of complying with requirements for the protection of children and vulnerable adults. As a mandated person (Children's First Act 2015) you must report abuse to the appropriate authority (go to the Tusla website for more information). Relevant national guidelines include; Safeguarding Vulnerable Persons at Risk of Abuse (HSE); HIQA National Standards for Adult Safeguarding; Tusla Children First National Guidance for the Protection and Welfare of Children (2017).

Section 9 demonstrates the importance of acting within the limits of your knowledge, skills, competence and experience. This is where accountability for your decision making will be necessary and you will need to stay within your scope of practice. I will clarify this in more detail in the following example.

Case Study 3

- Johnny is a forty-year-old man with an intellectual disability. He lives in a residential care home and enjoys weekends at home with his parents. His parents are friendly and have a good relationship with all the staff in the house. He has just returned home from a few days in his parents' house. His mother hands you a bottle of antibiotics on her way out and says 'Johnny needs to take the next one at two p.m.'
1. What section of the Code of Professional Conduct and Ethics is relevant in this scenario?
 2. What do you have to consider?
 3. It is an hour until the next dose is recommended, what do you do?
 4. What could you learn from this scenario?
 5. What could be done differently next time?

Answer

In this case you must consider whether Johnny has the capacity to take this medication independently. What level of support does he need? Johnny has an intellectual disability, so he would be categorised as a vulnerable adult. He needs to understand what he is taking the medication for and it will need to be risk-assessed before he can self-medicate.

(More information is available on HIQA's website under Medicines Management Guidance).

The next thing to consider is whether the medication, is on the medication administration sheet (MAS). If it is **not** on the MAS you cannot administer it without permission from Johnny's GP. If you, did you would be in breach of your employer's safe administration of medication (SAM) policy and of Section 9 of the code. This is beyond your '**knowledge, skills and competency**' as you are not a GP.

Ring your manager to seek advice: you cannot give Johnny the medication: neither can you let him go without it. Look in particular at Section 9 (f) you need to be able to justify your decision-making and will be held accountable for it. It is important to understand your duty of care when it comes to medication management.

Section 10 Continuing Professional Development (CPD)

This is an important section, so we shall give it a special focus here. The theory of lifelong learning underpins CPD, along with the concept of being open-minded and self-aware; prepared to learn new things, no matter how experienced you are, so you can identify any gaps in your knowledge and address them. Social care workers need to take responsibility for keeping their skills, competencies and knowledge up to date. Keeping yourself informed of any changes to practice, and most important, what you base your decisions on. You need to be aware of all relevant legislation, regulations, policies and guidelines that influence and guide your practice. Furthermore, social care workers need to act within the limits of their skills (as highlighted in the above case study).

One technique that enhances CPD is being able to reflect on your practice. Reflective practice gives you the time to look back on your practice critically and develop your skills. From the case study example above, how could you apply reflection to questions 4 and 5 in order to develop your skills? Reflecting on this scenario will enhance not only your future practice, but also your decision-making ability. This reflective learning will offer you some insight in how to prevent a similar incident happening again, by bringing in some control measures to mitigate the risk. It is noteworthy to mention that it takes practice to become a reflective practitioner.

Engaging in CPD can be completed in two ways; formally or informally. Informally, it can be practical 'on the job' learning from the people you support, from colleagues or other health and social care professionals, or anything that you feel might enhance your skills and knowledge in some way. Examples could be the chats we have with a more experienced colleague, the sharing of thoughts, being honest with our feelings and challenging ourselves as to why we think a certain way. Or, you can go down the more formal route and attend a course or take some training. Implementing anything new into your practice;

that you learned from a course; can bring its own challenges. It all depends on the situation you are trying to apply it to. Changing the way people think or a work culture can be complex; for example, if your colleagues/team feel 'Sure that's the way we always do it around here', how do you overcome that? Reflective practice can be a way to explore these barriers to change. Exploring your practice; through the lens of reflection; can be either a positive or a negative experience. It will depend on you, your experience, how much support you seek, how self-aware you are and what is going on in your own life at the time. Furthermore, not all new skills and knowledge have to be practice-based; you need to get the balance right. When you work in the caring professions, having a good work/life balance is paramount. Getting this balance is vital to prevent 'burnout'; and this should be one of your core principles when working in social care. You give so much of yourself to supporting others, building relationships that can often be complex and challenging, that you need to be mindful of yourself. For example, completing a course or workshop in mindfulness can still be considered CPD, as long as you can reflect on how the learning has enhanced your practice and benefited the people you support.

Social Care Ireland (SCI) is the professional representative body for the social care profession in Ireland. SCI has a designated CPD co-ordinator, whose role is to complete a training needs analysis with SCI members. This can take into account what new practices or models of care are being developed or implemented in practice. SCI works in conjunction with the HSCP's office, which partially funds the facilitation of a number of training events and workshops. The advantage; of not only being called a social care worker, but also being under the umbrella of the HSCP's office means you can also avail of interdisciplinary events and training. For example: you work in the disability services with an aging population. You are supporting someone that over time becomes a falls risk. An assessment is required for this person to live safely within their home. Do you think this is outside your 'knowledge, skills or competence'? The benefit of coming under the HSCP umbrella, is that you can avail of interdisciplinary education provided by occupational therapy or physiotherapy; so, for example, you can upskill in falls risk management. You can then mitigate risk better by understanding what you need to be looking out for to prevent a fall. Having access to this kind of training enhances people's ability to make more informed professional judgements backed up by interdisciplinary learning.

To demonstrate that you are compliant with CPD requirements as a registered social care worker you must show evidence of and record the CPD you have undertaken. So; what does this entail? Thirty CPD credits must be accrued over a twelve-month period. To put this into context, one hour of learning equates

to one CPD credit. Remember, this is not the supermarket, where we collect points just for turning up and spending money! You need to be able to reflect on your learning and record any evidence that supports how it has enhanced your work. You should be able to answer questions like; How did you implement your learning into your practice? What does that look like? How have you applied this new skill or knowledge into your practice? What was the benefit to the people you support? What was the benefit for your colleagues? The Social Care Workers Registration Board in CORU, has put together a CPD Guidance Document and supporting documentation, which provides direction and tools for registrants on how to build and demonstrate reflective learning. SCI has a CPD portfolio that you can also use with some good practice examples.

A registrant can be audited by CORU to ensure that they have a system and process in place to maintain their knowledge, skills and proficiencies. A worker, if called upon, must submit the recorded evidence of their CPD. Just to recap, the main reason we engage in CPD is to upskill. As a registrant, you also need to record your involvement. What CORU are interested in is reflective learning and you can use any model of reflection for this. CORU have adapted the Kolbs cycle of experiential learning to inform their CPD process.

CPD Process



Author-created diagram: CORU's reflective model, adapted by CORU from Kolb's learning cycle of experiential learning

The table below lists some examples of the types of learning activities in which you might engage. As mentioned above, it is not as clear-cut or as easy as

collecting points in the supermarket; you need to reflect on what new or enhanced learning you achieved and how it made a difference to your practice, on a professional or personal level, as seen through the lens of a reflective model. Planning your CPD for the year ahead makes this much easier to navigate and it can help to link in with your supervisor and colleagues. Being able to identify what the gaps are in your skills and knowledge will also help with planning. Ask yourself questions like; Who will I be key working for the next year? What skills can I develop to support this person more effectively? What training can I attend that will enhance my contribution to the team? Are there any personal learning goals I have set for myself? As a member of your professional body, SCl, there are a number of advisory groups and special interest groups you can join.

Support for CPD for social care workers types of learning activity

Discussions with colleagues	Gaining and learning from experience	Active engagement in research
Active engagement in supervision or mentoring	Keeping up to date with research evidence in support of best practice	Maintaining records of your CPD engagement
Peer review	Active involvement in multidisciplinary groups, support groups, development or peer learning groups or voluntary work	Active participation in a CORU board, committee or assessors' panel
Active participation in professional body	Publication of an opinion piece, a clinical audit, a case study or research article	Subject-specific conferences
Learning through the use of online resources	Membership of professional networks	Work shadowing
Writing clinical protocols, policies or procedures manuals	Undertaking postgraduate education such as postgraduate certificate, diploma, masters or doctorate	Specialist lecture, workshop or demonstrations
Professional reading and study (for example, CORU website and publications, professional publications, journal articles, webinar, online libraries or educational videos)	Professional or Clinical supervision	Sharing information/ learning from CPD activities with work colleagues
Reading and reflecting on literature, case studies, discussion topics either individually or in a group (for example, journal club)	Reflection on critical incidents or complex cases, or review of critical incident and development of action plans in response	Visit to another department or area of organisation

(Table available from <https://www.coru.ie/files-education/cpd/scwrb-support-for-continuing-professional-development.pdf> (CORU nd:14).

Section 11 signifies your responsibility to obtain consent from the service user before any intervention or assessment commences. Ensure, as far as possible, that consent is acquired voluntarily. You will need to provide the service user with

the relevant information in a format they understand and in a timeframe that suits them. They will need to understand the information and the decision they will have to make. All of this needs to be in place in order to get informed consent.

Case Study 4

You are working with a person with an acquired brain injury. It is dinner time and you need to assist them to physically eat their dinner.

1. What section of your Code of Professional Conduct and Ethics is relevant to this case study?
2. How would you go about doing this?
3. What do you have to think about before carrying out the above task?
4. What could you do to build trust with the person?

Answer

You have a personal responsibility to make sure the person understands what you are going to assist them with. Consent is important. It is fundamental that you ask the person if it is okay to support them to complete the task before initiating assistance. You need to understand how this person usually gives consent. The key principle here is to consider that there are many other methods of communication other than verbal, that people need to be active participants in decision-making, and the social care worker needs to be aware of individual responses. If a person has limited verbal communication, you could consult another worker or read through the care plan to see how they like to be supported. Building trusting relationships is vital within social care. This is how we pick up on non-verbal cues to know someone is comfortable with you coming into their personal space. Sometimes this takes time and patience.

Section 12 is a significant change to all HSCPs' practice, not just social care professionals, and it relates to the idea of capacity. It falls under the remit of the Assisted Decision-Making (Capacity) Act 2015 (ADM) and the UN Convention of the Rights of Persons with a Disability (UNCPRD) and it was ratified in Ireland by President Michael D. Higgins in December 2015. It is a fundamental shift from a paternalistic approach to a rights-based approach for a person with a disability (look up www.inclusionireland.ie for more details).

Practitioners must always assume that all service users in their care have the capacity to make their own decisions, even ones they may disagree with. If there are any doubts around capacity, it is up to the practitioner to demonstrate

otherwise. Depending on the impact of the decision being considered, it may have to be assessed by a multidisciplinary team. It should not be automatically assumed that, a person who has mental health challenges or a disability, cannot make decisions for themselves.

Ireland will have a new office Decision-Making Support Services that will promote the rights of people who may need support with their decision-making capacity. This was due to commence in 2020, but has been delayed for financial reasons.

TASK 6

Look up the webpage <https://decisionsupportservice.ie/1>. Does Ireland still use the title Ward of Court? Read this Irish Times article: 'Replacement wards of court system to be delayed without budget funding' (Kitty Holland, Irish Times). <https://www.irishtimes.com/opinion/letters/decision-support-service-must-be-funded-1.4351825>

As a social care worker, it is paramount that you support a person's ability to make decisions and adhere to the guiding principles under this ADM Act. There has also been a change in the language used, especially around recording this information. For example, where previously the wording might have been, 'In Robbie's best interest he will get the No. 17 bus to his day centre' it would now be, 'It is Robbie's will and preference to get the No. 17 bus to his day centre'.

TASK 7

For some useful resources on the Assisted Decision-Making (Capacity) Act (2015) and the Guiding Principles, look up; National Quality Improvement team within the HSE Legal Capacity; Josephine Mc Loughlin www.legalcapacity.ie

Section 13 is all about effective communication. For instance, the service user and/or young person must understand what is being asked of them. There are many ways to communicate and; if anyone you support is challenged in this area, they should have a care plan in place to support this need. Keeping your files up to date is important, for continuity of care and to ensure that you pass on any relevant information to your colleagues and the team. One of the standards of proficiency a social care student must achieve is to be able to recognise all behaviour, including behaviours of concern, as a form of communication. This means that you may need to understand what was the antecedent before the

behaviour occurred and if there was a trigger. The challenge in social care is to reduce these mitigating factors.

Communicating with service users and/or young people can be complex and perplexing; for instance, they may, due to their circumstances, have a lack of trust in adults. Being able to explain to a young person and/or service user what is going on in a way they will understand is a core skill as a social care worker. You may have to adapt your communication style or technique to fit the situation and person you are communicating with. Written communication is another area that can be difficult to master. Social care workers practice is primarily relationally based, but due consideration needs to be given to factual, accurate and non-emotive records. All records kept on service users and/or young people are maintained, and care needs to be taken with them as they are legal documents. Please note that Freedom of Information Act 2014 allows individuals to access this information.

Section 14 looks at acting in accordance with the principles of 'open disclosure'. Another name for this is 'open communication'. This means being honest and open with people if they have experienced an adverse event that may have caused them harm. It needs to be completed by a responsible person in a timely manner. This needs to be carefully balanced in terms of disclosing something to a service user that may cause greater harm, and should be done in consultation with the line manager and/or team depending on the situation. It is not about blame but all about integrity and professionalism. An adverse event could, for example, be a service user being given the wrong medication and having to seek medical attention. On 12 November 2013, Health Minister Dr James Reilly launched a national policy and guidelines on 'open disclosure' with three supporting documents, staff support booklet, a patient information leaflet and a staff briefing guide. The National Quality and Improvement Team in the HSE is responsible for this.

Section 15 highlights the significant role placements have for students in obtaining their practical skills. It is important to role-model best practice when supervising students or new colleagues so that you can assist, advise and support them. This will support the development of the professional skills, values and attributes they will need to perform their duties when dealing with services users and/or young people and families. For example, you would be expected to assist a colleague who is encountering difficulties and provide advice/support as appropriate. Take an active role in providing assistance, advice or support where you can.

Section 16 goes into more detail. If you take on the role of teacher or supervisor (practice educator), you will need to meet the standard expected of someone

in that position; for example, you should have a train the trainer qualification or have completed a supervision course. You need to plan ahead and set goals that are agreed by all parties involved, setting the parameters for the role; for instance, one of the starting points before having a supervision session is writing up a contract between the two parties. Being a reflective practitioner is an important skill here, so that you can support someone going through the reflective cycle and help them see how it might be useful to apply it to their practice as a social care worker. In order to teach someone else the skills they require, you will need to have those skills yourself.

Section 17 looks at accountability for your decision-making, especially if you delegate tasks to others; for example, if you assign a task to a new graduate they will need to be supervised correctly, so as not to put the service user at risk when carrying out the task. Again, you need to be working within your skill and knowledge base when doing this. For example, if a student was on placement in the disability services and a staff member asked them to go to the shop with a service user and the student was not made aware that the service user likes to run away. The social care worker in the unit is accountable for this decision, as the student was not informed of this. If this service user was known to abscond it would be recorded within a risk assessment, outlining what controls are in place to mitigate against this potentially dangerous situation. One control that may be in place is to use a walking belt with the person and this would have to be passed by multidisciplinary team, as it is seen as a restrictive practice. The idea of the belt is so that the service user can feel you beside them and if they run you can go with them. It can also act as a deterrent. The important consideration here is that if you ask someone to do something you need to give them all the information before doing the task, in order to complete the task safely and it is imperative that the service user is never be put at unnecessary risk.

Section 18 outlines that, record-keeping has become more stringent under GDPR legislation, which has added another layer of regulation to all citizens' personal information. Everything you record about a person in your care should be seen as a legal document and written down clearly and factually. You must adhere to any policies and procedures in your organisation, in writing clear, accurate, up-to-date reports. In general, service users have the right to access any information that is held about them.

Section 19 is an important section of the code that addresses health, safety and welfare risks. This states how you must follow risk assessment policies and procedures; to assess potential risks in the workplace and your areas of practice, and it is your responsibility to try to minimise, reduce or eliminate any risks identified. Oversight of risk assessments should be regularly reviewed by the

team to make sure that the same mitigating factors are still relevant and to review whether all the controls in place are sufficient or if they need to be adapted. Any time a change is made, it is important that the whole team is informed. There will also be a Safety Statement which you will need to familiarise yourself with and sign off on.

Sometimes; in your practice you will come across a service user and/or young person who poses a risk to your safety. You need to know what the risks involved are, so that you can take appropriate measures to protect yourself and others. This can be a challenging environment to work in, but; if possible, try to make reasonable efforts, if appropriate, to go ahead with your interactions with them. Try to visualise a weighing scale with the risk on one side and safety on the other, and trying to strike a balance. Another way of looking at this is positive risk-taking or positive risk enablement; this links in with Section 12 and consent and is underpinned by autonomy and making independent decisions. For example, if you are supporting a service user and/or young person to build capacity to make their own decisions, even ones that might be disagreeable, and if the impact of their decision causes an imbalance to the scale, you will have to devise a risk assessment and may have to inform a multidisciplinary team.

Section 20 states that you are duty-bound to report any concerns about the care and support a service user and/or young person is receiving. This is your number one priority at all times; not what the team thinks or any loyalties that you may feel towards a colleague. When I started practice, we used to do full body lifts to transfer service users; however, we have now learned that this is unsafe practice, which puts service users, yourself and/or others at risk. We now have ceiling hoists and bespoke slings to avoid these unsafe practices. Using a hoist/sling as a control measure lowers the risk and brings the risk/safety scales back into balance.

If you felt there was a serious risk to a service user you would need to consult with your line manager and/or team depending on the situation. You could also raise concerns outside your organisation if you felt the issue was unresolved and that there was a serious breach of behaviour or malpractice. Go to the HIQA website for more information.

Case Study 5

You have been working a few weeks in a children's residential care unit for young people. You are

told one particular young person in your care is a risk of absconding; they have absconded from the unit in the past. You have to go to the supermarket with this young person. They run off and you have tried to follow, but you are concerned that the situation is getting dangerous they are dodging back and forth across the road and you are afraid they may be injured by passing cars. However, you are also concerned about letting them out of your sight as they have engaged in very risky behaviours in the past.

1. What section of the Code of Professional Conduct and Ethics does this relate to?
2. What would you do?
3. What are the key factors you need to consider?
4. How could you involve the team to discuss what happened?
5. Where would you record this information?

Answer

This is a tricky and potentially dangerous situation and the first thing you would do is call for help. Your number one priority is to try and follow the young person if it is safe to do so. Sometimes in social care you have to make on-the-spot decisions. Therefore, understanding the potential risk factors before an intervention commences means you are informing your practice. Furthermore, this will support your decision-making competencies. Being able to follow the risk assessment for this young person is paramount. Risk assessments are there to bring balance to risk and safety, especially in this particular situation. This incident should be explored further in supervision using a reflective model. This will support and enhance your practice if this situation happens again. It should also be brought to the team to review the risk assessment to see if more supports could be brought in to support this young person's needs. You would be responsible to write up an incident report that is factual, accurate and non-emotive.

Section 21 discusses professional indemnity and this will be important when you are registered. This is similar to having insurance for your car and it is the law in Ireland. SCI the professional representative body for the social care profession, will offer this as part of their annual membership fee or alternatively, you could source this independently.

Ethics

You must always maintain a high standard of ethics.

TASK 8

Read ETHICS, Sections 22-26 of the Code of Professional Conduct and Ethics for Social Care Workers (page 23-26)

Section 22 acknowledges that, as a student you will be aware of the ethical obligation that you have, if you carry out any research. You will need to be mindful of the data that you collect and how you use that data. As a social care worker, ethical obligation is a similar concept but delves deeper into your competencies as a practitioner. You will need to comply with this section, the attributes of ethical behaviour, behaving with integrity and being honest, and as a practitioner your obligation is to this code first and foremost. Please ensure that you always conduct yourself in a manner that respects the rights and dignity of others.

Section 23 specifies the need for the rights and dignity of people using the service to be upheld. Follow the legislation on discrimination under the Equal Status Acts 2000-2018, and be conscientious of the nine grounds that discrimination can be founded on; similarly, you must not condone discrimination by others.

TASK 9

Think about a time when you felt a member of your team disrespected a person in your care. If you don't have much practice experience, can you think of a time you or someone in your group of friends was disrespected?

1. What might be considered disrespectful behaviour towards a service user, by a staff member or another person?
2. What do you think you might do if you encountered a situation in which a staff or other person was being disrespectful to a service user?

Answer

One role of the social care worker is to challenge negative discrimination and/or unjust policies and practices. Fundamentally, social care work practice is underpinned by social justice. You need

to advocate for the people in your care. Having a non-judgemental attitude is vital. If you encounter a staff being disrespectful towards a service user, you are duty bound to report it. Your obligation under this code is to the service user.

Section 24 stipulates how to avoid conflicts of interests. For instance, you cannot accept financial contributions from parents or service users, as this may be perceived to affect your professional judgement. You should also avoid entering into any contracts that might cause conflict with this code.

Section 25 outlines how to undertake research in an ethical way. You must seek approval from an ethics committee before undertaking any research, especially if you are working with vulnerable service users. You must always follow the legislation around conducting research, for instance; the Data Protection Act 2018 (Section 36 Subsection 2) (Health Research) Regulations 2018.

Section 26 covers how to advertise truthful, accurate, lawful information that is not misleading. If you recommend a product to a service user, the recommendation must be based on your professional opinion.

Section 27 Responsibility specific to social care workers This code is specific to social care workers and it is something that can be overlooked in service provision. The role of supervision. There are some great resources available on HSELand; for example, there is an e-learning module on supervision, which provides a good introduction to the theory and framework behind effective supervision.

The work of the social care worker can be isolating, with unsociable working hours, and you may not see your team members regularly. Evidence on 'lone working conditions' from the Health and Safety Authority (HSA) indicates that engaging in professional supervision can obviate some of these risks associated with lone working. Professional supervision can be formal, with your line manager, or it can be supported with peer supervision, in order to provide yourself with a safe space; where you can reflect on your practice, with like-minded colleagues. Being able to reflect on your practice is a fundamental skill in social care that comes with experience and you will need to work on becoming a reflective practitioner (see Section 10). The role of the social care worker can be emotionally charged, and it can be challenging to work through and adhere to the code of professional conduct and ethics, but this is also how we grow as professionals.

Conclusion

The aim of this document was to go through each part of the Code and provide some insight into how to apply the Code to your practice. As a student on placement, you can use the Code to evidence best practice and see how you can replicate that in your future practice.

Social care work is underpinned by the ability to form and maintain relationships with people encountering challenges and experiencing adversities at particular times in their lives; being able to reflect on your practice and understand your professional judgement; building your skills and competencies and fundamentally protect the people you support. It is essential that as a social care worker you understand how to uphold human rights, as well as respect the right to self-determination and autonomy of the people you support. Using people's will and preference to promote the right to participation, being kind and caring and understanding people's lived experience; is the foundation for person-centred practice. I believe that registration is well received; when it comes to recognising the vital work social care workers do; advocating and working alongside the most vulnerable people in society.

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Chapter 8 – Hazel Finlay (D1SOP8)

Domain 1 Standard of Proficiency 8

Recognise the importance of practising in a non-discriminatory, culturally sensitive way and acknowledge and respect the differences in beliefs and cultural practices of individuals or groups.

KEY TERMS

Differences in beliefs and cultural practices
Non-discriminatory practice
Cultural sensitivity
Cultural competence
Everyday activities

Social care is ... a helping hand that values and respects

TASK 1

Write a reflective piece on your personal values and beliefs and how they are (or are not) helpful in your development as a social care worker.

Acknowledge and Respect Differences in Beliefs and Cultural Practices

The word **culture** relates to the particular set of knowledge and characteristics shared by a group of people, for example ethnic minority groups, social groups,

people of the same gender, people with disabilities and so on. In this chapter, the focus will be on culture and ethnic diversity in social care practice.

While Ireland has had diverse cultural and ethnic groups for many centuries (e.g., the Irish Traveller community and a small number of refugees (Loyal 2003)), since the 1990s Ireland has become an increasingly diverse society, with approximately 535,475 non-Irish nationals from 200 different nations recorded in the most recent census (CSO 2016). This diversity in our communities has significant implications for the social care profession and the delivery of services in all areas of social care. The challenge for those involved in social care is to understand and respect the beliefs and cultural practices of diverse communities, to recognise the particular challenges individuals and communities face due to their migrant and/or ethnic status and to practice in a non-discriminatory and culturally sensitive way.

The relationship between the social care worker and the service user forms the basis of everything we do. Meaningful and trusting relationships create a space for service users to make positive changes in their lives (McCann James, de Roiste, & McHugh 2009). To build meaningful and trusting relationships we need to be self-aware and understand how we relate to others. When developing self-awareness it is important to reflect on our own personal values and beliefs and how they influence our behaviour and our relationships with people. Social and cultural factors such as gender, class, race, ethnicity, age, disability, sexual orientation, religion and so on determine our value base. We are often unaware of our values and beliefs until they come into conflict with those of others (McCabe and Timmons 2013). Working with diverse communities could potentially lead to conflict if we try to impose our own values and beliefs on the people we work with. Building meaningful and effective relationships with diverse communities requires the worker to be reflective, compassionate and open to learning about values, beliefs and cultural practices that are different from their own. We need to explore the identity of others without preconceived judgements and listen to and acknowledge the particular challenges individuals and communities face due to their migrant and/or ethnic status. Social care programmes are designed to build critically reflective and diversity competent workers by helping students develop a clearer sense of their own identity/diversity through the exploration of their own attitudes, values and beliefs and how they are (or are not helpful) in their development as a social care worker. The significance of culture and ethnic diversity is not only seen in the increased diversity of the people we work with, but also, the increased diversity of our social care students. How students engage in social care education with their peers,

builds the foundation for becoming diversity competent or culturally competent social care workers.

TASK 2

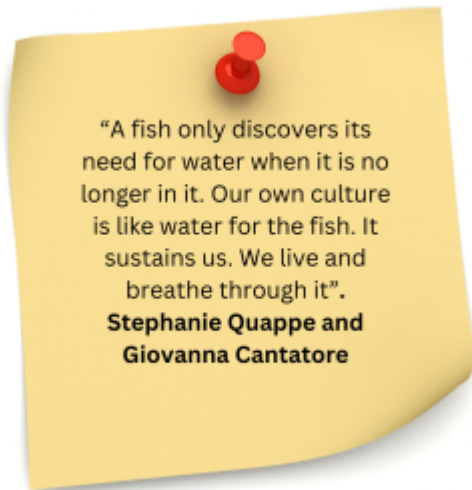
Watch the documentary '[Direct Provision – Ireland's Asylum Seekers](#)' (28 October 2017). From watching this documentary, what have you learned about asylum seekers in direct provision?

- Understanding of wider political, social and economic concerns
- Understanding of the link between migrant/ethnic status and rights and entitlements
- Impact of poverty/discrimination/exclusion
- Impact on family life
- Impact on mental health and parental capacity
- Impact on children's development and welfare
- Impact on human rights
- Non-Discriminatory and Culturally Sensitive Practice

Principles of human rights and social justice are fundamental to social care work. As social care workers, we are legally required to respect and uphold the rights of the people in our care. National standards and guidance documents such as Safeguarding Ireland and HIQA's recent *Guidance on a Human Rights-based Approach in Health and Social Care Services* and the Social Care Workers Registration Board's Code of Professional Conduct and Ethics (SCWRB 2019) promote a human rights- based approach in our health and social care services. A rights-based approach in social care work requires the worker to promote and protect the rights of the people in their care. These include the right to autonomy; the right to make important decisions about their own lives; the right to dignity and respect; the right to participate in family and community life; the right to equality; and the right to live a life free from discrimination and abuse (Safeguarding Ireland & HIQA 2019).

Culturally sensitive or ethnic-sensitive practice requires the social care worker to recognise and value differences in the beliefs and cultural practices of the individuals and groups in our care. However, being sensitive to cultural/ethnic needs and differences is not enough; good practice should also be anti-oppressive. Anti-oppressive practice is important in social care as many of the people we work with are from populations where their diversity can place them at risk of discrimination and oppression (McGinnity, Grotti, Kenny, Russell 2017). According to the Social Care Workers Registration Board (2019), in addition to a human rights-based approach, social care workers should also promote social justice in their practice. This requires the worker to critically examine their own

work practices, challenge discrimination and unfair policy, and respect diversity and different cultural practices.



A Culturally Competent Approach

Culturally competent practice is a relatively new and emerging concept that incorporates both culturally sensitive and ethnic-sensitive practice and anti-oppressive practice. This approach is relationship based and 'calls for the worker to be able to practise in ways that are consistent with expectations in the client's culture' (Yanca & Johnson 2008:53). When we are culturally competent in our practice, we adapt our skills to meet the needs of the service user and understand the effects of diversity on the worker, the services user, the environment and how all three interact (ibid.). Culturally competent practice or diversity-competent practice can extend to all areas of culture and diversity including gender, class, race, ethnicity, age, disability, sexual orientation, religion, etc. (ibid.).

Developing a Culturally Competent Approach

Understanding Self	Understanding Social and Political Factors	Understanding Culture of Diverse Group	Diversity-competent Skills/Practice
Values Beliefs Attitudes Prejudice	Oppression Racism Discrimination Rights and Entitlements Human Rights Exclusion	Values Beliefs Attitudes Cultural Practices	Reflection Self-awareness Relationship Building Empathy/Compassion Communication/ Partnership Research/ Understanding Listening/Learning Non-discriminatory Non-judgemental

(Adapted by author from Yanca and Johnson 2008)

TASK 3

Putting a Culturally Competent Approach into Practice in your Setting.

- Ask your student to read this case study and answer the following questions.
- Prepare a case study relevant to your setting that will help the student understand how to practice in a culturally sensitive way.

Case Study 1

You are working in a youth project with young people from the local community. Over the past few months, a number of young people currently living in direct provision have joined the group. You have noticed that there seems to be a divide between the children from the local community and those living in direct provision.

What do you do?

1 Understanding oneself (social care worker)

- examine own beliefs, values and prejudices
- research, learn, understand and respect difference
- be open to new ideas, traditions and routines

- listen to and learn from service users
- build relationships that value and empower the service users

2 Getting to know each other (focus on positive aspects of culture and break down language and cultural barriers)

- culture day (meals, traditions, hair, dress, appearance, language, social interaction)
- life story pictures/collage (identity, values, lived experience, family, friends)
- creative work/group work (values, beliefs, norms, discrimination, racism, exclusion)
- food culture days (cook foods from own culture and share)

3 Finding common ground (identify shared values and common interest)

- shared positive experiences
- group/fun activities, e.g., football, cinema, dance, swimming
- day trip/camping out
- creative work/group work (identify shared values, hopes and dreams)

4 Celebrate diversity (focus on positive aspects of diversity and how it can enrich our society/communities)

- culture day/party
- share new knowledge and ideas
- share talents and skills



Tips for Practice Educators

When students begin their practice placement journey, they should be encouraged to continue to engage in reflective practice; exploring their own, attitudes, values and beliefs and how they influence their responses to their practice placement experiences. Writing a daily reflective journal will allow students to capture their experiences and responses while providing the space for deeper understanding and self-awareness. This learning can be used to improve future responses and help students to understand the effects of diversity on themselves, the environment and the service user.

It is important that students have an induction period when they first start their placement. This usually involves some research on the purpose and values of the agency, the policies and procedures that guide the work of the agency and the needs of the service user group. It is important for students to engage in research and recognise theories that relate to the particular service user group and approaches and interventions used to respond to these needs.

Practice educators may need to guide students in understanding the needs of the service users. It is important that students do not make assumptions about service users because

they perceive they come from a similar background to another service user or someone they know.

Rather than claiming to be diversity competent and to understand other cultures, students need to engage with and listen to the people they work with. Practice educators should encourage students to take an inductive approach when making links between theory and practice (see Yanca and Johnson 2008). An inductive approach requires the student to be open minded and put aside any preconceived judgements they may have about a particular group of people. Students should be encouraged to listen and learn from the people they work with and apply academic knowledge to their placement learning and experiences.

The above 'Task – Putting a Culturally Competent Approach into Practice in your Setting' may be useful to practice educators and students, and it can be applied to most areas of social care work. The 'Task' provides practical tips to help students develop a deeper understanding of their own diversity and, how it impacts their responses, the environment they work in and the service users they engage with. It offers practical and fun ways to listen to and learn about the people we work with, thus creating a space for positive relationships to grow and for students to develop cultural competence in their practice.

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Chapter 9 – Deirdre Connolly (D1SOP9)

Domain 1 Standard of Proficiency 9

Understand the role of policies and systems to protect the health, safety, welfare, equality and dignity of service users, staff and volunteers.

KEY TERMS

Understanding policies and systems

How policies and systems develop

Role of policies and systems in protection

Effect of policies and systems on social care workers

Social care is ... about all of us. It is about recognising that at any time we, or someone we care about, may need care and support to live a whole and fulfilling life and be safe. Social care policies, systems and practice seek to address the tendency at a societal and individual level to 'other' people who have different experiences and needs from our own, to ensure that there is high-quality, fair and equitable care and support for anyone who needs it.

Introduction

The standard of proficiency set out in the CORU standards expects that social care staff will understand the role of policies and systems in protecting the health, safety, welfare, equality and dignity of service users, staff and volunteers (Domain 1, Standard 9). But what are policies and systems? Where do they come from? What is their role in protecting the health, safety, welfare, equality and dignity of the people who use services and the staff and volunteers involved in

their care and support? And what is the effect of these policies and systems on social care workers when they are delivering person-centred care and support?

In this chapter I am going to look at these questions in detail based on research and using the lens of my own experience, first as a social care worker in voluntary services and latterly in my role developing standards, guidance and policies for social care services at an organisational and national level. By doing this, I aim to illustrate how the social care sector has changed since the early 1990s, how social care has been shaped by emerging national policies and systems that inform day-to-day practice, and finally the effect these policies and systems have on social care workers.

Understanding Policies and Systems

First, let's take a look at policies. What is a policy? At a high level, there are social policies. These are developed by states and governments to address the social needs of people in society in areas such as housing, health, education and social services (Blakemore & Warwick-Booth 2013; Spicker 2014). While it might be difficult to see the connection between such high-level social policies and the day-to-day policies and procedures of your organisation, it is these social policies that ultimately inform many organisational policies. At an organisational level, policies can be understood as a set of rules or guidelines for an organisation and its staff to follow in order to deliver safe, high-quality care and support to people using its services.



At a very basic level, policies set out what staff members actually do in their day-to-day work to meet the care and support needs of the people using a service, and what they aim to achieve. I will go into more detail about the relationship between social policy and organisational policy in the next section. One common example of an organisational policy, recognisable to all social care workers is a recording and documentation policy. While not universally loved, the

importance of recording your work in a timely, accurate, consistent and clear way cannot be overstated (HIQA 2012).

By doing this you ensure that there is a clear overview of the person's wellbeing before, during and after any intervention. This information can then be used to inform aspects of the person's care and support, reflecting what is working well and not so well, and allowing you and the service user to decide together what adjustments may need to be made so that any interventions are effective. Recording and documentation is fundamental to good person-centred planning, and also to your own supervision and reflective practice.

Turning now to what is meant by systems, as referred to in the CORU standard; these are the structures that an organisation puts in place to organise its staff, its resources and its facilities to ensure that organisational policies can be implemented and the organisation can achieve its aims. Continuing with the example of recording and documentation, services should have a system in place to support staff to consistently record and document their work. Although the format may vary from service to service within an organisation, or even from task to task – for example, there may be an ICT system where staff input case notes in an online file, while staff might have a hard copy of a supervision template that they complete and store in a folder – the fundamental purpose of the system remains the same: to accurately record and document essential information and to do so in a consistent manner.



Taken together, then, the aim of policies and systems is to create a clear framework for staff in which to practise so that they know what to do and how to do it. This in turn provides a level of consistency and predictability for people using the service, which is very important. Without clear policies, and robust systems to support social care workers to implement them, it is very difficult for organisations to protect and promote the health, safety, welfare, equality and dignity of people using

the service, staff and volunteers, in line with both CORU standards and other national standards.

Reflecting on my own experiences of policies and systems, a great deal has changed since I began my career in social care nearly thirty years ago. Before I

did my degree in social care in the late 1990s, I worked in the access service of a Dublin University providing academic support services to students with disabilities. Then I worked as an information and research officer in a small charity supporting people affected by HIV and AIDS. While the overarching objective of my role in each of these services was clear – for example, researching and providing information in an accessible way – how I was expected to work on a day-to-day basis was less clear. There was a brief job description, but no formal induction or introduction to policies (such as they were), no supervision, and little in the way of procedures or systems. Though there were occasional team meetings, the size of these services meant that the line managers simply took it for granted that everyone knew what they were supposed to do and would learn from each other on the job. And, in general, we did know what to do, and just got on with it. I did receive occasional feedback, usually from another staff member and sometimes (but rarely) from a manager, but it was all very ad hoc. Although I was fairly confident that my work was meeting the needs of people using the service – at least, they seemed happy with it – I was working very much in isolation. It was very hard for me to fully grasp the wider context of what I was doing or how my work fitted into a bigger picture. In fact, looking back, I'm not sure there was a bigger picture! It is very hard for any social care worker to develop in their role in these circumstances.

It was only when I started my degree in social care that I began to see this 'bigger picture' more clearly, to understand what informed and shaped social care more generally, and to gain an understanding of where my work, in particular, sat within this wider paradigm. My studies allowed me to break down social care practice into its key components, to see the relationship between wider social issues and the lived experiences of people and why some needed support from social care services. I also began to see how social policy informs legislation and how both inform organisational policies and systems and social care practice on the ground (as discussed from a variety of perspectives by others in this book).

TASK 1

Read Chapters 4, 13 and 16 for a few examples of how legislation has influenced policy at both national and organisational levels.

How Policies and Systems Develop

As I touched on in the previous section, social policy informs the development

of many of the day-to day policies and systems within social care services. But where do social policies come from?

One such policy with which we are all familiar is *Children First National Guidance for the Protection and Welfare of Children*, the national guidance for the protection and welfare of children. First developed in 1999 by the Department of Health and Children, it has gone through several iterations, the most recent version published in 2017 (DCYA 2017). While Children First articulates in detail the responsibilities for statutory social workers and An Garda Síochána, as set out in the Child Care Act 1991, it also states clearly that it is the responsibility of all those working with children to keep them safe. Although the policy has developed over the years, the objectives of Children First have remained unchanged since 1999. They are: to raise awareness of child abuse and neglect; to improve the response to concerns about a child; to ensure that people working with children understand their responsibilities in this regard; and to enhance communication and coordination of information between disciplines and organisations.

Practical Example 1 Reflecting on My Practice

As previously discussed, my own awareness of policies and systems began in college. During this time, I started working in a residential service for people with intellectual disabilities. In this service, there was a strong focus on meeting the psycho-social and physical needs of the people living there, and a clear commitment to their wellbeing. The service had practical procedures in place to be followed by staff when providing care to each person – everything from planning daily activities, to family engagement, to medication administration. However, as a staff member in that service, I felt little connection to the wider organisation and had no real sense of continuity between services. There were some organisation-wide health and safety policies, and systems for recording staff hours, but care planning, incident reporting, and adult and child safeguarding policies, all common policies in services today, were not in operation uniformly across the organisation. Instead, each residential or day service developed its own local policies and procedures based on the presenting needs of the people using the service, often in response to an incident. These policies and procedures, and the systems that supported them, were generally useful and created a practical framework for staff to work within at the time. However, as they weren't connected to any social policy, legislation or strong evidence base, when the needs of the people using the service changed, these policies didn't necessarily meet these emerging needs. And, because staff had put time and energy into writing these policies, and had embedded systems to support them, they were difficult to change.

This national policy is connected directly to your organisation's child protection policy. It underpins any child protection and welfare training you receive and

the system you use for recording, documenting, submitting and following up on child welfare and protection concerns. Additionally, any adult safeguarding policy in operation in your service has also been shaped by the principles first described by Children First and now reflected in the National Standards for Adult Safeguarding (HIQA & MHC 2019). Children First is a clear example of how a high-level social policy, enshrined in legislation, can shape social care practice on the ground.

Role of Policies and Systems in Protection

What role do policies and systems have in protecting the health, safety, welfare, equality and dignity of people using or delivering social care services? Looking back at Ireland's historical approach to protecting the safety and wellbeing of people using social care services (as well as health and mental health services), we are all too aware of the failure to protect people who need care and support when services are hidden from view, as illustrated in the 2021 final report of the Mother and Baby Homes Commission of Investigation (DCEDIY 2021), or where there are inconsistent policies and fragmented approaches, as outlined in the Department of Health's report on the response to COVID-19 in nursing homes (DoH 2020).

Research shows that the provision of social care services in Ireland, up until the late 1990s, was largely hidden from public view (Connolly 2019; Linehan *et al.* 2014; Raftery & O'Sullivan 1999). Despite ongoing calls in the social care sector for legislation and external monitoring, the role of the state remained at one remove, with very little co-ordination or oversight of the work of the many services in operation across the country. Although the development of guiding legislation for children's social services began in the 1980s, resulting in the 1991 Child Care Act, and regulations for disability services were approved in 2000s (Health Act 2007), the establishment of bodies to assess compliance with the legislation and regulations only happened in 1999[1]The Social Services Inspectorate (SSI), established in 1999, was subsumed into the Health Information and Quality Authority (HIQA) on its establishment in 2007.[2] in response to high-profile reports of abuse and neglect² (Connolly 2019; Jones & Smey Carston 2016).

Although these external oversight systems are often put in place in response to an incident or a failure to protect people (Koornneef 2010), as can be seen here in Ireland, such systems have also been established in response to the increased

demand for accountability by social care services themselves (Featherstone *et al.* 2012). It is generally accepted now that services and individual staff members must be able to evidence that the work they do is having a positive impact on the lives of people using their services. It is also increasingly necessary that services can prove that the work they do represents value for money (Martin *et al.* 2010).

In my own work, I saw this increased demand for organisational governance structures and professional accountability when I started work as a housing support worker at a national housing and homeless and advocacy organisation in the early 2000s. This demand was driven in part by organisational expansion and in part by the expectations of central governing and funding bodies such as the Dublin Regional Homeless Executive (then the Homeless Agency) and the Health Services Executive (then the Health Board). At this time, the organisation was keen to develop consistent cross-organisational policies and systems and to train staff to use them effectively. All of this was aimed at improving quality across the organisation, improving outcomes for people using services and, crucially, being able to demonstrate effectiveness to funders, both statutory funders and the general public (whose donations funded a significant proportion of its activities).

Looking again to the example of Children First as a guiding policy, at the time the organisation was working on the development of a child protection policy aligned to Children First, as well as child protection training that was contextualised for staff working in housing and homeless services. The policy and training worked together to ensure that children who might be more vulnerable to abuse and neglect due to their housing circumstances, or the problems that their parents were facing, were supported by staff who knew how to recognise the indicators of abuse and neglect, and how to respond to these in an appropriate and timely way.

Management in the organisation were keen to involve staff members in this process, not only to ensure that the policy and the training reflected the diverse circumstances of children's lives, but also to promote staff buy-in and the implementation of the policy in day-to-day practice. In my role as a housing support worker, I worked with families who were moving from homelessness into housing, supporting them to address a range of issues that were negatively impacting their wellbeing and their ability to sustain a home. The organisation recognised my knowledge and experience in this area and so I was asked to get involved in developing both the policy and training, as well as in delivering the final training package to staff.

- The Social Services Inspectorate (SSI), established in 1999, was subsumed

into the Health Information and Quality Authority (HIQA) on its establishment in 2007.

- These cases included the Kilkenny Incest Case (1993), the Inquiry into the Operation of Madonna House Report (1996), and the HSE report on Leas Cross Nursing Home (2006).

Following this experience, I moved away from frontline work and was employed by the organisation as its standards development officer. This provided an opportunity for me to work on the development of many other organisational standards and policies, all informed by research and all with the input of frontline staff. Later, I moved on to creating systems for auditing the compliance of individual services with these standards, developed processes for services to assess their own compliance and areas for improvement, and systems for people using the services to provide feedback on their experience of the service and whether it met their expectations. These structures and systems helped to ensure that the organisation was meeting both its legal obligations and, more important, its obligations to deliver high-quality, safe and consistent support to people using the service. It is important to note that while all these systems improved the governance and accountability of the organisation, this was all internal assessment of compliance, because housing and homeless services did not fall under the remit of the external regulatory body, HIQA. And, in fact, they still don't!

Effect of Policies and Systems on Social Care Workers

The intended effect of policies and systems is to create a framework to support staff in their day-to-day work, reduce ambiguity and inconsistency, and set out clearly what should be done in a variety of situations. Of course, social care practice is by its nature extremely complex. The work of social care workers must also be informed by their knowledge, experience and creativity. We know from research that policies and systems can in fact act as a constraint on innovative practice, and compliance with policies and systems becomes an end in itself (Boyd *et al.* 2017). It is important that a balance is struck and that staff are not burdened or stifled by excessively policy-driven or bureaucratic systems. Additionally, it is important to note that when policies seem at odds with the purpose of the service, or when the systems to implement them become too burdensome, staff often ignore them. This leads to staff developing

their own way of doing things, which in turn leads to inconsistent care and support, ultimately impacting on the safety and wellbeing of those using the service (Breachin *et al.* 2000).

To illustrate some of the effects of policies and systems, I'm going to take a detour here to bring in research I undertook as part of my master's dissertation. Specifically, I looked at how social care managers experienced HIQA's inspection and monitoring process to understand the effect it had on their practice (Connolly 2019). Although the focus of my research was primarily on participants' experience of preparing for, participating in and following up on HIQA inspections, the research also touched on how social care has changed over time, what this change has meant for social care workers in their day-to-day work, and what effect this has had on the safety and wellbeing of people using services. Nearly all participants talked about how they had witnessed a significant increase in the number of policies and systems in their organisation to ensure compliance with the national standards that HIQA assesses against. They found that these policies meant that staff spent a lot of time on recording and documenting the work to evidence compliance with the regulations and standards, taking time away from direct work with people using the service.

Nevertheless, my research showed that social care staff believe that external inspection, and the policies and systems needed to ensure that the service can evidence good practice for inspection, is necessary. It holds them (and their service) accountable for their work, and thus improves the quality and the safety of the services for the people using them (Connolly 2019). However, the research also highlighted a possible drawback of external inspection, whereby services are found to be 'gaming the system' by providing inspectors with the evidence of compliance they require, while not actually improving the services for the people who use them (Boyd *et al.* 2017).

Ultimately, what the external inspectors want to see, and what ensures the best possible outcomes for people using the service, are organisations where national standards, policies and systems are meaningful, internalised and lived out in day-to-day practice by both management and frontline staff (Connolly 2019; Featherstone *et al.* 2012; Koornneef 2010; Smithson *et al.* 2018).

Consider This

As a social care worker, part of your role is to create opportunities for the people using the service to be involved in the development and review of policies, and the systems that support these. By doing this you can help to ensure that these structures reflect the needs of people using the service, and are in line with best practice.

Conclusion

The thread running through this chapter is the importance of understanding what frames your work the social policy, the legislation, and the organisational policies and systems that follow from these and recognising how it affects your practice. It takes time to understand this, but as you build up your knowledge and experience, this framework will become clearer to you. It is there to guide your work and ensure that the people you are caring for and supporting receive a high-quality, safe and consistent service. Over time, you will be able to reflect on whether the policies and systems in your organisation are benefiting the people you work with, or whether they need to be reviewed. And as you gain more experience and are able to see how these policies are influenced by social policy and legislation, you will be in a position to contribute to reviews of these in a meaningful way so that they are fit for purpose.

TASK 2

What policies and systems frame the work in the service where you are on placement? Talk to your supervisor, the staff team and the people who use the service about how they experience these policies.

- Do they know these policies and systems exist?
- Do they know where they came from?
- Do they think they work?
- What would they change about them?

Tips for Practice Educators

As discussed, students need time and support to understand the role of policies and systems in your service in action, not just as a concept.

Beginning of placement: discuss with the student the relevant policies and systems that they need to know about, and when and how these are intended to support their work. Show the student where the service policies are located and give them time to review them, setting aside time in the first few weeks of placement so that they can ask you questions about them.

Middle of placement: this is the time for the student to take an active role in critically understanding the policies and systems that frame the work, and the ethos that informs them, and how people who use the service experience them.

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Chapter 10 – Anthony Corcoran (DISOP10)

Domain 1 Standard of Proficiency 10

Understand and respect the confidentiality of service users and use information only for the purpose for which it was given.

KEY TERMS

Personal
information
confidentiality
GDPR
Breaching
confidentiality
Staff-to-staff
confidentiality

Social care is ... professionals from an array of backgrounds providing support to vulnerable groups and individuals who are marginalised, disadvantaged or has additional requirements to help them achieve their potential.

This chapter will discuss: what personal information is; what confidentiality is; confidentiality between staff; when confidentiality might be broken or breached; how information relating to a service user is used only for the purposes for which it was gathered; and the legislation impacting confidentiality in social care work. It aims to explore from a theoretical perspective the role social care workers play in maintaining confidentiality while also giving guidance on how to demonstrate confidentiality in practice. It will explore the knowledge that underpins confidentiality and also how confidentiality applies to social care settings including homecare, residential care, day services, homeless services and hospital settings (HIQA 2012).

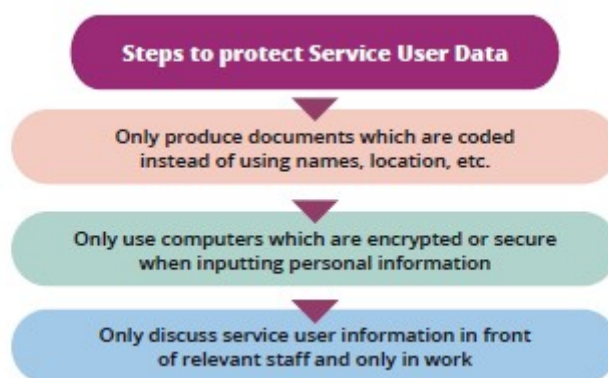
What is Personal Information?

Personal information is data about an individual that can be used, directly or indirectly, to identify them, from a combination of data such as their name, address, race, health status, allergies, physical/ mental disability history, political opinions, religious beliefs, age, sexual orientation, fingerprints (to mention a few examples). This information can be held on computers, mobile phones, external hard drives, tablets or in physical files. *Privacy* is the individual's right to control when, where and with whom their information can be shared, as outlined in the Data Protection Acts 1988 and 2003.

Tip

Personal information is information that can be used to identify an individual either directly or indirectly with additional information (such as name, address, location, disabilities, etc.).

The Data Protection Act, implemented in Ireland in 2018 (DPC 2018a), was designed to protect the personal data of individuals in the European Union (EU). In Ireland, since 25 May 2018, this is implemented through the General Data Protection Regulations (GDPR). The legislation applies to the processing of personal data in the EU. It sets obligations on data controllers and processors to protect the data of the individual/s it relates to and gives the individual the right to the privacy of their own personal data. Where a breach or potential breach of GDPR occurs, you should notify the manager or supervisor in the service (DPC 2018b). Under the Freedom of Information Act 2014, a service user or member of staff can gain access to the personal information held by a service provider about them.



Author-create diagram: Steps to Protect Service User Data

In practice

In social care, information about service users is contained within the service and may be provided to the key worker and staff who work with the service user as well as the manager or supervisor. Personal data about service users could include, for example, their age, family details, mental health status and case history. This data can be stored in a variety of formats such as service user files, daily records and computers. The data on service users and staff within the service are to be protected by the service provider and the staff who process the data. Staff members have access to personal data on service users in work when writing daily reports and adding to service users' care plan. This includes what is said about service users in team meetings, supervisions and in work – this should also be kept confidential.

Tip

Always remember: think before you speak. For example, Do I need to pass on this information? Does passing it on benefit the service user or is it for my benefit?

What is Confidentiality?

Confidential information is private information. Confidentiality is the protection of personal information that relates to service users and staff within the service. Confidentiality applies to all information that service users or staff give to other individual(s), either orally or in writing, and it applies to information gained through observation. Social care workers must comply with confidentiality as an aspect of their duty of care to their service users ('always follow employer guidelines and relevant legislation when handling service user information' (SCWRB 2019)). Service providers may redact service users' and staff names and use codes or pseudonyms to protect their data should it become lost or accessed outside its intended use.

A social care worker in the position of having access to or being given data on service users works in an area where their career is based on the ability to maintain confidentiality. The protection of confidential information is vital across all professions, but especially in the caring professions as the information tends to be of a sensitive nature and relates to vulnerable individuals.

Confidentiality between service users and professionals in the caring roles is highly important and forms the basis for the therapeutic framework of

appropriate boundaries. This creates a safe space for the development of a meaningful and positive working relationship to begin. By breaking confidentiality, the professional loses the trust of the service user, puts their work contract at risk; and they could be at risk of legal action (HSE 2018).

Tip

Social care workers work in an area where their career is based on their ability to maintain confidentiality.

In practice

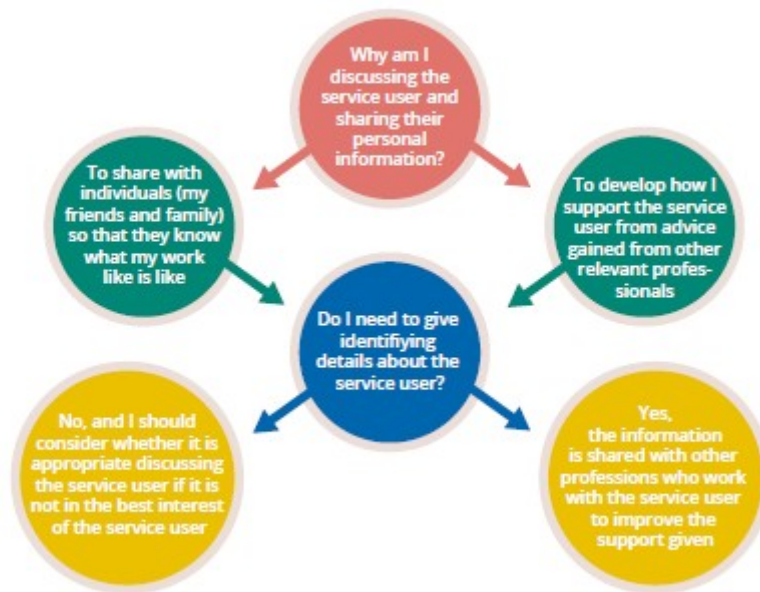
If a service user no longer trusts the staff who work with them, it limits their ability to fully avail of the service and achieve their goals. At the initial stage of relationship development with a new service user, the social care worker should discuss, at the service user's level of understanding, the boundaries in place, such as: the limitations of confidentiality; not being able to add the service user on social media; and other relevant boundaries in the service.

Tip

Confidentiality applies to existing and past service users a social care worker has worked with. Even service users who pass away are equally protected by confidentiality.

TASK 1

Use the diagram below and follow the process using your own information as a case study.



This diagram was produced by the author to guide ethical decision-making regarding the sharing of service user information

Confidentiality between Staff

Confidentiality applies not only to service users' information but also to information held on staff members, including information about staff members shared by other staff. When working in social care, information staff share with each other should be considered private and confidential unless there is a risk to the individual or other people. Due to the sensitive nature of the work, social care workers can at times have demanding challenges to overcome. One study by Keogh and Byrne (2016) found that 90% of social care workers have experienced violence in the workplace. As a form of self-care, staff may discuss their concerns or worries with colleagues, which may include personal information about their home life. When a staff member shares personal information, this should be viewed as confidential information and treated as such. If a staff member's performance is being impacted by personal life issues (which they have made you aware of), the best course of action is to discuss this with the staff member in question. If the impact is significant, encourage the staff member to share the issues with their manager to ensure that it does not affect their work. If the staff member is unwilling to discuss the issue with their manager and it is impacting

their work with service users and putting others at risk, you should bring the issue to your line manager or supervisor.

Tip

When a staff member shares personal information about themselves, this information should be treated as confidentially as information you have from a service user.

Tip

Staff should be mindful of the impact their personal life has on their work performance and seek the support they need to be 'fit for practice'. It is your responsibility to access support, especially if it is not adequately provided within the organisation.

Legislation Covering Confidentiality in Health and Social Care in Ireland

The laws relating to confidentiality come from the common law duty of confidentiality, the Irish Constitution and the European Convention. Healthcare professionals are legally obligated under these laws to protect the service user's confidentiality. There are legal sanctions for breaches in service user confidentiality.

Certain offences and provisions, such as various forms of abuse, override confidentiality. For example, if a child is hit by their parent this is a criminal offence which must be reported to the appropriate authorities such as the Gardaí and/or Tusla (the Child and Family Agency). Safeguarding concerns must also be reported when someone is at risk. Where a staff member is a mandated person there is a legal obligation under the Children First Act 2015 to report child protection concerns to Tusla (Tusla 2015).

Below is a list of the laws that impact confidentiality and that social care workers are obligated to follow in their work:

- Human Rights Act 1998
- Data Protection Acts 1988 and 2003
- Freedom of Information Acts 1997, 2003 and 2014
- Care Act 2014
- Health and Social care (Safety and Quality) Act 2015

- Data Protection Act 2018 and GDPR

Tip

The confidentiality of service users and staff is protected in law and when a breach in confidentiality occurs there are various forms of legal sanctions in place to manage these breaches.

Breaches of Confidentiality

A breach of confidentiality is a disclosure of information to an individual without the consent of the individual who owns the information. A breach of confidentiality breaks respect for the individual's privacy and the confidence in which the information or data was given. In the case of a personal data breach, the controller shall without undue delay and, where feasible, not later than 72 hours after having become aware of it, notify the personal data breach to the supervisory authority in accordance with Article 55 of the GDPR.

Confidentiality in social care is not absolute. If an individual discloses that they are a significant risk to themselves or there is a risk to someone else, the social care worker must break confidentiality and report the risk to their manager or supervisor and the relevant authorities. This is especially important where a child or a vulnerable person is involved. Where a service user has broken the law, you must report it or place yourself at risk of appearing to be complicit by association. In social care work, as the service users are typically vulnerable members of society, where confidentiality must be broken it should be done appropriately to protect the service user, staff and members of the public.

Tip

When a service user is at risk to themselves or someone else, inform the service user that you will be sharing this information with your manager and then report the matter to your manager or supervisor and the relevant authorities immediately.

Where multidisciplinary teams are involved, information about the service user

may be passed between the social care workers, social worker, doctor, psychologist and other relevant professionals working with the service user.

Examples of breaches of confidentiality:

- Sharing confidential information about a service user with your family or friends.
- Talking to another member of the staff about a service user who the other member of staff does not work directly with as part of the service user's team.
- Talking in a public place where other individuals can hear you discussing a service user's confidential information.
- Losing technology (laptop, computer, USB stick, handheld device, phone, etc.) which contains confidential information on service users, staff and the service, whether encrypted and secure or not.
- Sharing a service user's information outside the confines of confidentiality and consent. This situation creates confusion and constitutes a potential breach as it is unclear whether this information can be shared with staff or other professionals working with the service user.
- Losing a service user's file or emailing private information to the wrong recipient.

Tip

When seeking advice from others about a service user, remove names, locations, gender and other identifying details.

What to do when a Breach Occurs

Where a possible breach of confidentiality occurs, staff should report their concerns to their manager or supervisor in the service. After being notified, the manager or supervisor should investigate the breach of confidentiality and follow the service's policy on breaches of confidentiality (DPC 2018b).

- Where the breach occurred due to something of concern expressed by the service user around harming themselves or someone else, a risk assessment must be completed by the service provider. Relevant professionals and

authorities should be notified where a risk is present.

- Where the breach has occurred from staff disclosing information inappropriately to other people, the service manager or supervisor should take the staff member through the appropriate disciplinary procedure.

Where a breach happens, the first step is to discuss it with the manager or supervisor immediately, giving clear information based on the situation. More social care workers in recent years have become mandated reporters after completing the Children First e-learning programme offered by Tusla, which has been implemented from the Children First Act 2015 (Tusla 2017). Mandated reporting (reporting child protection concerns) may involve breaking confidentiality where child protection concerns are at or above the threshold set by Tusla, such as abuse or neglect of the child. In this situation the staff member must contact their manager, supervisor or company child protection officer immediately and if the incident breaches the Tusla threshold a Tusla report must be completed.

With the best intentions in the world, at times breaches in confidentiality can occur. A breach of GDPR must be reported to the Data Protection Commissioner within 72 hours of becoming aware of the breach. Examples of breaches in GDPR can be losing records containing service user or staff details, uploading data onto the wrong computer or network, emailing data to the wrong individual, etc.

TASK 2

What does confidentiality mean to the service user?

Consider what it is like to be a service user in your service where the service and staff hold a range of information about you. How might you feel if you discovered that staff who work with you have been discussing your private information to other staff who do not work with you, and with their family members?

Would you trust that staff and service provider after discovering this?

Confidentiality in Practice

As a social care worker, respecting the service users is a critical aspect of the work which was discussed in Domain 1 Proficiency 5. In social care, the service user may lack capacity to consent to confidentiality or know when confidentiality has been broken. As a social care worker, therefore, it is essential that you understand

confidentiality and the limitations it has in practice. When you need to share information about a service user, the first step is to seek advice from the manager or supervisor in the service. Using the scenario below as a case study, consider if confidentiality was breached.

Case Study 1

As a social care worker, you are supporting a service user at their own residence where they live independently. You are covering shifts for another social care worker who is out sick for the week. When you are supporting the service user, you are told that when the usual staff is on shift, she often falls asleep on the couch, while the service user watches TV in the same room. Last week, while the staff member slept, the service user walked to the local shop alone and came back without the staff knowing. As a social care worker, you are concerned for the safety of the service user. The service user asks you not to tell anyone else about the incident, as the 'sleeping' staff member is a really nice person and has been working with the service user for a long time.

In the above scenario a breach of confidentiality is required to protect the safety of the service user due to the risks involved. As the social care worker covering the shift, you should inform the service user that you will have to discuss this information with your manager and, while it is great that the service user was able to go to the shop unsupported, it should be discussed as part of the care plan in place. Then this information must be passed on to the manager or supervisor in the best interest of the service user.

Service User Information and Consent

The right of service users to control their private information is an aspect of self-determination. The result of not respecting the confidentiality of the service user can be that the service user no longer trusts the staff and service provider, and the service user might refuse to give vital information, such as their health status, to the service provider.

Steps to protecting confidentiality include:

- Only relevant information about the service user is collected and this information is stored appropriately, with a written contract explaining why the information is being collected.

- The service provider may only give 'relevant information' about the service user to staff.
- Personal data is only stored as long as is necessary in a secure location such as a locked room or encrypted laptop.

Tip

The decision to disclose service user information should not be done lightly and should be done with the guidance of the manager or supervisor in the service

In Practice

At times information on a service user may only be partially passed on to staff. This can be to protect the service user from further trauma, which can have both positive and negative implications. The positive benefits of not disclosing all the service user information to staff is that it reduces potential breaches of confidentiality, respects the privacy of the service user and encourages professional boundaries ('need to know' basis). The negative implications of not disclosing all the information about a service user is that staff may ask the service user questions about their life, which may be triggers that the staff is unaware of. Staff may unwittingly make the service user feel vulnerable if they ask questions about events in their past that they do not wish to share. For example, a service user who was abused by a family member being asked by staff, 'Do you see your relations often?' This could easily cause a situation to escalate, leading to an outburst triggered by the topic being discussed.

Typically, the manager in the service would decide what information should be disclosed to staff. Where staff show that they are able to maintain confidentiality over time it gives the manager assurance that staff are professional and that there is a reduced risk of breaches in confidentiality. This will lead to staff being given full disclosure of service user information more often.



Tips for Practice Educators

1. Explain to students the types of personal information your service collects on the service users and where this is stored.
2. Ask the student to read and summarise the key points of the Data Protection Act 2018
3. There are multiple tasks within this chapter. Select a task and ask the student to complete this task for your next supervision session.

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Chapter 11 – Noelle Reilly (DISOP11)

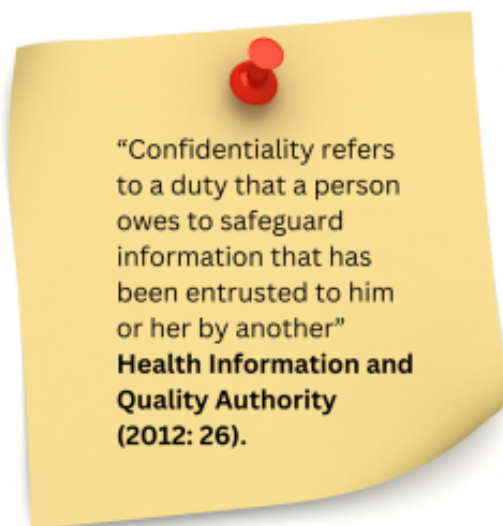
Domain 1 Standard of Proficiency 11

Understand confidentiality in the context of the team setting

KEY TERMS

Relevant
legislation
Confidentiality
Team
settings

Social care is ... professionals from an array of backgrounds providing support to vulnerable groups and individuals who are marginalised, disadvantaged or have additional requirements to help them achieve their potential.



This chapter explores the concept of confidentiality in a team setting with a focus on the legal, ethical and regulatory framework, through a case study based in a residential care setting. It is important that service users and their families have confidence in the staff and the service provided to them. Service users and their families expect that their privacy and confidentiality is respected (HSE 2018). Social care workers often work as part of a multi-disciplinary team, and confidentiality can pose

particular challenges when information has to be shared with other agencies. If confidentiality is understood and evident in day-to-day practice in a team

setting, it contributes to effective relationships between professionals and service users.

Relevant Legislation

The Data Protection Acts 1998 and 2003 place obligations on all organisations to safeguard the rights of individuals in relation to the processing of their personal data. Under the Data Protection Acts a person's data may only be used or disclosed for the purpose for which it was collected or for a directly related purpose. In addition, under the Freedom of Information Act 2014, all persons have the right to access information held by public bodies about them to the greatest possible extent, consistent with the public interest and the right to privacy (HSE 2021). Coupled with the Irish legislative framework, social care workers must adhere to the Code of Professional Conduct and Ethics for Social Care Workers, which is explicit in terms of acceptable behaviour related to confidentiality and privacy:

Part 2. Respect the Confidentiality and Privacy Of Service Users

2.1 You must:

- a) Keep service user information securely and, subject to other provisions of this Code, treat it confidentially, including guarding it against accidental disclosure.
- b) Share service user information with others only where and to the extent necessary to give safe and effective care or where disclosure is mandated by law.
- c) Inform service users of the limits of confidentiality and the circumstances in which their information may be shared with others.
- d) Obtain the consent of a service user before discussing confidential information with their family, carers, friends or other professionals involved in his/her care.
- e) Always follow employer guidelines and relevant legislation when handling service user information.
- f) Always follow best practice in relation to the use of service user information in clinical audits, quality assurance, education, training and research.

2.2 You should:

- a) Continue to treat service user information as confidential even after the death of the service user.

b) Be aware of the following circumstances in which disclosure of confidential information in the absence of consent may be appropriate, justifiable and/or required by law: to prevent harm to the service user or a third party to prevent harm to the public at large to comply with a legal requirement.

c) Inform the service user of the disclosure unless this would cause them serious harm or put the health, safety or welfare of a third party at risk.

d) Where you decide that disclosure is justified, you should ensure that the disclosure is made to an appropriate person or organisation, and that the extent of the disclosure is minimized to relevant information. (SCWRB 2019)

It is clear that confidentiality is an important legal and ethical duty of social care workers. In addition to the legal and ethical frameworks discussed, children's residential centres must comply with the National Standards for Children's Residential Centres.

Section 8.2.5 of the National Standards states that:

Arrangements are in place for sharing and transferring information in an efficient and timely manner to support effective decision-making. These arrangements clearly outline who staff share personal information with, in the best interest of each individual child, and the manner in which this is done to protect the privacy and confidentiality of the child the information relates to (HIQA 2018).

TASK 1

Write something personal on a piece of paper and put in an envelope. Give it to a friend. Ask them to hand the envelope around a group of their friends, with each person minding the envelope for a couple of days. Then the original person gives the envelope back to you unopened.

1. How do you feel about completing this task?
2. What thoughts come into your mind knowing that private information belonging to you is being shared among a group of people, some of whom you do not know?
3. What was it like to think that other people had access to your personal data?
4. How did you feel when the envelope came back to you unopened?

TASK 2

You are an employee working in a mainstream residential centre. One of the young residents in the centre (Ciara, aged 14) tells you that she has been hanging out with a boy in her class during school and she would like to meet him during her free time. They are 'just friends', but she thinks she would like to get to know him better. Ciara asks you not to tell everyone on the team because she is a bit embarrassed about her feelings for the boy and does not want everyone to know that she fancies him. You are from the area and have heard rumours that this boy's extended family are engaged in criminal behaviour, although you do not know the boy himself.

1. What do you say to Ciara?
2. Who do you tell? What do you record?
3. Which information from this case study is accurate and factual?
4. What are the limits of confidentiality in this scenario?

Discussion

The following analysis is based on Task 2. There are multiple variations depending on a range of factors. There is no 'one size fits all' in social care. Below is one possible team response to the case study which incorporates legislative, ethical and regulatory factors, but is not absolute.

1. Explain to Ciara that it is normal to feel a bit embarrassed about admitting that you fancy someone and thank her for telling you. However, remind her that in order to arrange for her to see the boy during free time you will need to speak to the team, and the social worker, so that free time can be discussed. This is also an opportunity to remind Ciara that there are no secrets in the team and that all information is shared within the team so that all the young people in the house are safe. Thank her for talking to you about it and assure her that her request will be discussed and that you will come back to her about it.
2. Remind Ciara that everyone on the team will be respectful of the information and will not share it with others, unless it is feared that she might come to harm, for example if she did not adhere to the free time guidelines and they needed to go look for her.
3. You cannot discuss your concerns regarding the young man with the resident as these are rumours and not based on fact. However, this

information may contribute to the risk assessment or safety plan protocols until verified.

4. The team, on being provided with the information, must not discuss this case outside the team setting unless Ciara becomes at risk, at which time it may become necessary to share information with specific professionals, for example An Garda Síochána or the school principal, depending on the nature of the concern.
5. The team must adhere to guidance provided by Ciara's social worker in terms of what information is shared with family members. This information will be available in Ciara's care plan.
6. Under Freedom of Information legislation, service users have access to their records, so if information has to be shared with other professionals it should be happen in a respectful and non-judgemental manner – it's not what you say, it's how you say it.

Paperwork to be completed:

1. Young person's log/daily record
2. Risk assessment
3. Social work contact
4. Individual/key worker
5. Minutes of team meeting
6. Updated absence management plan

Over to you

- Does anything else come to mind?
- Are there other factors to be considered?
- How might this scenario be managed in your setting?
- Would you handle it in a different way?



Tips for Practice Educators

1. Write a fictional case study for your service and ask the team to provide possible solutions.
2. In relation to TASK 2 – in supervision, tell your student what approach you would take and why.

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Chapter 12 – Maria Ronan (DISOP12)

Domain 1 Standard of Proficiency 12

Understand and be able to apply the limits of the concept of confidentiality particularly in relation to child protection, vulnerable adults and elder abuse

KEY TERMS

Confidential

ity Child

protection

Vulnerable

adult Elder

abuse

Life story work

Limits of
confidentiality

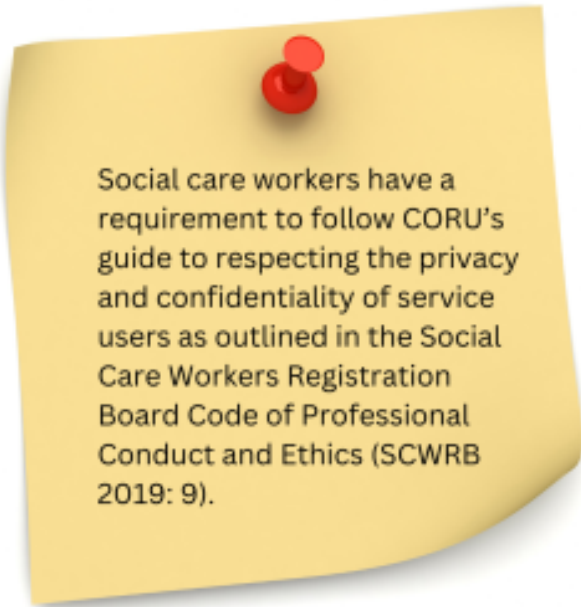
Everyday activities

Social care is ... a privilege. It gives us an opportunity to share in someone's life journey. When a person has vulnerabilities and we have a chance to make their life better in some way, for example making an effort to converse with a non-verbal person, being there consistently for someone on their long winding road through rehab or ensuring that an older person knows that their life continues to have value, we ourselves will be rewarded with an increase in our feelings of self-worth. Social care also means fun and enjoyment – there can be laughter with the people we support, even in the most challenging situations.

Confidentiality: Definition



'Confidentiality refers to a duty that a person owes to safeguard information that has been entrusted to him or her by another' (HIQA 2012: 26).



Social care workers have a requirement to follow CORU's guide to respecting the privacy and confidentiality of service users as outlined in the Social Care Workers Registration Board Code of Professional Conduct and Ethics (SCWRB 2019: 9).

TASK 1

Describe a time when you told someone something important that you asked them to keep private and later found out that they had told others. How did this experience make you feel – about the other person, but also about yourself, for instance, your ability to make judgements?

Understanding Confidentiality

Going through life, we all have experiences we would prefer that no one else knows about. These experiences can result from a range of factors including biological, environmental, social, financial, health, substance misuse, to name but a few. However, when a person enters the care system – which can occur at any stage in the life cycle – files are opened and records are updated on a continuous, probably daily, basis. The range of information that social care workers are obliged to document is comprehensive: monitoring health issues and all medication that has been administered; instances of challenging behaviour; contact with family members and others known to the person; the person's ability or otherwise in relation to their own personal care; foodstuffs they like and dislike; all social outings. Indeed, every possible aspect of the person's life may be recorded.

Among the reasons for this are to ensure that the various staff coming on duty are kept apprised of the person's needs and are also aware of the person's impact on others using the service, particularly in relation to verbal and physical behavioural issues. However, for anyone to know that their personal business is documented, in either hard copy format, on a computer or both, could, at a minimum, make them feel uncomfortable.

TASK 2

Think of a time when you made a mistake, when you did something that you regretted, something that you hope other people have now forgotten all about. Try to imagine this incident being documented in detail and placed in a file. Consider how you might feel if you knew that many different people, over a long period of time, would read over this and would know all about what had happened. What emotions could come up for you?

Understanding Confidentiality from the Other Person's Perspective

When working in a social care setting, you may be asked to sign a statement of confidentiality, but even if you are not, you have an ethical and moral obligation to respect people's right to privacy. Furthermore, there are statutory obligations on social care workers to comply with confidentiality guidelines. The *Social Care Workers Registration Board Code of Professional Conduct and Ethics* details the obligations on social care workers in relation to respecting the privacy and confidentiality of service users (SCWRB 2019: 9-10). To read about the key data protection legislative frameworks applicable from 25 May 2018 resulting from the General Data Protection Regulations, go to the Data Protection Commission's website: www.dataprotection.ie.

In social care work, there are many cohorts of people with different types of vulnerability and support needs, and even within particular cohorts, some people will need greater levels of support than others; areas of concern include child protection, vulnerable adults and elder abuse. Indeed, all children and vulnerable adults, as well as older people, can be at risk of abuse. The Health Service Executive (HSE) sets out the definition of abuse, the types of abuse, who can perpetrate abuse and where abuse may occur, in its guidelines on safeguarding vulnerable people at risk of abuse (HSE 2014: 8-10). This document also provides clear information on topics including recognising abuse, safeguarding and the roles and responsibilities of staff at different levels.

Importantly, this publication states that 'All vulnerable persons must be secure in the knowledge that all information about them is managed appropriately and that there is a clear understanding of **confidentiality** among all service personnel'; that concerns or allegations are shared among staff 'on a "need to know" basis in the interest of the vulnerable person' and that 'No undertakings regarding secrecy can be given' (HSE 2014: 7-9). This section of the Safeguarding Policy and Procedures document, indeed the entire document, will be hugely beneficial to all those entering or currently working in social care.

Areas of social care where we may be privy to confidential information:



This infographic was created by the author to illustrate key areas of safeguarding: child protection, vulnerable adults, and elder abuse.

Social care workers learn the details of people's lives in various ways. A certain amount of knowledge of someone's personal information is necessary in order to be able to help them, either in a crisis situation or to plan long term for optimum care. Other times we work creatively with a person by listening to their accounts of their past experiences, to help them understand their situation or simply to validate their lives. An example of this is life story work.

Life Story Work and Good Confidentiality Practice

Life story work is an intervention that can help children who have experienced bereavement or who are not living with their biological parents, such as children in residential or foster care, or adopted children. The Irish Foster Care Association (IFCA) states that the goal of life story work in working with children is to create a safe space in which a child can explore their past, present and future.

The information gleaned from any life story work should be treated in confidence, in the same way as information obtained in other ways such as from multidisciplinary team members (doctors, psychologists, social workers, speech and language therapists, nurses, psychiatrists, etc.). It is imperative to be aware that families, friends, carers and other professionals do not have an automatic right to data about a service user; consent should always be obtained prior to discussions with anyone other than your immediate colleagues. Even after the death of a service user, their privacy should be respected. If there is any uncertainty around what to disclose or to whom, your manager will provide guidance based on policies, legislation and their own professional experience.

Limits to Confidentiality

It is important never to give a supported person an assurance of confidentiality as information may come to light when undertaking life story work – particularly for children in foster/residential care – which would need to be passed on to the relevant authorities.

National guidelines on reporting allegations of or suspected abuse have been introduced, with many sectors also having their own guidelines (Lalor *et al.* 2007: 292-3). CORU states that concerns must be reported to the appropriate person or authority in order to ‘prevent harm to the service user or a third party; to prevent harm to the public at large, [or] to comply with a legal requirement’ (SCWRB 2019: 9).

In many sectors such as residential childcare, social care workers have to deal with quite upsetting and difficult issues when they learn of trauma experienced by some children and young people. Having to tell a person who confided in you that you have a duty to notify an authority figure can be a challenge when you want children who are out of home and have had a range of different adults in their lives to trust you. Nonetheless, if you have any concerns at all, always inform an appropriate person (such as your manager) or authority (for example An Garda Síochána).



CORU's guidance to the person making a report is to 'inform the service user of the disclosure unless this would cause them serious harm or put the health, safety or welfare of a third party at risk' (SCWRB 2019: 10). Such a situation could be distressing for the student or social care worker: not only have they learned of a difficult issue but the person in their care may feel let down. This is why it is vital that no promise of confidentiality is ever made. Although the priority is to support the person who has made

a disclosure, appropriate professional supervision should be mandatory for the student or staff.

To guide students in reflecting on challenges around confidentiality and trust in social care, McCann James *et al.* (2009: 113-25) offer a fictional scenario in a

residential centre for children and young people. Questions are provided for students to consider when attempting to navigate their way through the ethical considerations they may face. Sociological, psychological and professional perspectives are presented.

Confidentiality is also a key consideration in life story work with older people and those with dementia. Pouchly *et al.* (2013: 116) describe life story work as 'biographical approaches used with individuals with communication or memory difficulties within health and social care', suggesting the central role that recording memories and gathering items such as photographs can have in helping to sustain a person's identity and treasure their memories. An example of a life story book template can be found in the appendix to this article (Pouchly *et al.* 2013: 125-6).



Tips for Practice Educators

In order to meet this proficiency, it is vital for the student to understand the importance of confidentiality. One of the priority tasks of a practice educator when students commence their placement is to explain the necessity of confidentiality and to ask students to sign a statement of confidentiality (this document may in any case be an essential component of students' practice placement portfolios). Throughout a placement, students should be afforded regular opportunities to read national and internal policy documents relating to confidentiality, and to ask questions, as some of the terminology may be unfamiliar to them. As different matters arise, educators can remind students of the importance of not discussing what happened with anyone outside the immediate service. This will demonstrate on an ongoing, practical basis how reading around confidentiality relates to real-life situations, giving students an insight into applying theory to practice.

Each work placement agency will differ regarding how much access students are given to service users' files, and clear guidance must be provided. If a student is required by their college to complete a case study on a service user, they should be assisted to identify a service user who either has the capacity to consent to being the subject of a case study or whose next of kin will be happy to give consent. However, even if the case study is sanctioned, the person's identity should always be anonymised. While the responsibility to do so will have been explained to students in college it should be re-emphasised by placement staff and the student's supervisor should read the portfolio to ensure that identifying details have not been inadvertently included.

Students might not be aware that even family members are not automatically entitled to information. It may be that only the certain people such as named family members, or someone who has been granted (enduring) power of attorney, can be notified of matters pertaining to a service user. In particular, if a student will be answering the work telephone,

they will need to know with whom they may discuss issues, even of a non-sensitive nature. Furthermore, a student may wrongly believe that any person working in the organisation, or other professionals such as those on a multi-disciplinary team involved in the care of those supported by the placement agency, have a right to access data. The placement supervisor should apprise students of legislation, codes of confidentiality, best practice in this area and the internal policies of the agency, and monitor their understanding.

Crucially, students need to be informed of the legal and ethical dimensions regarding the limits of the concept of confidentiality. Staff can discuss with students situations where disclosure of confidential information to the appropriate authority is an ethical and/or legal necessity: these include where there is a risk of harm to the service user or others, where abuse is suspected, or to comply with a legal requirement. Tusla's guidelines on the Children First Act 2015 and the HSE's *Safeguarding Vulnerable Persons at Risk of Abuse* provide comprehensive guidance on this aspect of safeguarding (Tusla website; HSE 2014).

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Chapter 13 – Sarah Joyce (DISOP13)

Domain 1 Standard of Proficiency 13

Be aware of current data protection, freedom of information and other legislation relevant to the profession and be able to access new and emerging legislation

KEY TERMS

Data protection
Freedom of
information
Legislation
Modern social care in
Ireland

Social care is ... empowering people to become the best version of themselves

In recent years there have been vast changes in social care in Ireland. What was once viewed as a vocation has now become seen as a broad profession. Social care is still based on caring for those who are vulnerable and marginalised in our society, but now it is underpinned by legislation and a professional title. The primary legislation underpinning social care in Ireland is the Health and Social Care Professionals Act 2005, which recognised 'social care worker' as a professional title, a pivotal moment in gaining professional recognition for social care workers. This shift to a professionalised sector ensures that service delivery is underpinned by legislation and accountability. One of the most recent changes to come into effect is how we use, store and share information.

Data Protection

In their day-to-day work, social care workers deal with large amounts of data,

including information on service users and organisational information. The Data Protection Act 1998 (DPA) outlines how this information should be processed, in other words how we as social care workers use it. It is imperative to note that service users must consent to their personal data being processed (Tarafdar & Fay 2018). One example of information gathered by social care workers in the homeless sector is the holistic needs assessment (HNA). The HNA is a vital and comprehensive document that follows service users from service to service, enabling staff to have access to important information without service users having to re-tell their story, which is needlessly repetitive and sometimes difficult (Homeless Agency 2009:8).

The 'rough sleeper count' is an example of statistical data gathered by the Dublin Region Homeless Executive (DRHE) and Dublin City Council (DCC). The count is carried out twice a year by council and frontline staff of various organisations, including the Peter McVerry Trust, Simon and Focus Ireland. Staff are split into teams and each team is given a catchment area to cover. The teams count the number of people sleeping rough on that night and the information is then broken down into different categories. For example, in the 2018 count, 110 people were identified as 'rough sleepers': 84% were male, and 16% female; 42% were non-Irish nationals, 58% were Irish nationals, and 31 individuals did not reveal their nationality. This information is vital in identifying how many people are sleeping rough at any one time (alongside increases/decreases in rough sleeping) and what resources are required to assist rough sleepers to exit homelessness (DRHE 2018).

As we can see with the rough sleeper count, inter-agency work is imperative in the homeless sector. People who are homeless often have multiple complex needs stemming from housing needs – addiction, mental health, behavioural needs, dual diagnosis. It is almost impossible for one person or one organisation to meet all those needs, so a lot of inter-agency work is required. When working together, it is vital that organisations adhere to the Data Protection Act and are mindful of never using clients' names when sharing information; instead, initials should be used. Emails containing sensitive information should always be password-protected.

The EU General Data Protection Regulation (GDPR), which came into effect in May 2018, is the most important change in data privacy regulation in 20 years. It places a strong emphasis on consent and has strengthened how consent is gathered before information can be exchanged between organisations. When a client enters a service, they are asked to sign a consent form, which allows staff to liaise with other organisations on behalf of their client, for example the client's GP, or their local authority. It is important to explain to the client that this consent

is to enable staff to advocate on their behalf with other organisations. Clients must be made aware that this consent can be withdrawn at any time. There are penalties in place for any organisations that breach the regulations. It is a positive step for the protection of data belonging to everyone, especially those who are most vulnerable (European Commission 2019).

Task 1

The Security Company Tessian list 18 of the biggest GDPR fines in the EU in 2020-2021. Read the list and discuss why the fine was given?

<https://www.tessian.com/blog/biggest-gdpr-fines-2020/>

Freedom of Information

The Freedom of Information Act 2014 gives people autonomy over their personal information. It allows any member of the public to access personal information about them held by government bodies, bodies receiving state funding, and any other bodies that may hold personal information relating to that individual. It also allows people to amend their information where necessary (Government of Ireland 2019).

Dublin City Council's Corporate Plan (part of the Strategic Framework For Action 2015-2019) found that in 2016 there were 80 responses to freedom of information (FOI) and data protection requests from the homeless sector (Pyne 2017). FOI requests can be made for numerous reasons, including: to access official records held by government departments or other public bodies; to update or correct personal data; or to find out why a decision about a person has been made by a public body. If a person is exiting homeless services, they may wish to access what information is in the public domain about them from their time in homeless services. This is their right and a request can be made in writing or via email. The following information must be included in the request: be specific that you are making an FOI request; clarify exactly what information you are requesting; and supply a copy of current identification (Government of Ireland 2019).

An FOI application form for the HSE is shown below.

Title of Form and destination of the request		
Copy to: Decision Maker []	FOI Call Centre []	Application Ref No:
Health Service Executive		
Request for Access to Records		
Freedom of Information Act 2014		

1. Details of Requester (Please Use Block Capitals)			
Surname		Address	
Maiden Name			
First Name(s)			
Date of Birth			
Tel (home):	Tel (business):	Fax:	E-mail:

2. Personal Information (If request is for non-personal information, go to 3. below)
Before you are given access to your personal information, you will need to provide proof of your identity <i>(tick one)</i>
If you are requesting personal information in respect of another person, the consent of that person <i>(tick one)</i>

3. My preferred Form of Access is: <i>(please tick one)</i>
(a) To receive photocopies []
(b) To inspect the original record []
(c) Other format [] <i>(Please specify):</i>

4. Application

I request administrative access to the information/records detailed overleaf: ☐ (please tick)

If this is not feasible, I request access under Section 12 of the

Freedom of Information Act 2014: ☐ (please tick)

Signed:

Date:

5. For Office Use Only

	Admin Access	FOI Access
Date Received		
Date Acknowledged		
Identity Confirmed	☐ Yes	☐ No
Consent Verified	☐ Yes	☐ No
Access Granted	☐ Yes	☐ No

6. Details of Information/Records Requested

Describe the records as precisely as you can. If you are requesting personal information, please state the address at the time the record was created, and the Department/Hospital/Clinic attended within the

Please note: to help in processing your request, the information on this Form will be stored in electronic format.

Social care workers should know how to obtain data via an FOI request, either for themselves or for service users. For additional information, see <https://foi.gov.ie>. Social care workers must understand the relevance of how they write and record information on service users, including reports, handovers, client files and incident reports. This information may be used in the future and it is vital that social care workers can stand over any documents they have written.

Case Study 1

An incident occurs in a homeless hostel. A service user is involved in a physical altercation with another service user. Two staff are alerted to the incident when they hear shouting. They try to calm down the two service users and find out what caused the altercation. Before the staff have defused the situation, one of the service users leaves the building. The second service user follows and a second verbal altercation ensues outside the service. After a calm word from the staff one of the service users returns inside the building and the second leaves for a walk to cool down.

TASK 2

Write up an incident report for the case study.

When writing up the incident report, it is vital to pay attention to facts. At what time did the staff hear the shouting? What did they hear being said? How did the staff approach the situation? What did they see when they got to the service users? Who else was present? When were management informed? How did the staff debrief afterwards? What was the follow-up?

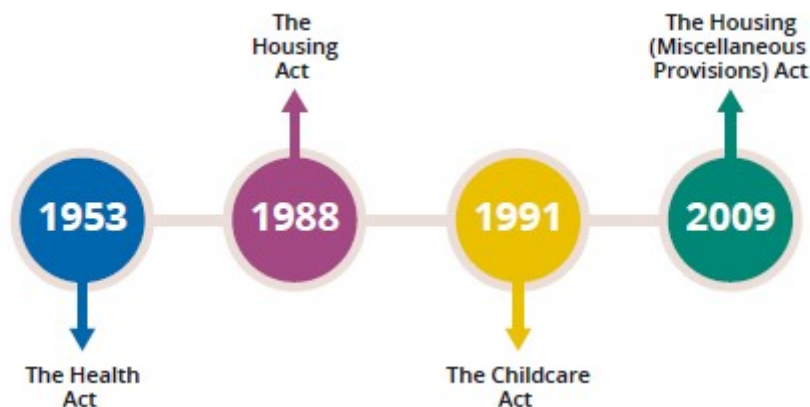
It is important to archive all information in accordance with the organisation's policies. Most records are held for between two and ten years, depending on the content. After this time they are destroyed. The retention of data has numerous uses, from government research to historic use (how data is analysed over time, generating trends) (Geraghty 2014).

Legislation

Legislation begins its life as a bill, often proposed by government. The bill can commence in either the Dáil or the Seanad, but it must be passed by both Houses to become law. The contents of the bill are discussed by government before it is introduced to the Dáil. The government will also consult with groups that the bill may affect, for example lobbyists, voluntary organisations and the public. Occasionally, a Green Paper is drafted – this is a discussion paper inviting ideas from the groups mentioned above. The report stage follows, when the bill is examined section by section. The bill is then sent to the Dáil, where it is voted

on. If it is passed, the bill goes to the Seanad, and the Seanad has 90 days to pass, reject or return the bill. Once passed, the bill becomes law (Oireachtas 2020).

As social care is a large and diverse sector, a number of laws and regulations apply to it. The primary legislation underpinning social care is the Health and Social Care Professionals Act 2005. The development of CORU (Ireland's multi-profession health regulator) was broadened to include the Social Care Workers Registration Board in 2015 and this was instrumental in assuring that social care is underpinned by the highest standards possible (Power & D'Arcy 2017).



This timeline infographic was created by the author to illustrate key legislative acts and their years of implementation

Some legislation relates specifically to homelessness. According to the DRHE, key legislation relating to homelessness in Ireland includes the Health Act 1953, the Housing Act 1988, the Childcare Act 1991 and the Housing (Miscellaneous Provisions) Act 2009. The Housing Act 1988 was the first Act to legally define homelessness. The Act states that a person is considered homeless if:

- a) there is no accommodation available which, in the opinion of the authority, he, together with any other person who normally resides with him or who might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of,
- b) he is living in a hospital, county home, night shelter or other such institution, and is so living because he has no accommodation of the kind referred to in paragraph (a), and
- c) he cannot provide accommodation from his own resources.

For information on all key legislation relating to homelessness, see www.homelessdublin.ie/info/policy.

Case Study 2

Joe is 42 and originally from Dublin City. He served a four-year custodial sentence for a drug offence in a prison in Dublin. While he was in prison, Joe tackled his addiction and is now over three years drug free. He is determined to turn his life around and turn his back on criminality. Before he was released from prison he had a factory job lined up through a friend. Prior to his release he reached out to family to see if he could stay with them on his release. Unfortunately, there was nowhere suitable for him to stay. As a result, Joe links in with his local county council to try to source a bed for when he is released. He is given a bed in a one-night-only hostel. He is told he will need to use the Freephone service to book back in each day and see if a bed is available. Joe is really worried that this will affect his sobriety and his job prospects post-release.

TASK 3

Discuss the above case study. What type of legislation would support Joe on release? Where could he go for information and support?

Recommendations were made by two different Oireachtas committees to introduce emergency legislation in an attempt to tackle the homeless crisis. These recommendations included rent freezes, restricting the sale of rental homes, and ending the use of 'one night only' emergency accommodation. This is an example of recommendations that may emerge to become legislation in the future (Holland 2019).

TASK 4

Go online and type in your name. Find some information that is available about you.



Tips for Practice Educators

Divide the class into different groups resembling the different sectors of social care. Can the groups find out the legislation related to each sector?

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Chapter 14 – Teresa Brown and Margaret Fingleton (DISOP14)

Domain 1 Standard of Proficiency 14

Be able to recognise and manage the potential conflict that can arise between confidentiality and whistleblowing.

KEY TERMS
Whistleblowing
Understanding social care
Confidentiality
Whistleblowing
Legislative framework

Social care is ... based on building relationships and making connections by drawing on the personal, academic and professional self.

TASK 1

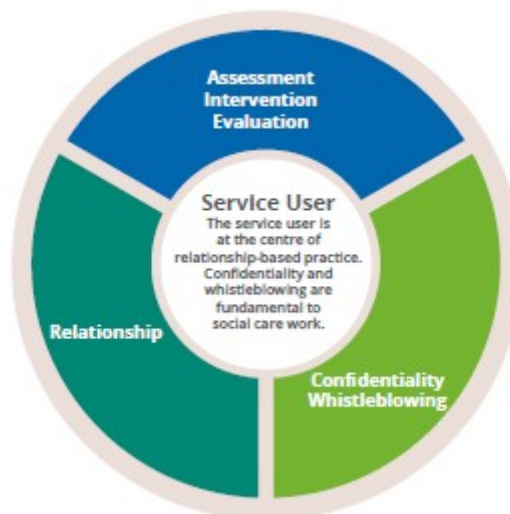
Think of a time when you were asked to keep a secret, but it didn't feel right.

Understanding Social Care Work

Social care has been a great companion in our life journey. It has equipped us to manage in difficult times, reminded us of our good fortunes, grounded us in

reality and opened many doors to opportunities that we might have otherwise overlooked. Drawing on the personal, academic and professional self is key to social care practice, and this requires the integration of knowledge of self, ongoing development of skills and competencies and the ability to be present for those around us. Building relationships and connections has been the cornerstone of our social care experiences and working with others has shaped not only our practice but our perspective on life itself.

Social care has been defined and redefined over the years, but recently CORU (SCWRB 2019) has offered a broad definition that will finally take social care practice into the professional realm. Social care practice is constantly changing and evolving to respond to societal care needs and demands. The individual is at the centre of the work and social care workers ‘engage in assessment, intervention and evaluation in a way that is bespoke, co-produced, fluid and organic’ (McGarr & Fingleton 2020). These processes are the bedrock of purposeful planning and service provision; however, despite the adaptations of defining social care, relationship have always been at the core of social care practice. Fundamental to this relationship-based approach is confidentiality and allied to this is the facility to engage in the whistleblowing process, now enshrined in Irish legislation.



The diagram was created by the author to illustrate the central role of the service user in social care, with a focus on assessment, intervention, evaluation, relationship-based practice, and the importance of confidentiality and whistleblowing.

Confidentiality

TASK 2

Read the Code of Professional Conduct and Ethics (SCWRB 2019) and find all the references to confidentiality and whistleblowing.

Confidentiality is a central feature of the relationship between the social care worker and the service user. The concept of confidentiality occupies a central position in social care educational programmes and is consistently referenced in legislation (Data Protection Act 2018) and policy (HIQA 2018; SCWRB 2019). However, despite our ethical and legal duty to respect confidentiality, we recognise that confidentiality cannot be absolute; there are many exceptions to client confidentiality, exceptions that are related to welfare and protection guidelines. More recently, social care workers are encountering ethical issues relating to confidentiality; computerised systems mean that social care workers have had to incorporate the use of technology into practice and must be cognisant of their impact on confidentiality and whistleblowing. The often-overlooked ethical issue in social care literature is the complexity of confidentiality when applied to whistleblowing events. Integral to our discussion on proficiency 1.14 ('Be able to recognise and manage the potential conflict that can arise between confidentiality and whistleblowing') is our view that challenging unethical practice and reporting concerns is a key element of social care workers' practice. There is clear guidance in our *Code of Professional Conduct and Ethics* on managing the potential conflict that can arise between confidentiality and whistleblowing, outlining the expected standards of behaviour and response.

Social care history gives us an insight into an organisational and societal culture that was not conducive to whistleblowing. The Ryan Report (2019) highlighted how witnesses stated that there was an awareness that children were being abused. The report stated that local people who were employed in residential centres as professional and ancillary staff and who tried to highlight the abuse were punished, and pressure was brought to bear on the child and family to deny complaints made. However, the social care landscape has changed and there is now an understanding that those who whistleblow are striving to improve service provision and delivery. The framework of support is articulated in Tusla's guidelines, which state that Tusla is committed 'to

addressing concerns and supporting workers in speaking-up relating to potential wrongdoing in the workplace and to providing the necessary support for workers who raise genuine concerns (Tusla 2017: 7).

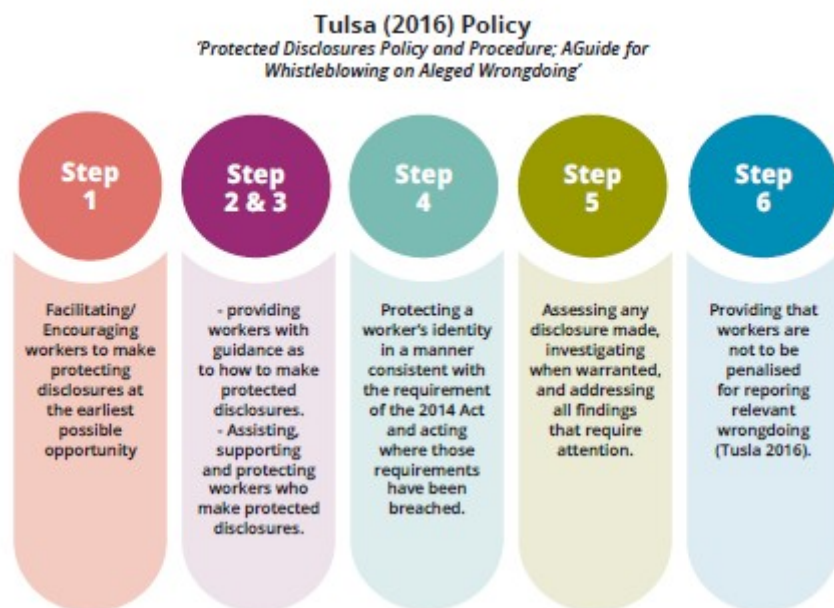
What is Whistleblowing?

The term whistleblowing originated from British police officers blowing their whistles to warn the public of a crime in progress. In addition, private business owners would use their own whistles to alert police that a crime was being committed. Current understanding of whistleblowing is the disclosure by a person working within an organisation of acts, omissions, practices or policies by persons within the organisation that are considered wrong or harmful to a third party. Reporting and/or highlighting these perceived practices has become known as whistleblowing (Tusla 2016). There have been highly publicised examples of whistleblowing in the media, particularly the account of whistleblower Garda Maurice McCabe. McCabe's disclosures of practices in An Garda Síochána led to some significant reforms in the force and to some major political debates, which resulted in a Tribunal (established in 2017), which examined whether there had been a smear campaign against him by the force. The case focused on the treatment of McCabe, who was falsely accused of child sexual abuse after he raised concerns about Garda malpractice. He settled his actions against An Garda Síochána and Tusla over the processing of a false allegation against him. This case demonstrated the complexities of whistleblowing, highlighting in particular the level of stigma attached to the act of whistleblowing. Arguably, however, there has been an attitudinal shift from 'snitch' to a more respectful orientation of acting responsibly and this is evident in the legislative framework.

Legislative Framework

The Protected Disclosures Act 2014 aims to protect workers from reprisal where they voluntarily disclose information relating to wrongdoing in the workplace that has come to their attention. The term 'worker' is defined broadly and includes employees, contractors, the self-employed, agency workers and people on work experience and placement. All public bodies are now required to have whistleblowing procedures in place to deal with disclosures under the 2014 Act

by workers who are employed by them and to provide details of these procedures to their workers. The Tulsa policy entitled *Protected Disclosures Policy and Procedure: A Guide for Whistleblowing on Alleged Wrongdoing* encourages workers to raise concerns about serious wrongdoing within their workplace rather than ignoring a problem or reporting it externally. The document states that Tulsa is 'committed to maintaining the highest standards of honesty, openness and accountability and actively encourages those with knowledge of wrongdoing to come forward' (Tusla 2016: 5).



This flowchart of the Tulsa (2016) Policy for whistleblowing, created by the author, on alleged wrongdoing, outlines the steps to facilitate disclosures, support workers, protect identities, assess disclosures, and ensure protection from penalisation.

There are penalties for any employers or other persons who punish or intimidate persons for whistleblowing, through various legislative frameworks. The Safety, Health and Welfare at Work Act 2005 and Employment Permits Act 2006 offer protection to whistleblowers; and the Protections for Persons Reporting Child Abuse Act 1998 provides protection for people reporting suspected child abuse in good faith. Despite legislative protection, issues can emerge with the potential conflict that can occur between confidentiality and whistleblowing.

Confidentiality and Whistleblowing

As social care workers we are aware of the limits of confidentiality when we have a duty to disclose information, but this is different from whistleblowing.

DUTY TO DISCLOSE	
Obligation	
Involuntary	

Balancing the obligation to highlight concerns against our duty to maintain confidentiality is a challenging ethical issue faced by social care workers. When considering whistleblowing, one could argue that if the issue is about a particular person or individual case, one can see the argument for confidentiality. Conversely, if it is about organisational practices, the need for confidentiality and the enforcement of confidentiality can cause particular challenges. These challenges are centred on enforced silence and secrecy. Confidentiality can be revealed as problematic and may be viewed as a means to silence and isolate.

The SCWRB Code of Professional Conduct and Ethics (2019) puts the safety of service users ahead of personal and professional loyalties. The code can guide and support our practice and help us manage the conflict that can arise between confidentiality and whistleblowing. Section 2 of the code refers to respecting the confidentiality and privacy of service users.

You Must	You Should
a. Keep service user information securely and, subject to other provisions of this code, treat it confidentially, including guarding it against accidental exposure.	a. Continue to treat service user information as confidential even after the death of the service user.
b. Share service user information with others only where and to the extent necessary to give safe and effective care or where disclosure is mandated by law.	b. Be aware of the following circumstances in which disclosure of confidential information in the absence of consent may be appropriate, justifiable and/or required by law: to prevent harm to the service user or a third party, to prevent harm to the public at large, to comply with a legal requirement.
c. Inform service users of the limits of confidentiality and the circumstances in which their information may be shared with others.	
d. Obtain the consent of a service user before discussing confidential information with their family, carers, friends, or other professionals involved in his/her care.	c. Inform the service user of the disclosure unless this would cause them serious harm or put the health, safety or welfare of a third party at risk.
e. Always follow employer guidelines and relevant legislation when handling service user information	d. Where you decide that disclosure is justified, you should ensure that the disclosure is made to an appropriate person or an organisation, and that the extent of the disclosure is minimized to relevant information (SCWRB 2019: 9).
f. Always follow best practice in relation to the use of service user information in clinical audit, quality assurance, education, training and research.	

SCWRB Code of Professional Conduct and Ethics (2019: 9)

Case Study 1

Maura has been working for a number of years as a social care worker in a residential unit. She enjoys her work and has a very positive relationship with service users and colleagues. In recent weeks one of the service users told Maura that Jane, the unit manager, had borrowed money from her. The service user did not want to make a complaint but was very worried about Jane. When Maura spoke to Jane about this, she noted a smell of alcohol on Jane's breath. Jane was upset when confronted about borrowing money and confided in Maura that she was going through a difficult time. The following week, when balancing the weekly budget, Maura noticed that money was missing. Maura was very upset over the incidents and unsure what to do next. She is fearful about reporting her concerns as Jane is a very popular manager and well-respected by senior management.

This case study demonstrates that one of the most difficult aspects of

whistleblowing is unethical practices of a colleague; unethical practices that you think may be overlooked or even supported by management or the organisation. It can be difficult to report these incidents, and the following statements can be justifications that you may use to avoid being a whistleblower.

- The manager has given her life to the job over the years, so she probably deserves the money she is taking.
- It might just be a loan that she will pay back.
- Misappropriating resources for personal use is no big deal – lots of people do it.
- If it's my word against the other staff member, nobody will believe me.
- The service user does not want to cause trouble; she confided in me.
- The service users would be annoyed with me; they talk about loyalty and consider people who inform to management as 'rats'.
- I don't have the energy to pursue this matter.
- Speaking about our unit may give the team a bad name.
- I am breaking service user trust and confidentiality.
- Social care is a small world; people will think badly of me because Jane is very popular.

These statements provide an insight into the complexities of managing the potential conflict that can arise between confidentiality and whistleblowing. It is therefore important to consider our responsibility as social care workers: in our daily practice we encourage and support services users to use their voice in highlighting injustice; we too must use ours. Arguably, whistleblowing in social care work could be viewed as a type of advocacy, as it can highlight unethical behaviours or practices on behalf of service users. Social care workers who perceive or witness poor practice and face the dilemma of whether or not to act need to access emotional support and professional supervision. Greater attention needs to be given to the support that is available for those who are involved in whistleblowing. Seeking out support is important; supervision team members or other professional colleagues may all play a role in this support matrix. The media reports of whistleblowers' experiences describe limited supports and some negativity from colleagues towards those who highlighted issues, so it is vital to be able to identify those who may be able to offer support, advice and structures to follow the correct procedures.

External supervision may not be available, but it may be a resource your agency could consider providing if requested. External supervision can offer a confidential and safe space for workers to discuss whistleblowing events. If

external supervision is not available, it is important that there is one identified person within the organisation with whom whistleblowers can discuss the issue and gain support.

TASK 3

The HSE's national 'Your Service Your Say' office comes under the remit of the National Complaints Governance and Learning Team (NCGLT) within Quality Assurance and Verification (QAV). (See www.hse.ie/eng/about/qavd/complaints/ysysguidance/appendices/ysysleaflet/ysys-feedback-leaflet.html. **not working**) Your Service Your Say ensures the fundamental right for people to voice opinions, provide comments and make a complaint, with a focus on creating a positive environment and culture to encourage and learn from feedback, especially complaints. Create an easy-to-read poster/flyer for a range of service users explaining how to access this service and how to make a complaint. <https://www2.hse.ie/complaints-feedback/>

Organisational Response

How do we create cultures where we can manage the potential conflict between confidentiality and whistleblowing? Organisational policies may require confidentiality to be enacted to protect whistleblowers in relation to due process if an investigation is under way. When professionals are following policy regarding confidentiality, this can be isolating and enforced silence can create a culture where rumours and gossip can exist. However, it is important to note that if there is a conflict between your agency policy and the SCWRB Code of Professional Conduct and Ethics, your professional and legal obligation is to this Code (2019: 23).

The importance of creating cultures that are open to complaints was identified in the Office of the Ombudsman's *Learning to Get Better* report (2015). This report looked at how hospitals handle complaints and found that people do not complain because of the feared negative repercussions, and they believe that complaining will not make a difference. The report recommended the need to create cultures that welcome complaints and highlighted the importance of acting on lessons learned. The open disclosures policy (HSE 2019), which has been adopted by several social care organisations, promotes the following:

- Full knowledge about the person's care and treatment is facilitated
- Clients are informed when things go wrong

- Meetings will be organised to discuss what happened
- A sincere apology can be made if there was an error while caring for the person
- Clients will be treated with compassion and empathy (HSE 2019).

If management structures are not open to complaints or to staff highlighting issues, professionals may report outside their organisations, so we need to ensure that internal avenues for reporting are accessible, clear and supportive. The importance of organisations having a whistleblowing policy in place cannot be overstated, and the existence of a whistleblowing policy demonstrates an agency's openness and transparency to areas of concern. By having clear policies and procedures for dealing with whistleblowing, an organisation shows that it is open to information being brought to the attention of management. It is only when social care workers feel safe and supported in their organisations that they will be confident about exposing concerning practices and managing the potential conflict between confidentiality and whistleblowing.

Arguably, if we construct and view whistleblowing as a positive and proactive action, it may lead to important information about risks or poor practice being brought to our attention. Social care workers at the frontline are often best placed to identify deficiencies and practices before things reach crisis point, so the importance of social care worker role as the watchdogs of organisations is central.

TASK 4

Watch the YouTube video on Whistleblowing in Social Care: Improving Organisational Practice: www.youtube.com/watch?v=oKtGgH7-eR0. In small groups, reflect on how this learning relates to placement experiences.

Tips for Practice Educators

Social care programmes will have covered whistleblowing in terms of definitions and policies; however, students would benefit from ethical scenarios that allow them to reflect on the following from the SCWRB Code of Professional Conduct and Ethics.

- Put the safety of service users ahead of personal and professional loyalties (p. 9).

- Insofar as possible, protect service users if you believe they are or may be at risk from another professional's conduct, performance, or health (p.8).
- If you become aware of any situation that puts a service user at risk, bring this to the attention of a responsible person or authority (p.8).

How do students raise concerns about safety and quality of care?

A. Inform an appropriate person or authority if you are aware of systems or service structures that lead to unsafe practices which put service users, yourself, or others at risk.

B. Raise the issue outside of the organisation if your concerns are not resolved despite reporting them to an appropriate person or authority.

C. Act to prevent any immediate risk to a service user by notifying the relevant authorities of any concerns you have about service user safety as soon as possible.

It is important that students are informed about the policies and processes for whistleblowing and that they are given support and direction if they need to challenge unsafe behaviours and cultures and organisational wrongdoing. Students need to be reassured that they can disclose openly and safely without fear of adverse consequences. Some students may find it difficult to challenge unsafe behaviours and organisational wrongdoing for fear of failing a placement or impacting future employment opportunities.

Practice educators and placement supervisors should be cognisant of this and be aware of the need to support students to take appropriate action if necessary. Course provider and placement provider policies should set out the processes and the support students can expect to receive from their colleges if they raise concerns or whistleblow.

Finally, the SCWRB (2019:20) outlines clearly what steps students should take when they have concerns:

Suggested procedure for decision-making

- a. Identify the problem and gather as much information as you can. Ask yourself if it is an ethical, professional, clinical or legal problem.
- b. Review the Code of Professional Conduct and Ethics and identify the relevant parts. Check other professional guidelines too, such as those of the HSE or government departments, as well as any relevant legislation.
- c. Discuss the issue with professional colleagues, being mindful of your obligation to respect the confidentiality of the service user.
- d. Consider asking your professional body for advice.
- e. Evaluate the rights, responsibilities and welfare of everyone affected. Remember that your first obligation is to the service user
- f. Keep notes at each stage of the process. Consider different solutions and decisions.
- g. Evaluate and document the potential consequences of each option.
- h. Choose the best solution or decision based on your professional judgement.
- i. If you have any concerns about the legality of your chosen course of action, seek professional advice at the earliest opportunity.
- k. Put the solution or decision into practice, informing all the people affected.
- l. Remember that you are accountable, as an autonomous practitioner, for the consequences of the solution or decision that you choose.

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Chapter 15 – Janine Zube (DISOP15)

Domain 1 Standard of Proficiency 15

Be able to gain informed consent to carry out assessments or provide interventions and document evidence that consent has been obtained.

KEY TERMS

Understanding the role of
social care workers
Variety of contexts (roles/
settings)
Documenting informed
consent
Interventions as planned
practice
Assessments

Social care is ... an invitation into a person's home and life, who pays your wages, the HSE or Tusla, for example, the se

Interventions and assessments are central to planned social care practice with service users, and efforts are made to gain service users' informed consent. Service users may be living in long-term care, such as disability or homeless services, or in community supported living. It must be noted that in some sectors informed consent may not be given, or required, for example in special care. This chapter begins with an introduction to informed consent and continues by looking at the role of the social care worker and the different tasks/interventions for which consent is needed. This chapter also describes the process of obtaining and documenting consent. Of the eighty standards of proficiency, two relate to informed consent. This chapter focuses on obtaining and documenting informed consent and Chapter 16 (Domain 1 SOP 16) provides an overview of the

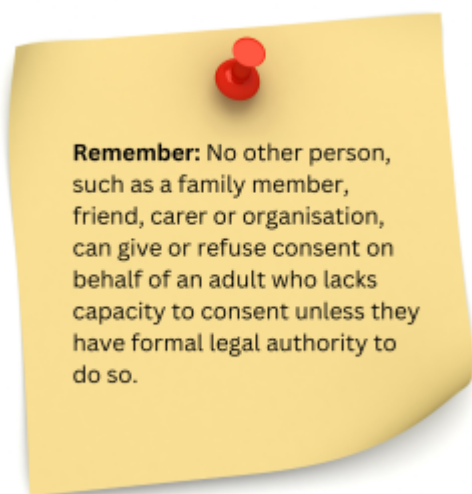
legislation and guidelines governing informed consent for people with a lack of capacity.

Task 1

Read Chapter 16 for an understanding of the legislation and guidelines governing informed consent for people with a lack of capacity.

Informed Consent

If your work involves supporting and caring for people, you must have the person's consent to what you propose to do with or for them, for example carrying out personal care. This respect for people's rights to determine what happens to their own bodies and life is a fundamental part of good practice and also a legal requirement. Adults are always presumed to have capacity to make healthcare decisions, unless the opposite has been demonstrated. However, anyone can experience temporary lack of capacity due to severe illness, loss of consciousness or other similar circumstances at some stage in their life. If there is sufficient reason to question the presumption of capacity, the person's capacity should be assessed. Social care workers have a duty to maximise capacity and all efforts must be made to support individuals in making decisions for themselves where this is possible.



HIQA (2020) states that informed consent is a process for obtaining permission or agreement before conducting any intervention, receipt or use of a service or participation in research, following a process of communication in which a person using a service has received enough information to enable him or her to understand the nature, potential risks and benefits of the proposed intervention or service on or for

disclosing a person's information.

Informed consent is 'freely given, specific, informed and unambiguous indication of the data subject's wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her' (European Parliament 2016).

While this is all good, you may ask yourself how you will be able to obtain informed consent from a service user who uses alternative forms of communication. As social care workers we always assume capacity of the person, even when someone requires support with his/her decision-making. It is important to document that informed consent has been given for an intervention and services, healthcare organisations and service providers have traditionally used paper-based consent forms on which intervention, services, procedure, together with risks and benefits, are noted.

The first step is to get to know the person and build a relationship. Once you have familiarised yourself with the means and communication method of the person, you will be able to adjust and amend information to the format of preferred communication.

Informed Consent Gaining: An Interactive Cycle



*Author-created diagram:
Through practical support at the
right time and in the right place*

TASK 2

You can make information accessible by using picture-supported information pamphlets or short video clips. Watch the following video and consider what information you could redesign for the benefit of your service users: <https://fb.watch/5-DjAkbiBJ/>.

Interventions

If you work in residential settings, you will be expected to support a person in daily life activities including personal care. It is important to respect the choice and preference of a person when providing personal care. Supporting a person with such intimate care always requires informed consent. Consent should also be gained for alternative arrangements, such as if a preferred support gender/person is not available. A person's decision-making and comprehension can be supported by additional user-friendly and accessible information, consent can be completed remotely, and the process can become paperless. One form of digital consent is dynamic consent, which invites service participants to provide consent in a granular way, and makes it easier for them to withdraw consent if they wish. This can mean that you as the professional have to become creative and inventive, making information accessible through the preferred choice of communication. This could be developing an easy-to-read version which is picture-supported or having a group discussion on particular subjects. The more information a person receives and understands, the better able they will be to make an informed decision.

You will also support people in making choices regarding their life and future. Supporting a person with profound disability will require a more adaptive format of giving informed consent. You may have to consult with someone who knows the person you support best or link in with an appointed independent advocate. A good example is the current pandemic. While we are all experiencing difficulties living with the pandemic and its restrictions, it is certainly much harder for service participants and vulnerable service users in our communities. Some of the hardest decisions our service users had to make was giving informed consent to cocoon and, more recently, consenting to receive the COVID-19 vaccine.

This has presented a specific challenge across services providing support for the elderly, people with disabilities and people of all ages with acquired disabilities. You may have to support a person who presents with momentary incapacity. Social care workers may have been suddenly presented with opinions from family members, and we all have our own opinion on vaccines and the necessity of protection against COVID-19. However, it is important that the person has all information and makes an informed decision. When presented with differences of opinion and the aspect of protection, it is crucial to document all interaction with the person. For example, a social care worker provided support to a person with an acquired brain injury by giving accessible

information to the person. To obtain informed consent a series of ten questions around COVID-19 and the vaccine were developed, such as:

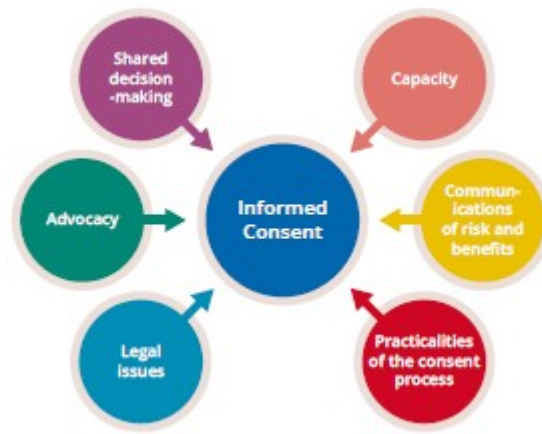
- Do you know about COVID-19?
- Would you like a vaccine which could protect you from COVID-19?

While the person initially declined the vaccine, it needed to be established whether they really understood what, in general, is meant by a vaccine. Reviewing medical records, if available, or consulting with a person who knows your service user well may give an indication of your service user's understanding of the concept of vaccines. Further, tailing questions such as 'Did you get a vaccine for polio or tuberculosis as a child?' might help to establish whether the person has received a vaccine before.

Once the ten questions were established a conversational interaction about COVID-19 was conducted with the person. To provide credibility and demonstrate informed consent, the ten questions were asked in the same order twenty times. During the first five conversations, written documentation of the conversation was completed with the person. During the remaining fifteen, informed consent was given by the person to record four conversations establishing informed consent and the wish of the person to receive the COVID-19 vaccine.

Visual supports relating to vaccines can also help the person to understand the issue. The HSE website has a list of these (see www.hse.ie/eng/services/covid-19-resources-and-translations/covid-19-vaccine-materials/covid19-vaccine-easy-read-and-accessible-information/).

Here we must emphasise that you will have to record and document all efforts made to seek informed consent from the person you support. You will act as a liaison between stakeholders such as family members, clinicians and the person you support. This can be challenging and complex.



Author-created diagram with key factors in informed consent: shared decision-making, advocacy, legal issues, capacity, risk communication, and process practicalities.

Understanding the Role of the Social Care Worker

Social care work is a very diverse role which involves working with people in a practical way through general day-to-day activities in a range of settings. This includes working with people with disabilities, mental health problems, minority groups, ethnically and gender-diverse individuals and groups in private and public settings.

A social care worker will, in a holistic and client-centred approach, develop personal growth and care plans for the person or group they support. They might be supporting a homeless person to find work or somewhere to live, teaching a service user with a disability to be more independent or helping an adolescent who has lived in care to adapt to life as a self-sufficient adult. More, in some settings or at times, a social care worker may become involved in working alongside the service user's family to ensure his or her natural support network (family) understand and support the development plan of the individual. Social care workers will stay in touch with other relevant stakeholders such as individual support agencies and multidisciplinary clinicians or liaise with other professionals on the service user's behalf. At times, the role requires assertiveness and the ability to provide 'tough love'. Sometimes, service users will need to be told 'no' and have alternative methods demonstrated, especially children and adolescents who need support with behaviour management.

TASK 3

Think of how you would experience some of the difficulties your service users (on placement or within your service) are experiencing. Focus on one issue and think of a meaningful intervention. Include a list of all the people who could be involved to support the person receiving the intervention.

Supervision is essential during this time, and engaging in frequent supervision sessions will ensure that our practice is client-centred and rights-based.

Variety of Contexts (Roles/Settings)

If you work with people with disabilities it is important to highlight that community participation should be inclusive and meaningful. If you ever thought your research days were over once you completed your undergraduate thesis, think again! The better your research skills are, the better you will be at sourcing inexpensive activities for people. In the case of a person with disability, joining a group predominantly representing people with disability may be a good start. The true skill is including all members of the community to either set up or join a common interest group. Suddenly you find yourself in the role of negotiation, or mediating between interest groups. Another skill to develop over time is how to access funding. This involves skills in accounting, being business savvy and promoting or marketing your project or supporting a service participant to take on a fundraising project.

You'll need to be well organised, confident and able to cope in potentially challenging situations.

You may find yourself supporting a person during a difficult time or after being admitted to hospital. This may require you to stay in the environment, organising and co-ordinating supports, engaging and informing other stakeholders, such as hospital personnel, who may not have the experience and resources to support a person with particular needs. Leadership and management skills are important as you will liaise with a number of people involved in a person's network, advocating and leading the delivery of care.

You might imagine that you will most often link with medical or clinically trained stakeholders, but you might find yourself supporting an individual accessing housing through county councils; applying to the Department of

Social Protection for financial supports; leading multidisciplinary case conferences; or dealing with family conflicts.

As a social care worker you may work with children, young people, families and/or significant others, social work teams, other healthcare providers and government agencies, schools, training agencies and community groups to care for, protect, and support vulnerable or dependent service users, individually or in groups, in conjunction with the wider multidisciplinary team and other relevant agencies that aim to ensure the welfare of service participants and you will act as an advocate as appropriate. You will contribute to the planning and evaluation of individualised and group programmes of care, which are based on needs identified in a holistic approach with your service user and others, and delivered through day-to-day shared life experiences.

In residential, day services, community or special care settings you will be part of a team providing a safe, caring environment for service participants – children, young people and adults – with the primary aim of providing the intervention necessary to address the issues that are preventing them from living at home or of preparing them to live independently with the support of aftercare services or individualised services.

Interventions as Planned Practice

Because we are working with people in all their individuality we must ensure that our skills develop and grow over time. It is important to form positive relationships with service users built on time and trust.

You will learn all about theories and approaches that will become your basic tool box for your career as a social care worker when you graduate from college. These skills will be observing, analysing and assessing situations and people's needs. However, not every person you work with will understand the traditional methods of communication, learning and interaction. Naturally, due to the limited resources available, you will become creative in sourcing material, accessing community initiatives or even shaping entrepreneurial skills; not reinventing the wheel, but making it more efficient, working to the needs and abilities of your key person/group.

Developing and implementing creative activities fulfil a variety of purposes, including: relationship development; increasing self-esteem; improving hand-eye co-ordination; and stimulating memory. These are all used in healthcare, the disability services, care for the elderly and the youth and community sector.

Creative and recreational intervention are designed to meet the individual needs of service users within these sectors.

You will conduct assessments based on the needs of the person you support. At times this may be challenging due to a variety of reasons, for example: a limited ability to communicate via traditional communication methods; being unsure of one's own wants and desires; lack of confidence; and past experiences. For example, a person with a severe disability may communicate in a non-verbal way. To support this person you have to get to know their likes and dislikes by finding a common language to communicate, for example by using pictures, audio or sensory supports. As key worker for this person you will become their interpreter and advocate. You will need to find the most natural way for this person to participate in the community and engage in activities of their choice with their peers. The need for social participation could involve bringing together people experiencing isolation for various reasons, such as mature age, having recently migrated or relocated, or mental health issues.

Challenging times, such as the current pandemic, demand creative solutions and adjusting your skills to develop, implement and deliver meaningful interventions. With limited physical contact you will find yourself having to use all means available to you to reach and engage with your service user(s). Some of the people you support will be tech savvy, but others may be hard to reach or may not have the means or technical advantages to stay in touch.

This proficiency is based on rights-based practice, therefore the importance of engaging with service users is discussed. Rights-based practice is a positive development; however, resources need to be available and accessible for workers to create a rights-based practice culture in order to 'gain informed consent to carry out assessments or provide interventions and document evidence that consent has been obtained'.

Tips for Students

- Be open to enter into a journey with your key service user/group, accompany their flow and speed to discover and support the growth and development of the individual/group. Enable the person/group to lead and develop the skills needed to reach personal goals.
- When planning your intervention or project, be patient with yourself.
- Building a relationship with your key service user/focus group is paramount to your intervention being successful.
- Think of a meaningful intervention for the person/group. Vitally, **match the intervention to their ability.**

- Use SMART goal to help guide goal setting. SMART is an acronym that stands for: Specific, Measurable, Achievable, Relevant and Time-based.
- Therefore, a SMART goal incorporates all these criteria to help focus your efforts and increase the chances of achieving your goal.
- Use and engage actively in all your supervisions with your practice supervisor.
- Last but not least, be kind to yourself during your journey. Reflect on your abilities as well as on your limitations and reach out to your practice and/or college supervisor
- Remember, a placement is a safe place to explore and develop your skill with the support of your placement supervisor.

Tips for Practice Educators

Engage the student in role play or introduction of attended group in placement (e.g., disability/aftercare).

Explore with the student their strengths and areas of interest areas. Find opportunities for them to familiarise themselves and engage with services and service participants.

Facilitate and create opportunities for students to experiences the difficulties service participants may face every day (e.g., engaging in activities while blindfold, using a wheelchair to explore daily activities, using ear covers).

Enable and engage student in reflective practice. Skill growth will come with practice. One practical exercise may be handing students particular responsibilities such as daily documentation reports or communication entries.

Be honest with your student if an invention/project may not be timely or realistic.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://tus.pressbooks.pub/standardsofproficiencysocialcareworker/?p=92#oembed-1>

[standardsofproficiencysocialcareworker/?p=92#oembed-1](https://tus.pressbooks.pub/standardsofproficiencysocialcareworker/?p=92#oembed-1)



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Chapter 16 – Moira O'Neill (DISOP16)

Domain 1 Standard of Proficiency 16

Be aware of current legislation and guidelines related to informed consent for individuals with lack of capacity.

KEY TERMS

Consent
Informed consent
Lack of capacity

Social care is ... being an extra support to a person in their time of need, being their information box, a spokesperson for them, a cheerleader behind them.

Social care is helping service users achieve their goals, whether large or small, and the belief that they have the tools within which need to be realised in order that they can do what is necessary to bring about positive change in their lives and the lives of their loved ones.

Consent

Understanding that the area of consent and capacity to consent is extremely complex is paramount when ensuring the rights of the service user. A lack of capacity can make those particular service users in our care who require support even more vulnerable as we endeavour to work with a human rights-based approach, ensuring that the rights of the service user are upheld and their needs are met. As students we are taught that each service user is an individual and to support their needs accordingly and to ensure that they are an active participant in their care needs.

Development within the area of social care gave rise to CORU being established to 'protect, guide and inform the public' (SCWRB 2017: 2), no more than the service users, particularly those with a lack of capacity, who avail of the supports available. This growth saw the views of the service user being

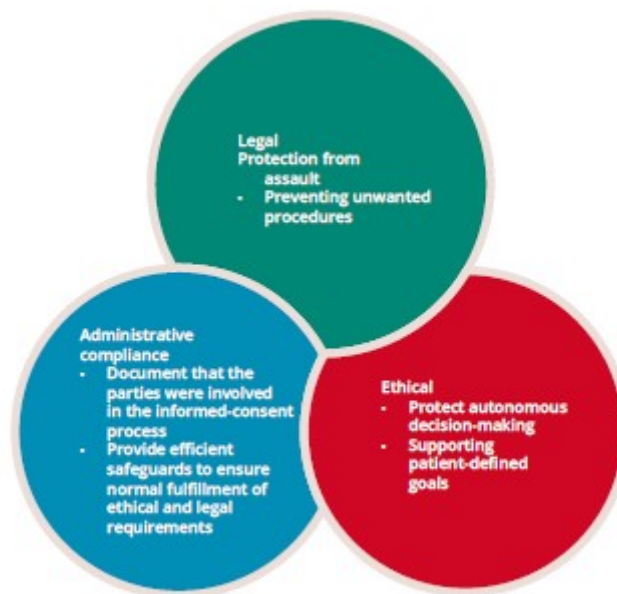
incorporated into care plans where historically their voices may not have always been heard and their consent not sought.

Many service users are extremely vulnerable members of society who experience adversity and access services for support to tap into and develop resiliency skills. Assistance is offered in areas such as youth and family services, mental health, homelessness, addiction and disability. Larkin (2009) highlights the difficulty in defining the term 'vulnerable', ultimately concluding that vulnerable individuals are those in society who are at risk or require support.

Nonetheless, we do not need to class those service users who lack the capacity to consent as completely vulnerable, as they can always make decisions regarding some aspects of their lives. We need to ask ourselves what we, as social care workers, can do in our duty of care to support their rights and empower them, while negating potential risk factors, to ensure that they are as independent as possible.

This chapter will discuss the role of social care workers and legislation in Ireland governing lack of capacity, which in turn governs organisational policies which are then interpreted and converted into practice by social care workers. There are many policies which often work in conjunction with one another to ensure the safety of all service users, especially those who are deemed to lack capacity. This allows them to live a life of their own choosing, safely, and with support and advocacy where needed from a social care worker.

The role of a social care worker is multifaceted and can often be challenging as a result. Their work entails a number of intertwined factors – legal aspects, ethical considerations and administrative compliance – as set out in the Venn diagram below.



Author-created diagram based on Hall et al. (2012: 534).

Hall *et al.* state that 'informed consent is primarily a legal and ethical concept' (2012: 533), discussing how autonomy can in fact be afforded to the service user in providing person-centred care that adheres to the legal and policy guidelines and requirements. Charleton (2007) states that 'ethics is central to human living' (p.2) and identifies an overlap in ethics and law for people with lack of capacity requiring social care intervention; where certain decisions cannot be made by the service user and ultimately rest with another, ethical considerations surrounding information, consent and confidentiality will arise.

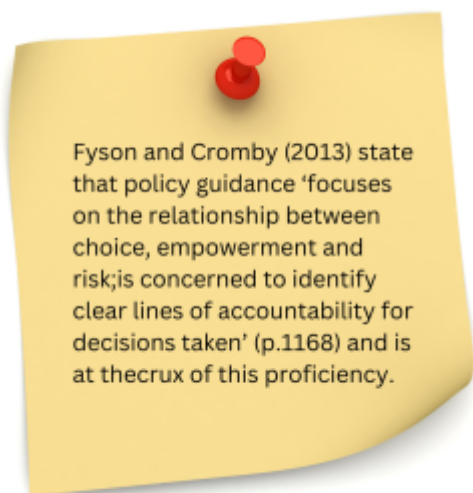
Sugarman *et al.* (1999) discusses how the requirement for obtaining informed consent is an expected part of practice and questions whether this consent is achieved meaningfully amidst the laws, professional guidelines and policies of the social care organisations. SCWRB (2017) introduced its proficiencies as a way to raise the bar for social care workers in providing intervention to those who access their services.

Informed consent is described in the Health Service Executive (HSE) National Consent Policy as a service user having a 'sufficient understanding' (2019: 53) of what is being proposed, while capacity is defined as the 'ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is to be made (2019: 12). The test is whether the service user can fully comprehend the intervention at hand and give their informed consent

and even be aware of their right to withdraw their consent if they disagree at a later time.

We must provide service users with accurate information and choice, and we should leave our own beliefs and values at the door. This approach will support the service user's autonomy and self-efficacy in their own culture of norms, values and beliefs. It is imperative that we as social care workers are working to empower the service user so that an open system of communication can be used to build valued relationships between the service user's family members, the services being accessed and the interventions being applied to ensure that the care provided to the service user is wholly person-centred.

The cornerstone of social care work is interpersonal relationships between the service user and the social care worker. Communication is a key element in developing trusting relationships and most important in good practice when seeking consent to interventions, and it should be an ongoing process. A service user will be more inclined to seek advice from and listen to their social care worker once a relationship has been developed that taps into the core conditions to encourage a service user's own potential.



Fyson and Cromby (2013) state that policy guidance 'focuses on the relationship between choice, empowerment and risk; is concerned to identify clear lines of accountability for decisions taken' (p.1168) and is at the crux of this proficiency. Social care provision has moved from a 'one size fits all' approach with the realisation that all service users are unique and require individual care plans to cater for their needs. A service user must be afforded the opportunity of deciding what is best

for themselves. It is important to balance the service user's right to make decisions regarding their own care and risk management in ensuring they are not a danger to themselves and to others. The person might feel very capable and able-bodied; however, if there is an overwhelming risk to their health and wellbeing, services might need to intervene.

There are two threads under Proficiency 1.16 regarding lack of capacity: children; and service users with diminished capacity. Under Irish law, an individual is deemed to have a lack of capacity to consent until they have

attained the age of majority, which is stated to be the age of 18, unless they have been married prior to this age (Age of Majority Act 1985).

However, Section 23 of the Non-Fatal Offences Against the Person Act 1997 states that the 'effective consent' of a minor who is 16 years of age or older allows them to make decisions regarding surgical, medical and dental treatments.

Article 12 of the Convention on the Rights of the Child advises that it is the state's responsibility to 'assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child' (UN 1990).

Other factors, set out in the MCI (Medical Council of Ireland) publication on the doctrine of informed consent, include disclosure, comprehension, voluntariness, competence and agreement (2008: 12). What this means in practice is that the service user is given information regarding the intervention, that they are seen to understand the intervention, that they partake in it without being pressurised, of their own free will, with surety.

However, there is an exception to this, which is transferred to guidelines and policy; information can be withheld from the child under a 'therapeutic privilege' or 'doctrine of necessity' clause (HSE 2018b: 5). One might appear to contradict the other. This particular clause implemented by the HSE provides that the wishes of the parents will be respected in the level of information provided to their child; however, this is in direct conflict with policies to empower the minor service user and may present an opportunity for a social care worker in advocating for their minor service user in line with *Better Outcomes, Brighter Futures* (DCYA 2014).

Children are deemed not to have the capacity to make decisions themselves because they are viewed as being incapable, by virtue of their age, of having the cognitive development to do so. Difficulties can therefore arise for parents and guardians where their growing child wishes to become more autonomous in their care plan or indeed withdraw their consent for intervention as a whole.

Social care providers will have set out specific policies regarding consent; for example, the Child and Adolescent Mental Health Service (CAMHS) provides a Parental Consent Policy (HSE 2018) which outlines best practice in providing information to explain the proposed treatment, why it is required, the benefits of it to the child, alternatives and risks to include consequences of not proceeding with the treatment plan as proposed.

Case Study 1

A young service user wishes to come off their medication as they feel overtired and sluggish in the evening. The parent who has consented to treatment would prefer for them to continue on the same dose as they are getting good reports from the child's school about their attention in class.

As a social care worker, how would you approach this scenario to cater for the wishes of the service user?

Having considered this scenario myself one thing that I would do is refer to the National Consent Policy: Part 2, particularly Section 4. I would give the young service user an opportunity of voicing their concerns. I would then be the child's voice and show that they are being listened to and heard in advocating on their behalf to their parent and then, during the multidisciplinary team meeting, to the psychiatrist prescribing the medication. One must work with the suggestions of the team in the decision-making process of assessing the risks and benefits for the service user and discuss matters arising with the parent of the child in reaching a solution that works for the young service user.

The Mental Health Act 2001 makes provision to allow the state to be appointed to act where a child's parent or guardian is deemed to have failed in their responsibilities to that child, and not just by reason of the child's own mental capacity. That child then becomes a ward of court, and decisions regarding the child's welfare rest with a person appointed best placed to make those decisions, known as their 'committee'.

Assisted Decision-Making Capacity Act 2015

Prior to the introduction of the Assisted Decision-Making Capacity Act 2015, applications for wardship could also be made for individuals who were, or who had become, incapable of making decisions regarding their own welfare and wellbeing. If their incapacity was certified by medical professionals, the court would assume responsibility for them. A person known to them could be appointed as their committee and thereafter be able to make decisions relating to the ward's medical treatment and financial decisions. Such practice was governed by the Lunacy Regulation (Ireland) Act 1871, depriving people with disabilities of their constitutional rights, an Act which has since been repealed by the Assisted Decision-Making Capacity Act 2015.

Moving forward, the court will appoint decision-making assistants or co-decision-makers who will support the person whose capacity has diminished.

The ward will be re-assessed and they will be transferred to one of the other new supports offered by the Courts Service. This move is designed to uphold the rights of individuals and support their decision-making capacity in areas within their capability and to recognise areas where they require the assistance of their decision-making assistant or co-decision-maker as appropriate.

The Assisted Decision-Making Capacity Act (2015) sets the test of a person's capacity. The 2015 Act was enacted into law following many developments, including the UN Convention on the Rights of Persons with Disabilities (2006); the Principles Concerning Continuing Powers of Attorney and Advance Directives for Incapacity; and Promotion of Human Rights of Older Persons (Kinsella & Harrison 2016: 34-5). These developments paved the way for allowing service users to resume the right to, and recognised their abilities to, make choices for themselves regarding their care and their wishes to provide self-determination.

Human Rights

Another example of lack of capacity is individuals with intellectual disabilities. The Universal Declaration of Human Rights provides that 'all human beings are born free and equal in dignity and rights' (UN 1948: 4). Degener states that while, as humans, we have our rights from birth, individuals with disabilities have traditionally had those rights withheld in what is seen as 'a form of protection – a form of caretaking' (2017: 5).

Article 1 of the Convention on the Rights of Persons with Disabilities, which was ratified in Ireland in 2017, states:

'The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

'Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (UN 2006).

However, capacity to consent is dynamic; if a person is shown not to have the capacity to consent in one particular area of their care it does not mean

that there is a lack of capacity to consent on the decisions and interventions pertaining to other areas of their lives. Historically, what may have been a blanket assumption of incapacity under the guise of protecting the individual has resulted in their rights being threatened, with many being institutionalised against their will.

Challenges could arise if a person with an intellectual disability wishes to work or to reside in the community outside the residential service. In these circumstances, it may become the role of a social care worker to assist in advocating on behalf of the service user.

Dhanda (2013) believes in supporting the service user in the context of universal legal capacity as a universal human right through co-facilitation or joint decision-making. A large cohort of service users have wished to have more control over decisions which affect them, so much so that further amendments may be made to the Assisted Decision-Making (Capacity) Act 2015 under 'Deprivation of Liberty', which is currently being proposed as an addition to Part 13 of the Act (DoH 2019: 4).

Another development in recent years was with the Criminal Law (Sexual Offences) Act 2017 repealing a ban on people with intellectual disabilities having sexual intercourse. The 2017 Act allows for 'protected persons' being afforded the ability to consent, replacing the blanket ban prohibiting sexual activities outright that had been introduced by the Criminal Law (Sexual Offences) Act 2003. Ní Aodha (2017) quotes Kathleen O'Meara of Rehab, who stated that it was an 'important step forward in opening up the law around sexual relationships for people with disabilities'.

Social care workers can be faced with a variety of ethical considerations and the boundaries that must be in place to ensure the safety and wellbeing of the service user. For example, where a service user with an intellectual disability wishes to have sexual intercourse with another service user, how is this situation dealt with by the social care worker and the multidisciplinary team? There are so many questions that are raised by this scenario. This would be of particular importance if, for example, a couple were engaging in sexual intercourse and one of the parties withdrew consent during the act. Section 48 (9)(4) of the Criminal Law (Sexual Offences) Act 2017 states that 'Consent to a sexual act may be withdrawn at any time before the act begins, or in the case of a continuing act, while the act is taking place'. From the moment that consent is withdrawn, and if the other party continues to engage in the act, the previous consensual act of intercourse becomes rape.

TASK 1

The movie Sanctuary tells the tale of a social care worker striving to do his best for his service user. Watch this film and make links to past and present legislation.

As well as the two groups set out above, some other categories of service users who may be affected by 'lack of capacity' legislation and guidelines/policies include those with mental health conditions such as autism spectrum disorder (ASD) or who have suffered a substantial brain injury following an accident or stroke, and individuals whose capacity is diminished by brain disease conditions such as dementia.

The Mental Health Commission has introduced a Decision Support Service (available at <https://decisionsupportservice.ie/>), although at the time of writing it is not yet operational. The service will provide information on a variety of situations that may arise when working with a person with reduced capacity. Despite the Assisted Decision-Making (Capacity) Act being signed into law in Ireland in 2015 it is not yet fully operational. The HSE (2020) has provided a range of online aids to prepare staff within its remit of health and social care under a National Quality Improvement facility.

There are a number of actions people can take to safeguard themselves in the future should they become incapacitated. An enduring power of attorney (EPA) is a document lodged in court under which, if the donor (the person transferring the power) loses capacity to make decisions for themselves, they transfer decision-making powers to a nominated party or parties chosen by the donor. The attorney has the power under law to make decisions concerning the medical and financial welfare of the donor until their death.

Another option is for the person to create an advance healthcare directive (AHD), a document often described as a 'living will'.

Specifically, this builds on person-centred planning, which is core to social care provision, to ensure a service user's autonomy: service users will be afforded assistance in decision-making only when required.

The AHD will record a person's wishes specifically in relation to decisions regarding their health should they become incapacitated in the future. Once the document is drafted to address the specific situation arising and executed while the person has full capacity and awareness of its meaning, it will have legal standing. The document can discuss a person's wishes regarding medical treatment and end of life care, to include 'do not resuscitate' instructions, should

such a situation arise in the future. The AHD will be a guide for healthcare providers and its contents can be revoked at any time by the service user. However, should the service user not have indicated their wish to revoke the document prior to its coming into force, its contents shall be valid. It should also be noted that the wishes contained in an AHD will override those contained in an EPA.

There has been much change in the area of social care provision over the past number of years. The one aim that is firmly in place is to safeguard the service user. Service users are now active participants, bringing to mind the term ‘nothing about us without us’, which can bring challenges in ensuring that their participation and choice will not cause them harm, and with the one goal of supporting their rights to the best of our ability.

Tips for Practice Educators

- Consider the points in the Venn diagram above.
- Always assume the service user has capacity to make the decision unless the opposite is proved.
- Ensure that you fully understand the intervention you intend to carry out with the service user and explain it to them in plain, easy-to-understand language.
- Remember that consent is an ongoing process. Approach each intervention as a new, separate task and support the service user to make the decision for themselves.
- Remember to document the approach you took as per your organisation's policy in your service user's care plan and carry out your ongoing health and safety risk assessment.

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Chapter 17 – Lauren Bacon (DISOP17)

Domain 1 Standard of Proficiency 17

Recognise personal responsibility and professional accountability for one's actions and be able to justify professional decisions made.

KEY TERMS

Personal
Responsibility
Professional
Accountability
Person-
Centred
practice
Professional
Decisions

Social care is ... an opportunity to harness human connection and spirit in a structured and purposeful way with the intention of improving the lives of others. Doing this is no easy task. Humans by nature go with the flow and engage freely with one another. However, the skilled social care worker must do this in a tactful and conscious way at all times, while not losing natural and meaningful engagement. With this role comes great responsibility.

Social care is a fine balancing act where you must simultaneously give and withhold the self when working with others. It is through the giving of self in everyday situations that you build and establish relationships with those you support. It is through withholding of self that you protect those you support from your own internal complexities, while also protecting yourself. This fine balancing act is managed through working in unison with the heart and head, each as essential as the other. There are times in social care where we must go into 'neck up' mode and use our head; education, the professional toolbox and the experience to make difficult decisions. However, we must never lose the heart and human connection within our work. By staying engaged with both, we can stand over our practice and justify our work and daily encounters. In times of difficulty, we must ask ourselves and reflect on the 'why' of our work. Keeping our 'why' at the forefront supports us to remain grounded and reflective throughout our work.

Personal Responsibility

As social care workers, we are personally responsible for the way we engage with others while exercising our professional duties of care and support. The Social Care Workers Registration Board Code of Professional Conduct and Ethics (SCWRB 2019) clearly outlines that it is the personal responsibility of social care workers 'to act in the best interests of the service users' (p. 8) by maintaining a 'high standard of personal conduct and behaviour' (p. 10). Workers must behave in a way that respects the dignity, privacy and confidentiality of the service user, without prejudice, discrimination, harm or abuse. Workers are personally responsible to ensure that they are mentally and physically fit for practice and are not under the influence of any substance. Understanding the principles of best practice, learning the codes of conduct and ethics and adopting an evidence-based approach will support you to maintain a high standard of personal conduct and practice.

TASK 1

Read the Social Care Workers Registration Board Code of Professional Conduct and Ethics (SCWRB 2019) and list all the codes of conduct and behaviour that you are personally responsible for.

Your personal code of conduct and ethics provides the foundation for your professional social care work toolbox (Lyons 2013). The social care toolbox is what you bring to work with you every day; it includes your values, attitudes and core beliefs. The key to harnessing this in order to positively influence your work lies in an active and purposeful engagement in self-awareness. Self-awareness relates to looking inwards and self-reflecting on your own values, views and core beliefs with the hope of improving yourself as a person and also as a social care worker (Lyons 2013). Lyons emphasises the importance of self-awareness, especially within a landscape that by its very nature will challenge our values, views and potential prejudices. Lyons states:

Social care practice is about making decisions for and behalf of others, and decisions are based on values, views and beliefs. If practitioners are unaware of their own issues, they will continue to work without regard to people's feelings, deeming that they know exactly what the other is feeling (2013: 103).

Therefore, practising reflection and being self-aware ensures that your social care toolbox remains in good working order in your daily practice, thus in turn contributing significantly to your ability and confidence in remaining accountable to your work and practice with service users.

Professional Accountability

Professional accountability in the social care sector can be a daunting challenge, especially for those working on the front line supporting our most vulnerable in society. Like most of our work, however, what is challenging can also be viewed as an opportunity, and a chance to break barriers and get positive outcomes for those we support. According to Kline and Preston-Shoot:

Professional accountability in the health and social care professions depends in no small measure on the quality of relationships between staff and service users, practitioners and managers, and teams of people in organisations. It rests on how well those involved manage and respond to certain uncertainty, the challenges and dilemmas that the work generates, the anxieties that practice and the management of practice create, the diversity that people bring and the disadvantages that impact on them (2012: 186).

Hearing phrases like ‘personal responsibility’, ‘professional accountability’ and ‘justifying professional decisions’ can sometimes induce feelings of self-protection. This is especially true in recent years within the ever-changing landscape of practice where accountability is now at the forefront. Working with people, especially vulnerable people, means that the stakes are often high, especially if anything goes wrong. We have seen this in recent years in media revelations of the concerning practices of some caring organisations. In day-to-day practice, many workers may fear legal repercussions, or internal investigations into the professional decisions they have made. These are real and genuine fears, and the reality is that things can go wrong when we are responsible for the care of the most vulnerable in society. It is imperative that professional accountability starts with accountability to service users by providing a safe and effective person-centred service. We do this by informing ourselves on best practice, learning the proficiencies and codes of ethical conduct for social care work, and reflecting on our encounters with others. In doing this, we can work without fear and get positive outcomes for those we support. We all have a personal responsibility to ensure that we promote open

communication with colleagues, the individuals we support, and line management to ensure that we are not promoting a blame culture in our environment.

Running parallel to the importance of self monitoring is the onus on line management and those in supervisory positions to support social care workers to navigate through the challenges of professional accountability and personal responsibility. Regular and protected time for supervision and support meetings is crucial, as is the promotion of team and peer support. Sharing learning, reflective practices and open communication are key and should be promoted by line management in all social care settings. Different areas and sectors of social care work fall within many different remits. In order to remain accountable within your chosen area, it is essential that you are aware of what these remits are. These may be, for example: legal remits, organisational policies and procedures, regulations, codes of conduct, and so on. You are only accountable in your work if you are aware of what the boundaries and remits of your work are. Having this knowledge should alleviate the worries mentioned above and give you confidence to move forward and not be fearful.



If you can confidently answer these questions every day, you are maintaining professional accountability. If you can't answer these questions, you may need to seek additional support. By using the Social Care Workers Registration Board Code of Professional Conduct and Ethics (SCWRB 2019) and following best practice principles in your daily work, you should gain confidence in your own practice and be able to justify the professional decisions you make.

Personal Accountability through Person-centred Practice

Professional accountability and personal responsibility go hand in hand in the social care profession. To be professionally accountable to your practice takes a skilled level of personal responsibility. As discussed above, professional

accountability is being knowledgeable of the remits and boundaries of your chosen sector and working within them. Personal responsibility is ensuring that you inform yourself of these remits and what is best practice for your service users. It also means knowing your limits and when to seek support. Best practice in a social care context should always begin by focusing on the person using the service. As Kline and Preston-Shoot (2012) mention, the quality of the relationships with those we support contributes significantly to the achievement of a high standard of care.

Within practice, the need to justify the professional decisions made will most likely not come up during the more straightforward encounters. It is most likely to come up in more complex 'what if' situations. We will look at one of these encounters in the next section. These are the situations where a decision needs to be made and you find yourself juggling many factors which need to be considered, such as (but never limited to) a person's will and preference, risk management, organisational policies and procedures, legal implications, professional codes, ethics and so on. The best starting point to tackle any situation or decision is by placing the person you are supporting at the centre, utilising a person-centred perspective. Person-centred practice means keeping the goals, wishes and aspirations of those you support at the centre of your work. A best practice organisation should have some sort of system in place which includes person-centred planning. This seeks to describe the person's vision for his/her life as a full member of the community and society and to identify goals and actions to support him/her to move in the direction of that vision (NDA 2005). A social care worker is most often the key supporter of an individual's person-centred plan.

Justify Professional Decisions Made

Above we looked at personal responsibility and professional accountability. Both are the active ingredients that, added together, support your ability to justify the professional decisions made. We will now look at a practice scenario to see an example of this.

Case Study 1

You are working in a service providing day supports to young adults with an intellectual

disability. Sebastian lives at home with his mother and two younger siblings. Sebastian is dropped at and collected from his service daily. He requires support to actively engage in the community as he can become overwhelmed in busy and unfamiliar environments. However, Sebastian enjoys going to a local shop, independently, twice a week, which he has practised over several months, as part of last year's goals.

During your key working sessions, you have supported Sebastian to complete his person-centred plan (PCP). Through this process he has identified that one of his goals is to travel independently to and from his service on public transport. The goal is discussed with Sebastian's mother as family support would be required to make the goal a success. Sebastian's mother expresses that this goal would not be a good idea. She says that it was tried in the past and was a complete disaster.

She says that it would not be safe for Sebastian and she would not be supportive of the plan. She reassures Sebastian that he is better getting a lift in and out in the warm car, and that he should focus on another goal, like going to Manchester to see a football match. Sebastian is the eldest sibling and his mother is a single parent. He is very protective of his family and wants everyone to be happy. He will often agree with what his mother says even if it is not in line with his own wishes.

TASK 2

Write down your initial thoughts. If you were Sebastian's key worker, how would you feel? What do you think you would do?

Keyworker 1 result:

The plan goes ahead. It was unsuccessful.

Outcome: Sebastian no longer wishes to travel independently due to the failure of the task. Sebastian's mother feels that the service put Sebastian at risk and knocked his confidence.

Keyworker 2 result:

The plan goes ahead. There are stumbling blocks but the goal is still in progress.

Outcome: Sebastian does not travel fully independently, but he does travel on public transport home each Friday with staff support. Sebastian still wishes to work on this goal and his mother is fully supportive.

Key worker 1:

Is a strong advocate for Sebastian and believes that Sebastian is an adult and his

mother should hold no influence on his personal goals. Key worker 1 goes ahead with the goal. There is a plan put in place and key worker 1 uses a 10-week travel training programme that has been successfully used in the past with other key clients.

At Sebastian's person-centred planning (PCP) meeting his mother is told that the training is taking place but is reassured that Sebastian will not be left alone. Key worker 1 discusses the plan with the staff team and drafts a staff support plan.

Key worker 1 is going through the practical travel training with Sebastian, which means accompanying Sebastian on the route. After doing this six times, key worker 1 decides without consulting family or the team to allow Sebastian to do a trial run. Key worker 1 walks with Sebastian to the bus stop and asks him if he would like to try the route alone. Sebastian is happy with this and agrees to give it a go. Key worker 1 leaves Sebastian and goes to the next bus stop, first informing Sebastian that she will be getting on at the next stop but will remain downstairs. When key worker 1 gets on at the next stop, Sebastian is visibly upset and becomes overwhelmed with the situation. Sebastian had become nervous at the stop when waiting for the bus and called his mother.

Key worker 1 returns to the service with Sebastian. Sebastian's mother is very upset that he was left alone, and that she was not informed of the plan. A formal complaint has been made. Key worker 1 will need to meet with her manager and explain what happened. Key worker 1's manager had not been informed of the plan to progress the travel training to a mock run. The result is as above and the goal of travelling independently to the service is now cancelled.

Key worker 2:

Is a strong advocate for Sebastian and believes that Sebastian is an adult and is entitled to set goals that are meaningful to him. However, key worker 2 understands that Sebastian's mother is a vital social support to Sebastian and her input is needed to make the goal a success. Key worker 2 supports Sebastian to progress his goal.

Key worker 2 reflects on what has worked well for Sebastian in the past, such as his goal of going to the shops independently. From Sebastian's person-centred plan (PCP), key worker 2 knows how important his relationship with his mother is and knows that her support is a key ingredient for success.

Key worker 2 and Sebastian devise a plan which is broken down into very small achievable steps over a period of a year. Key worker 2 links in with the manager to risk assess any potential stumbling blocks.

Sebastian shares his plan with his mother at his PCP meeting and her feedback is recorded. Each step of the plan is documented and clear dates and goals are set. Some of the steps are delegated to Sebastian to work on at home with support from his mother. The plan is in picture format so that Sebastian can see what is coming next. A support plan is also devised for the team. Sebastian is the owner of the goal and plan and is involved in every step including planning and organising.

Key worker 2 is going through the practical travel training with Sebastian, which involves accompanying Sebastian on the route. After several weeks, the next step of the plan is for Sebastian to do a trial run. Sebastian and his mother prepare for this step the night before, using his picture schedule.

The day arrives and key worker 2 walks with Sebastian to the bus stop and clarifies with him that he is comfortable to go ahead with the trial run. Sebastian is happy with this and the plan goes ahead. Key worker 2 leaves Sebastian and goes to the next bus stop, first informing Sebastian that she will be getting on at the next stop but will remain downstairs. When key worker 2 gets on at the next stop, Sebastian is visibly upset and becomes overwhelmed with the situation.

Keyworker 2 reassures Sebastian and returns to the unit. Sebastian has a cup of tea and they chat about how it all went. Sebastian is praised for what was achieved – he got on the bus, used the bus pass successfully and made his way to a seat. Sebastian explains that a small child on the bus shouted unexpectedly, which gave him a fright, causing him to become overwhelmed.

Sebastian calls his mother and tells her how it all went. Sebastian's mother reassures him and praises him for his efforts. Sebastian continues with the travel training, and key worker 2 adds to his supports to ensure that he has coping strategies to help him self-regulate if a similar situation should occur.

The progress on the goal is documented regularly and stumbling blocks are used as learning going forward. In the meantime, as part of the training, Sebastian now gets the bus home on Fridays with staff shadowing for support.

Learning and Reflection

Let's remind ourselves of the proficiency here:

'Recognise personal responsibility and professional accountability for one's actions and be able to justify professional decisions made'

Key worker 2 can be used as an example of best practice in this particular situation. While key worker 1 did follow some elements of best practice, ultimately they could not justify some of the professional decisions made.

Tools that key worker 2 used to ensure professional accountability/responsibility:

- Kept Sebastian at the core of all decisions.
- Recognised from Sebastian's PCP (evidence base) that the support and encouragement from his mother would be crucial to achieve success.
- Used past successes to inform supports; for example, knowledge gained from his previous goal determined that this plan would need a prolonged period of time.
- Ensured the information and plan was accessible to Sebastian – using a picture format with clear timelines.
- Involved his mother in the plan so that Sebastian could work on the goal at home, thus utilising his circle of support and increasing his confidence through encouragement.
- Linked in with the unit manager to risk assess any potential stumbling blocks.
- Reflected on every step with Sebastian and amended the plan when different needs arose.

The risks in both situations are the same; however, the professional approach used by both workers had different implications, both positive and negative. What is important here is not so much in the outcome but the process. While the ultimate result may be that the goal is unsuccessful, key worker 2 can justify the decisions made and can present all the steps taken to support the person. The approach used by key worker 2 will ensure learning even if the goal is not a success; and there will be no damaged trust between Sebastian, the service and his family supports.

It is crucial that we allow those we support to take positive risks. It is through risk-taking that we make mistakes and it is through mistakes that we often learn the best life lessons. Key workers 1 and 2 both promoted positive risk-taking here. Empowerment versus protection will always be a fine balancing act in your work

as a social care worker. By using all the tools available to you, as key worker 2 did, you can continue to challenge those you support and get the best outcomes for them.

While key worker 1's approach did not yield a positive outcome for Sebastian, all is not lost. There is learning in all practice. Reflective practice is an important element in ensuring professional accountability, especially at times when we may have not followed best practice and have had negative outcomes for those we support.

Complete the task below from the perspective of key worker 1 and/or as a team reflection.



As presented and cited in Dye (2011: 230):

Use Gibbs' reflective cycle to reflect on the practice of key worker 1's actions and steps and how they contributed towards their own professional accountability and personal responsibility.

Reflect as a team. Team accountability is as important as the actions of one key worker. How could the team have done things differently to ensure team accountability and team responsibility?

Tips for Practice Educators

A good understanding of this proficiency will be a crucial foundation for students entering

the social care sector. Being accountable is your personal responsibility, supporting you in being able to justify professional decisions you make. This can be especially daunting for students who may be limited in their practical experience. However, instilling in students that knowledge is power is an important aspect of achieving this proficiency. Having a solid foundation and understanding of professional accountability and personal responsibility will contribute to and support the student's ability to adhere to CORU's Code of Professional Conduct and Ethics for Social Care Workers (SCWRB 2019). Professional accountability and personal responsibility will be centrally guided and underpinned by this code as the student moves forward into their social care career.

You want students to have confidence in their capabilities and knowledge as they enter the workforce. What is even more important is that their competence matches this confidence. Students should tackle issues head on and not be afraid to have their voice heard. Informing themselves of the policies, procedures and regulations of their environment is a crucial first step. Sticking within these, they can then begin to navigate their way through real-life encounters. Having personal responsibility also includes knowing your limits and seeking support when needed. The most capable and trusted employees and colleagues are those who are honest and seek help/support when they are not sure how to proceed or do not know the best way to move forward or support a service user. Having open communication with colleagues and line management is a key skill that students should adopt from day one. Part of having professional responsibility and accountability is having the ability to put your hands up and admit when something has gone wrong or if a situation could have been handled differently. We are working within a human profession – we are humans. There have been many times when I have gone back to colleagues and service users to say I don't think I used the right tools, or maybe I could have used a different approach. This shows the people we support that we are human too and allows an open communication system that promotes discussion and troubleshooting together as a team. It is also important to prepare students that while they will witness good practice while out in the workforce or on placement, they may also witness bad practice or ill-informed practice. Recognising this and knowing the difference will be an important learning curve for students. There is always going to be an element of fear in our profession as the stakes are high and big mistakes can have detrimental affects on the people we support. We have seen the extreme of this through several exposures in recent years – all examples of bad practice and unjustifiable professional decisions. However, if you stay true to your core values, use the above guidance and always work within the remits of your sector, the level of risk is reduced and the potential for growth is huge.

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Chapter 18 – Iseult Paul (DISOP18)

Domain 1 Standard of Proficiency 18

Be able to take responsibility for managing one's own workload as appropriate

KEY TERMS

Responsibility
Workload
management
Time management
Self-care

Social care for me is ...

Supporting people with an intellectual disability,
Teaching, training, cleaning, sometimes making the tea.
Answering phones and writing reports,
While doing my best to get right supports.
It's driving and trying out lots of new things and
Holding a hand while someone gains their new wings.
It's walking and talking and learning about life,
Then figuring out how to have 'The Good Life'.
It's happy and sad, a bit scary at times and
Sometimes things just get left aside.
It's parties and picnics and roof's falling in,
Distraction and Action, people never give in.
It's planning and dancing and singing a song,
It's knowing it's okay when things do go wrong.
Saying Yes, Saying No, knowing when to let go,
And at the end of the day I get to go home.
Poem by Iseult Paul

TASK 1

Make a list of all the responsibilities you currently have. Include personal and professional responsibilities as well as those of a student.

Now choose the five you think are the most important and number them 1-5 in order of importance.

Reflect on what guided you in making your decision.

Responsibility

Social care workers are responding to a regulated sector therefore it is important that they take responsibility for managing their own workload. The next section explores this in more detail. The good news is that there are some very simple tools and strategies we can use to help us manage our workload.

The level of responsibility we have at any given time can vary and is often influenced by a number of factors. The poem 'Social Care for Me' gives a brief insight into this. Social care workers practise across diverse environments, with different service user groups, and their work is often conducted in difficult circumstances. The section on managing time explores ways of using time more efficiently and effectively, while introducing you to the concept of multiplying time. Social care students, especially those with no prior experience, may have expectations that they will have considerably fewer responsibilities than those they work alongside. This may be the case initially, but as students progress through college and practice placements the level of responsibility will increase. Read Jenny's story in the case study about how her supervisor's expectation of her ability to take responsibility for a set task differed from Jenny's ability to perform it. Different settings, management styles, the culture of the setting and the type of work can influence the level of responsibility given to students during placements.

There is a very long list of skills required by social care workers. Lalor and Doyle (2005:160) suggest that these skills can be categorised under five headings: Communication, Assessment, Planning, Intervention and Self-awareness. As our skills develop, so too do our responsibilities, and this can lead to stress. The section on self-care highlights the importance of self-care in social care and of creating a good work-life balance. As a social care student, you have a responsibility to show up to college, do the assignments set by your tutors, achieve the standard of education required by CORU and prove that you meet the 80 proficiencies set out in the standards (see <https://www.coru.ie/files-education/scwrb-standards-of-proficiency-for-social-care-workers.pdf>).

Responsibility is synonymous with accountability and can be associated with capability. For example, would you be responsible for performing tasks that you are not capable of? It would be lovely to be able to say that social care practitioners are not expected to perform tasks they are not capable of, but it would be remiss of me not to note that we are often asked or expected to perform tasks we feel or think we are not capable of.

TASK 2

Think about a time you were asked to do a task you felt you were not capable of doing.

How did it make you feel?

What could you have done differently?

Case Study 1

Jenny has been assigned the responsibility to make dinner for six residents, two staff and herself in a residential setting. Jenny's placement supervisor assigned her this task based on the assumption that Jenny can cook, but didn't actually ask Jenny if she could. Jenny has never cooked for a large group of people before and doesn't feel her cooking skills are good enough to produce a meal for everyone. This is Jenny's first placement and she hasn't been on shift at dinner time before. She is worried that she will fail her placement if she doesn't do a good job making the dinner.

What should Jenny do? Does she attempt to produce a meal for everyone, does she order food in and pretend she cooked it, does she say nothing and hope one of the other staff will do dinner, or does she discuss it with the other staff on duty?

In the end, Jenny discusses her concerns with the other staff members on duty, who reassure Jenny that they are there to support her, and as a team they come up with a simple solution. Jenny and one of the other staff members make the dinner together.

Sometimes in practice we learn by doing, and as a result we develop confidence in our knowledge and skills. Jenny learned by doing this activity with another member of staff, and the next time she was able to make the dinner independently. You may think the above scenario is unlikely to happen, but having to produce meals for individuals or groups of people, especially when it is your first time, can be scary – the last thing you want to do is poison everyone or appear incompetent. Learning how to cook is not on the curriculum for social care students but it is most definitely a skill required in some, if not all, social care settings. Tasks such as cooking or preparing a meal can provide opportunities to build relationships with staff or with service users, even if the cooking is not up to standard! As social care practitioners we have a responsibility to recognise and identify our own limits, and know when to seek advice from others (see Chapter 2 for more information).

TASK 3

Review a job description for a social care worker in a specific setting you are interested in, and look at the list of responsibilities. List the skills you already have that would enable you to take on some of these responsibilities.

Reflection and action planning can identify learning activities that help to build skills that lead to an increase in responsibilities (see Chapter 58, Domain 4-3). It is important to remember that you have a responsibility to show up and to conduct yourself in a professional manner in adherence to the social care code of conduct (see <https://www.coru.ie/files-codes-of-conduct/scwrb-code-of-professional-conduct-and-ethics-for-social-care-workers.pdf>).

It is your responsibility to have a realistic experience from each of your placements. Discuss with your college tutor or placement supervisor if you feel you are not gaining enough practice or support to meet your proficiencies and develop your practice.

Managing Your Workload

As previously noted, as your level of responsibility grows, your workload also grows.

Students are often worried about what they need to achieve to pass their course and placement, such as:

How will I make up my hours? How does theory translate into practice? Will I pass my exams, placement? What will I do for my intervention? What will I be doing? Will I be hanging round doing nothing? How am I going to manage my job and placement? Will I have to do personal care?



Author-created Diagram: Common Concerns and Questions About Placement: Navigating Challenges and Expectations

Tip: Don't panic! You have experience of managing your own workload

Students already have experience of managing their own workload, for example attending lectures, submitting assignments on time, managing college, work and their personal/social life. Practice placements differ according to the type of service provision and the environments in which social care work is conducted. Most students starting placements will have a settling-in period, and this is good practice, but this may not happen across all settings. A third-year student will have more experience than a first-year student, so supervisors and tutors will have higher expectations of them. Learning goals and pre-placement visits will provide valuable knowledge as to what students can expect from their specific placements and gain some understanding about their workload. Do your research on the specific setting.

As you progress through college and each of your placements your workload will increase, but there are a number of tools you can use to help you manage your workload effectively and efficiently. The To-Do list is popular, and can be created very easily either the old-fashioned way, with pen and paper, or using technology, such as an app on your mobile phone or computer. It is important not to have too many items on your To-Do list, so make a list for each day or shift. The important thing to remember is to use a system that works for you.

Tip: Look up www.mindtools.com/pages/article/newHTE_05.htm for tips in

preparing and using To-Do lists.

TASK 4

Make a To-Do list of all the tasks you need to complete.

[Today? This week?]

Once you have created your To-Do list, you need to review all the tasks on it and decide how you are going to prioritise them. The Eisenhower Matrix (see <https://www.mindtools.com/all0k5/eisenhowers-urgentimportant-principle>) is a useful framework that can help you prioritise tasks according to their importance and urgency. The matrix has four quadrants.

- Tasks in the first quadrant are both **urgent and important** and therefore have the highest priority. Tasks or decisions in this quadrant require immediate action and you must do them first.
- If a task is **important but not urgent**, it goes in the second quadrant – these are the tasks you can plan for. This is the quadrant we should try to manage most of our work in. (Planning is a core competency required for social care and when interviewing for jobs it is one of the competencies interviewees are asked to give examples of.)
- Tasks that are **not important but urgent** are those in the third quadrant, and these are the tasks you can delegate. Practice educators often delegate tasks to students on placement to free up their time so that they can focus on other tasks.
- Finally, in the fourth quadrant are the tasks, considered **not important and not urgent**. These tasks have the lowest priority and you might eliminate them from the To-Do list for that day or altogether. If they need to remain on the list, move them to the next day's To-Do list.

In his book *The 7 Habits of Highly Effective People*, Stephen Covey expands on Eisenhower's idea of what action needs to be taken when making decisions.

The Eisenhower Matrix

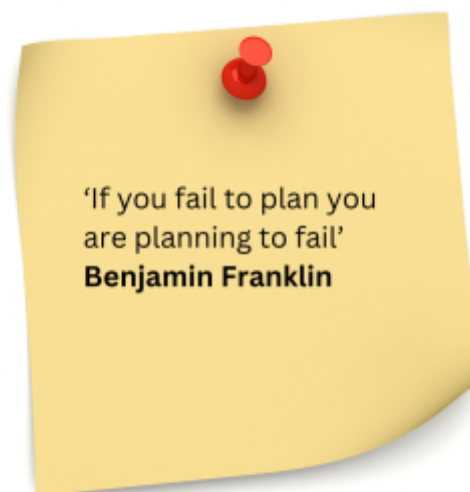
	URGENT	NOT URGENT
IMPORTANT	1. Both urgent and important Deadlines and crises (assignments, emergencies) Do	2. Important but not urgent Long-term development (planned study, planning your time) Plan
NOT IMPORTANT	3. Urgent but not important Distractions with deadlines (some meetings, some emails/ calls) Delegate	4. Not important and not urgent Frivolous distractions (frequently checking social media) Eliminate

Source: adapted from Covey 1989

TASK 5

Using the matrix, place each task on your To-Do list into quadrants based on its level of importance and urgency.

This exercise can assist you in identifying how best to manage your workload by planning how to use your valuable time.



If you are spending most of your time in quadrant 1 on tasks that are important and urgent, you are failing to plan effectively. If you are spending too much time on tasks in quadrant 4, like checking your emails or messages every five minutes, you are probably wasting a lot of your time. Of course, checking and answering emails is part of our job, but it is less urgent and important than tasks such as ensuring someone is safe or has assistance with personal care. Tasks in quadrant 4 may never get done, or their level of importance may change – in which case, move them to a different quadrant. Set aside specific times for emails and phone calls where possible, and get rid of the tasks that will waste time, like surfing the net for hours on end. The most important thing to do is to review your To-Do list, check off tasks completed and add new ones.

Managing Time

Time management skills are one of our core competencies.

Statements often heard in a day service for people with intellectual disabilities.	There aren't enough hours in the day
	I have no admin time
	Where's the time gone?
	Time flies
	I haven't got the time to do it
	I ran out of time
	Where am I supposed to find the time to do t
	I wish I had more time

A conversation with a friend and her son led to some reflection and thinking about how we use our time. His mother had made a remark about time going slowly, which led to a discussion about how time actually moves. He said he didn't understand why people said this kind of thing and made the point that 'time does not go slow or fast, it moves at the same rate each time'. This led to a debate about how people might *perceive* time as going quickly or slowly. The following arguments were made:

1. When we do something we enjoy, like going on holidays, or out with friends,

time flies.

2. When we do something we don't enjoy, like housework, ironing, sitting in a hospital, time drags.

To test this theory we suggested that he went to put the kettle on, stand beside it and watch it boil, then come back and tell us if the time had dragged. He pointed out that this would be wasting time. He said, 'I could be doing some press-ups while I wait for the kettle to boil and save time.' His point was that it would take the kettle the same length of time to boil, whether or not he was watching it. So he would use this time in a more productive way – he was using his initiative to manage his time more effectively. Social care often requires us to be creative in how we use our time. Emptying the dishwasher while waiting for the kettle to boil is just one example; going for a walk or coffee with a service user and having a 'conscious conversation' is another. Gordana Biernat (2016) suggests six ground rules for conscious conversations (see <https://www.powertalk.se/conscious-conversation/> for more information).

Good time management enables us to be more productive, and we often try to do more than one thing at a time, but does multitasking actually save time? In the above scenario you might think that my friend's son was multi-tasking, but let's take this a step further and consider the idea of him 'multiplying' his time.

In his 2015 TED Talk, Rory Vaden, a self-discipline strategist and bestselling author, explores the idea of multiplying time (see <https://youtu.be/y2X7c9TUQJ8>). He suggests that people need to forget about trying to manage time and instead think about self-management. In introducing his concept of multiplying time, he makes the point that the 'key to multiplying your time is to procrastinate on purpose'. When I was serving my apprenticeship in my previous profession, my mentor (who also happened to be my dad) always told me, 'Don't put off until tomorrow what you can do today.' The concept of intentionally putting things off, and thus multiplying time, is intriguing. Time moves at the same pace – an hour is an hour no matter what – so how can we multiply it? It requires a different way of thinking, and involves looking at the significance of tasks. In order to multiply time, you must give yourself the 'emotional permission to spend time on things today that will give you more time tomorrow' (Vaden 2015). Vaden offers a framework called the Focus Funnel (see Figure 1), which is quick and easy to use, and I believe can serve us well in social care. He suggests that as tasks pass through the funnel the first question to ask is 'Can the task be eliminated?'. One way of eliminating tasks is to say no to them in the first place. As social care practitioners we can struggle to say no, but we have to be realistic about what we can and cannot do, and know that it is sometimes okay to say no. Managing our

workload effectively and efficiently often involves saying no to additional tasks or responsibilities. As practitioners we need to be flexible, and saying no might not be a viable option, but when we say yes to one thing we are indirectly saying no to something else.

When a task cannot be eliminated the next question is, 'Can it be automated?'. Automating takes time but this is where spending time today can save time in the future, thus, multiplying your time. Vaden refers to this as 'ROTI, Return on Time Invested'. Setting up databases, templates for risk assessments or for support plans, or draft email responses are examples of how this is done in practice. If a task cannot be automated, can it be delegated? We often spend a lot of time on tasks that we could have delegated to others; the reason we don't delegate might be because we think that the other person cannot do the task or that we will do it better or more quickly. In his book *Successful Time Management*, Patrick Forsyth discusses the importance of investing time in order to save time. Spending time teaching others to do a task will save you time in the future, so think of it as a ROTI; or, in order to save time you must 'Speculate to Accumulate' (Forsyth 2019). Examples of this in social care might include teaching service users to do tasks independently, or teaching students how to run a specific activity or create support plans.

After each task has gone through the funnel and you have decided that it cannot be eliminated, automated or delegated, it drops out of the funnel. The only question left to answer is whether you should do it now or whether it can wait until later. If you must do the task now, you give yourself permission to 'concentrate and focus' on the task, free from other distractions. If you decide the task can be done later – what Vaden calls procrastinating on purpose – you 'hold' the task at the top of the funnel. At a later stage the task goes back through the funnel and this time it might be eliminated, automated, delegated or concentrated on. However, if the same task continues to be put off until later and constantly remains in a 'holding' position, then you should really have eliminated it, so be brave and take it off your To-Do list (Vaden 2015).

Figure 1: The Focus Funnel



Source: Adapted by author from Vaden (2015).

Case Study 2

Ted (not his real name), a gentleman with an intellectual disability, asked that a staff member bring him to his brother's and parents' grave, which was close to his day service. Ted had been supported for a number of years by staff to go to the family grave on anniversaries. Ted travels to and from his day service independently and accesses his community independently and yet he required staff support to visit his parents' grave. Ted's key worker asked him why he needed a member of staff to go to the grave. Ted explained that he didn't know how to get to the grave – 'Staff always come with me.' Ted also said he felt 'angry' with staff when they couldn't bring him when he wanted to go. Ted also expressed his wish to be able to visit the grave more often to 'keep it well'. This task has changed focus now and should be viewed as a goal for Ted to work on so he can go to the grave whenever he wants. Applying the Focus Funnel, this task is important; therefore it cannot be eliminated, it cannot be automated and at this early stage cannot be delegated. The result is that the key worker needed to concentrate and focus on this task and work with Ted towards a solution.

Ted and his key worker arranged to meet his other brother in the graveyard. Ted's brother led the way, and the key worker took step-by-step photographs of the directions to the grave. She designed a visual support plan using the photographs and then she accompanied Ted to the graveyard to check that they could use it to find the grave, which they did. Spending time on automating the directions made them simple to follow. To check this out, a volunteer who had never accompanied Ted to the grave before went with him. Using the visual directions, they were successful in finding the grave. The next step was to eliminate the need for staff to go with Ted to the grave, which involved training Ted. This could not be automated, so delegating the task was explored with Ted, and then his key worker delegated the task of training Ted to a social care student on placement. Ted and the student went off with their visual support plan the first day, and were successful in finding the grave. Over her practice placement the student provided

intense support training for Ted. Each time they went she reduced the number of prompts she gave him until she was not giving him any at all. To check that Ted was able to find the grave without any prompts she asked another student to accompany him and report back how it went and then focused on the steps that he was having difficulty with. Ted now goes to the grave independently, and sometimes his girlfriend accompanies him and they go for coffee afterwards. This has eliminated the need for staff support and has reduced Ted's anxiety and his anger towards staff.

The staff, particularly Ted's key worker, have multiplied time. They don't have to spend time doing an activity they don't need to or have to manage preventable behaviour incidents.

You might ask, 'Why wasn't Ted trained to do this task before?' The importance/urgency matrix would say it was important but may have placed it at a lower level of urgency. Staff failed to plan ahead and the task only became urgent when Ted became angry. The Focus Funnel changes our thinking in terms of how *significant* a task is and this particular task had been put off for far too long. The task had not been eliminated from Ted's To-Do list (so it was still on his key worker's list of things to do); it was important to him. The problem was that staff were procrastinating because of the time required. A little bit of creativity, a partnership approach, and time spent concentrating on making a plan led to better outcomes, thereby multiplying time. Vaden (2015) speaks about how emotions such as guilt, worry, fear and anxiety influence or dictate how we spend most of our time.

This led to reflections about how social care workers spend their time. The very nature of the work can be emotional; for example, in the service I work in, we have experienced an unprecedented number of bereavements in a short space of time. Emotions impact on how we spend our time, especially during times of grief or stress, in both our personal and our professional lives. Priorities change in such circumstances and our number one priority is supporting our service users and colleagues. Do we go look at our To-Do List for that day and see if we can place this important aspect of our work onto it and assign it a priority level or number? The answer is no. We know in this instance, or in a crisis, what we need to do; and the reason why we know is because we feel it. We all know our service users are our top priority and supporting them becomes more important than our paperwork, phone calls, emails or housework.

The first time the unit I work in experienced a bereavement, it was unexpected. As a team, we were not only upset but unsure what we should do. We had many questions:

- How do we tell the men and women in our service their friend has passed away?
- How do we support them with their grief?
- Should we cancel our activities for the day?
- Who should we contact? Who do we need to inform?
- Can we go to the funeral? How can we get everyone there?
- Is anyone coming to support us?

We spent a lot of time trying to figure out what to do that morning and how best to do it. We couldn't have planned for this particular event, but what we did do, as a team, was reflect on the experience and the likelihood of it happening again, and we created a 'bereavement protocol'. Having this protocol in place means that we know what to do and how to do it, and we don't waste time. We have multiplied our time.

Spending time with service users and building relationships is an important aspect of our job, and where students often think social care workers spend most of their time. Unfortunately, the reality is different, and a lot of time is taken up with admin tasks such as writing reports, answering or sending emails, making or receiving phone calls, creating risk assessments, doing the staff rosters, budgeting, attending meetings, doing housework and so on – the list is endless. In fact, a large portion of our time is spent working indirectly for or on behalf of service users.

TASK 6

Create a time diary and evaluate how you are spending your time. Tip: See <https://www.businesstrainingcollege.com/business/what-is-a-time-diary.htm>

Self-Care

The poem above gives some idea of what social care practice is like in a specific setting (intellectual disability). It highlights the various jobs that a social care worker does, from cleaning and making tea to spending time with people figuring out what supports they need or how they would like to live their life. The poem also demonstrates the flexibility required of the practitioner, and highlights some of the emotional aspects involved in the work we do. While each

social care setting is different, the truth is that all practitioners have numerous responsibilities, an ever-increasing workload and many demands on their time. Creating To-Do lists, prioritising tasks, and effectively managing ourselves and our time are all strategies we can use to develop our practice, manage our workload and be more efficient. Regardless of the setting, social care work is demanding and emotional and it requires practitioners to be not only flexible but also able to cope with all the various demands on them.

Pressures from personal lives and work lives can become overwhelming and, unless dealt with appropriately, lead to stress.

Professor Tom Cox notes that stress can occur when ‘an individual perceives an imbalance between the demands placed on them on the one hand and their ability to cope on the other’ (HSA n.d.: 6). Social care practitioners do not have a physical box filled with tools to perform their work; they are the tool box. So we need to look after ourselves and develop self-care strategies. Self-care should be considered a core competency of the social care practitioner, and as a student it’s important that you start developing and practising this skill. You may already have some self-care strategies, for example going for walks, playing sport, taking time for yourself, doing activities that promote self-care such as yoga or mindfulness. If you do not have a self-care strategy it is advisable to develop one. Believe me when I say you are going to need it, and it will be one of the strongest tools in your toolbox. Self-care strategies do not have to be expensive or elaborate; in fact, some are cheap and easy.

The trick is to have a number of self-care activities that will help you create balance in your life and prevent or, in some cases, manage stress.

Remember, if you do not look after yourself, you will be in no position to look after anyone else. Give yourself permission to make yourself a priority, put it on your To-Do list and allocate the time you need to focus on your self-care activities.

TASK 7

Identify a number of self-care strategies for social care students/workers. Create a personal self-care plan and start using it.

Tip: see Tygielski (2019) at: <https://www.mindful.org/why-you-need-a-self-care-plan/>

Tips for Practice Educators

An essential requirement for achieving this proficiency is the student's understanding of, and their ability to, manage their own workload. It is important for the student to recognise they will have different levels of responsibility based on their level of academic achievement and practical experience. It is also important to recognise that as an educator you have a responsibility to guide the student and ensure they are capable of managing the work and tasks that you assign during the placement. When your student makes contact to arrange a pre-placement visit, set aside the time to meet with them, give them a tour and an overview of the unit, introduce them to service users, and give them an idea of some of the tasks they will be expected to perform during placement. This is a good opportunity for you and the student to explore whether your particular setting is a right match for the student.

Instruct your student to look up the organisation's website so they can develop an understanding of the service, its history, its service provision and the responsibilities of the social care worker. In my experience, the biggest concern that students have when they come into a placement is how to communicate with service users and what to do for their intervention. If you work in a setting that supports people with an intellectual disability, instruct the student to take the online course "Communicating with People with Intellectual Disabilities", which is available at the HSE's online learning hub HSEland (www.hseland.ie). If your setting is also a day service for people with intellectual disabilities, ask the student to complete the New Directions module. There are lots of free courses available from HSEland website and some will be relevant to your particular setting.

Practice educators are often concerned about where they will find the time in an already busy schedule to supervise students. Consider the addition of a student or students to the team as an asset. Although you have agreed to supervise and support a student, service users are the ones accommodating them, so they should get something in return. As a practice educator, be creative, set specific tasks for the student that match their proficiencies and enhance the quality of service delivery. Consult with staff and service users for suggestions of work they would like the student to undertake. Examples might include: supporting and training service users to access their community; teaching and supporting service users to self-advocate; working with service users and key workers on aspects of person-centred plans and individual goals. Appreciate the difficulty for students to demonstrate initiative when they are starting a new placement. Planning on your part is essential. Design a specific timetable for students that will give structure to their day. Create a list of tasks students can work on during placement as this will reduce anxiety for the student, give focus for both of you, and the rest of the team will know what the student is working on.

Create an induction folder for your setting that includes relevant information, such as communication structures, policies and procedures and general information about how service is delivered. Maybe your student could create or contribute to one.

It is important that practice educators do not make assumptions that students can do specific tasks. Use supervision sessions to explore the strengths of the student, set realistic tasks and ensure they are managing their workload. Enlist the support of your colleagues, and have students shadow them in their duties.

Multiply your own time by setting aside time to teach students to do the practical aspects of the work, such as developing support plans, writing reports and facilitating activities. Think of this as return on time invested. Many students on placement have other commitments such as part-time jobs, families and college work. It is important that they recognise that, as their workload increases, they are at risk of experiencing stress. Encourage them to use a reflective diary and engage in self-care activities. As an educator it is vital that you recognise how you manage your own workload. As you will be leading by example, it is important that you demonstrate good practice in this proficiency. It is also important to ensure that your toolbox – you! – is in good working order. Self-

care is important for you too, and if you are not already engaging in self-care activities, you should think of starting. Think of it as a preventive intervention for yourself. Let me finish this chapter by sharing with you one of the most valuable online courses I have come across in recent years. It is called Mindfulness-Based Stress Reduction (MBSR), it is easy to engage with, completely free and can be found at Palouse Mindfulness: <https://palousemindfulness.com/>.

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Useful Resources

HSELand: the HSE's online learning and development portal – www.hseland.ie

Palouse Mindfulness: Mindfulness-Based Stress Reduction (MBSR) – <https://palousemindfulness.com/>

Chapter 19 – Mark Smith (DISOP19)

Domain 1 Standard of Proficiency 19

Understand the principles of professional decision-making and be able to make informed decisions within the context of competing demands including those relating to ethical conflicts and available resources.

KEY TERMS

Principles
Context
Leading decision-making
Social care staff team
Risk-averse culture

Social care is ... about keeping the service user at the centre of all decisions made, and achieving a balance between care, the environment, the context in which the decision is being made, and the resources available.

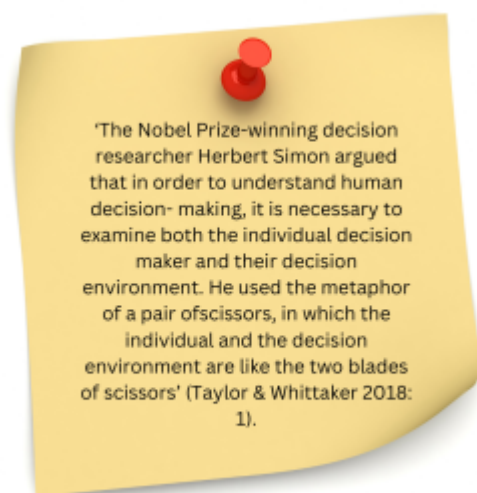
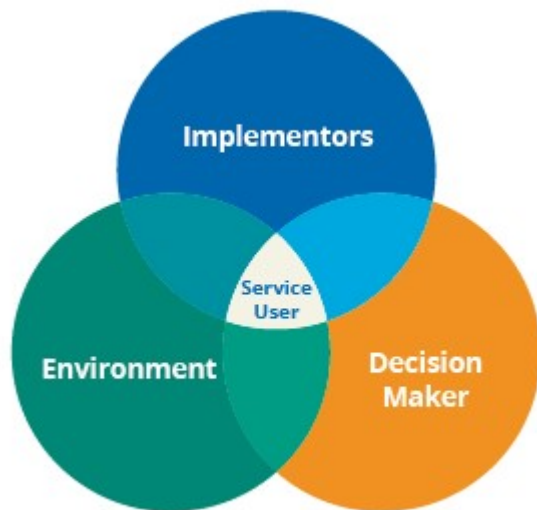
TASK 1

Reflect on a decision you found difficult to make, reflect on factors that shaped the decision. Were you satisfied with the outcome? If you had to make the same decision today, what would you do differently and why?

Principles of Decision-making

Working for 30 years as a social care worker I have experienced the challenges and complexities of professional decision-making. As social care workers, we

are in a constant process of decision-making during our day-to-day practice. This chapter is written from my experience of making decisions in children's residential care and special care services. Based on my experience, there are three key principles to consider when we make decisions: **the decision-maker; the decision implementors; and the decision-making environment**, with the service user or young person at the centre. The decision-maker and the decision-making environment are the key principles that influence the decision and the staff team are the implementors who turn the decision into the plan. However, those of us working in social care must also acknowledge the client, the young person we are working with, as the centre of the decision-making process. Social care work is about achieving the balance between the individual making the decision, the young person's care that as a social care worker you are managing, the environment and context in which the decision is being made and, finally, the resources available.



Source: Author created Diagram

The final key principle in decision-making is ensuring that the client group or person we are working with is involved to the greatest possible extent in the decisions made about their lives, at the level that is most appropriate for them. Social care workers are uniquely placed to be able to support the client in making decisions about their lives. It is my opinion that social care staff are the strongest advocates for the people we work with. This advocacy role in the decision-making process comes from working directly with the client group. This is especially true of those of us who work in residential care. It is therefore important that we support the client/young person in meetings and discussions about them.

This role of advocacy and supporting the decisions about the individual client

primarily occurs within the multi-disciplinary team. It can also occur in staff meetings and managers' meetings, but the key decisions are made within the multi-disciplinary framework. The process used by the multi-disciplinary team is seen as the most comprehensive decision-making process and the best way of making decisions about how a young person's care plan should proceed. However, a number of social care workers have shared negative experiences of decision-making at multi-disciplinary meetings. Brown (2016), in her research on relationship-based practice, highlighted that workers frequently felt that their role and contribution were not sufficiently recognised and acknowledged. In the inter-agency working relationships between the residential childcare worker, the social worker and the Gardaí, residential workers frequently perceived their relationship with the young person was ignored and undervalued. The notion of 'the closer to the child, the further from the decision' emerged from the data. Interviews with residential workers highlighted that although they shared decisions with professionals, they felt their contributions had less influence than those of other professionals, whom they described as 'relative strangers to the child', thereby undermining their professional contribution (Brown 2016). Social care workers therefore need to articulate these concerns prior to multi-disciplinary meetings and in supervision sessions. If possible, the young person should be involved in this multigroup. In our role as social care workers, we support the client's decision-making in a number of ways. Primarily we support the young person through key working and the development of the client's placement plan and development goals. These meetings can therefore be the most important meetings in a young person's care life.

Context of Decision-making

In social care, particularly in residential care, there are different types of decisions. The first type (***in the moment***) is the decision made when emotions are running high and there is a huge amount of tension. These decisions are often made in the context of an extreme situation. People who have worked in residential care will understand and have experienced these situations and how these decisions are made.

The other type of decision (***after the moment***) is made by the staff who are not involved and have not experienced the extreme emotion and should therefore be able to make the decision in a reflective environment. The important principle in this context of decision-making is having confidence in your own professional

knowledge and practice experience and that of your colleagues. This means that most of the after-the-moment decisions made about the programme of care for young people are made within the following frameworks: child in care reviews; multidisciplinary meetings; staff team meetings; and management meetings. However, making the decisions is often the easy part of the task. Ensuring that the decision is implemented by the team is the real skill, particularly within the context of competing demands, including those relating to ethical conflicts and available resources.

TASK 2

Read page 28 of the Code of Professional Conduct and Ethics for Social Care Workers (SCWRB 2019) for the suggested procedure for decision-making.

Leading Decision-making

As Smith (2009) identified, in residential care decision-making is a complex task that has to be managed and balanced. Harrison (2006) agreed with this point, but he also identified that decision-making would be improved if management focused on the critical issues. Strategic planning is beneficial in identifying what critical issues will have to be responded to. Strategic planning can also map out the direction where the organisation wants or needs to go (Barksdale & Lund 2006).

Organisational priorities and potential critical issues that need to be addressed can be dealt with, and the benefit of this process is improved service performance. Barksdale and Lund (2006) outlined ten steps needed for strategic planning, which are adapted here to apply to social care practice.

Steps	Details
1	Laying the foundations of the care plan or the decision in consultation with the service user,
2	Understanding the context and environment influencing the decision or plan.
3	Collecting relevant information.
4	Analysing the information and how it will impact the person, plan or decision.
5	Stating the mission, vision and values of the service.
6	Prioritising needs and identifying risks.
7	Designing the plan and outlining the desired goals (three months, six months, one year, etc.
8	Balancing needs, goals and resources.
9	Documenting and communicating the plan.
10	Maintaining the plan.

Our management group are working on introducing a ‘servant leadership’ type of management model (Spears 2002). This model is a long-term investment in the staff team which focuses on how to support the staff group and works on developing a strong culture within the organisation. Servant leadership looks at developing members of the team in a supportive capacity that will get the best out of the staff team who are working in the service.

In recent years, a number of institutions have jettisoned their hierarchical decision-making and replaced it with a servant leader approach. Servant leadership advocates a group-oriented approach to analysis and decision-making as a means of strengthening institutions and improving society. It also emphasises that the power of persuasion and of seeking consensus is superior to the old top down form of leadership. (Spears 2002: 9)

Investing in the team is important as the strength of the team is critical in carrying out decisions made by managers. As Harrison (2006) described, management is all about getting things done through other people. An important principle in decision-making is knowing whether the staff are able to carry out the decision. There may be a number of reasons why they are not able to carry out the decision, and some of these reasons may be obvious. For example, asking a new member of the staff team to deal with a young person who has a history of challenging and threatening behaviour to implement a task could result in a reaction from the young person. This is not a good use of resources and is not planning for success. In order to be ethical in our decision-

making we have to be mindful that we are frequently going to be confronted with dilemmas of rights versus responsibility, of confidentiality, choice and autonomy. There can be conflicts in the staff team when faced with ethical decisions and this can be challenging for the social care team and management. Some other subtler reasons might be resource issues and not enough staff being on duty to carry out the task successfully.

What has to be guarded against are two issues. The most important of these is that the staff deliberately do not carry out the decision because they 'feel that they know best', and/or that 'the decision is wrong'. It is therefore important to have a culture within the organisation that can guard against non-compliance and that the staff team and manager have a shared vision. We need to be cognisant of adhering to CORU's *Code of Conduct*, which states that a social care worker must 'be able to justify any decision you make within your scope of your practice, you are always accountable for what you do, what you fail to do and for your behaviour' (SCWRB 2019: 14). Also, non-compliance can occur if the staff team do not have the required skill set to carry out the task. Smith, in his book *Rethinking Residential Care* (2009), states that when he first worked in residential care, high-end incidents were rare, but when he left many years later, they had become a daily occurrence. He put this down to the fact that residential care has become more specialised, and as such, the young people with the most challenging behaviour are being placed together without the balance of other young people who have internalised the culture and are able to teach the existing culture to new admissions to the service.

Budgets also affect how and what decisions social care staff and managers make. What effect, if any, will the decision have on the service's budgets and the resources of the organisation? Social care, like all other services, must live within its budgetary limits. There will always be tension between frontline workers who are client-facing and who will argue about the need for more comprehensive services, and those social care staff who are the budget holders. This tension has been in existence since the development of services and it has an impact both on the delivery of services and, inevitably, on our decision-making process.

Social Care Staff Team



*Author created
diagram about
the acronym
TEAM*

When I first started in social care back in the 1980s, staff turnover was low, and residential care was seen as a positive career choice. People spent many years in the same setting, which allowed new members the opportunity to learn from an established team, and to grow and develop their own skills in building relationships and managing young people. In my experience an established staff team also had the time to mentor and support new staff. Smith (2009) notes that ‘in the past, experienced staff picked up how to work with groups through an apprenticeship model where they learned the tricks of the trade from older hands’ (2009: 88). In my own experience I was the new staff for almost a year. This is compared to residential services where there is considerable turnover and the expectation is for staff to stay only between three and five years in the residential care setting. This has resulted in a loss of ‘corporate knowledge’ and constantly having to train new staff, which leads to a poor retention cycle.

In the absence of cohesive experienced social care teams, it is important that the care staff team have a good culture and feel supported by the management structure. Staff need to feel that they can grow in their role as social care workers and be able to develop their decision-making capabilities. Organisations should strive to become learning organisations as this gives the staff the best chance of developing. However, this learning culture has to be created and to be created the senior management team have to invest in the social care team, and this is a 24/7 process: ‘becoming a learning culture has to rest on the values and style that is driven and championed by the senior team and becomes part of the operating fabric of the way the service runs’ (Stanley & Lincoln 2015: 200).

Creating stability and a stable staff team in which the social care worker is able to make decisions is one of the first goals of managing a team. In research conducted by Roncalli and Byrne (2016) into psychologists working in the mental health services in Ireland they found that supervisors had a seminal role in developing the staff who worked with them. The senior staff needed to show appreciation to the new staff, offer constructive feedback and be able to reward

innovative practices conducted by these newer staff. Once you, as leader/manager, can rely on your staff to make the right decision at the right time you can tackle the other important principles of decision-making.

TASK 3

Think of an example of constructive feedback you received from a manager or supervisor. What was the feedback and what impact did it have on you?

Risk-Averse Culture

Professional decision-making in a risk-averse culture has sadly become part of my experience of working in special care. Services that are involved with young people at risk can often move towards making defensive decisions and practices. This is due to the risks that the young person may have demonstrated or was exposed to prior to their admission to special care. It can also be described as a societal shift in the avoidance of harm and not wanting to re-expose a young person to risk they were involved in prior to admission to special care. Within this risk-averse climate, preventing the young person coming to harm drives decisions. As Brown (2018: 658) describes, society views harm as an outcome of irresponsible behaviour and the social care worker and the multidisciplinary team often feel that, if some harm befalls the young person, their decisions will be viewed through this black and white lens. Research by Kirkman and Melrose (2014) has highlighted the damage done to young people by these defensive cultures. As social care staff, we have to ensure that we are working with the young person to ensure that the best decision is made with them, and this is not just about avoiding risks.



Other important factors that have to be considered in the decision-making framework is to ensure that the decision is compatible with the agreed policy, whether that is a local agency policy or national guidelines.

Failure to comply with standards will have a negative impact on the service and could ultimately affect the registration of the service. We make decisions as professionals, and we need to be able to stand over the decisions that we have made and believe we have made them for the right reasons. Improved decision-making within an organisation leads to increased benefits for both young people and staff and helps to foster a stable culture. In conclusion, making decisions on a professional level is a very complex task. However, we engage in this task throughout our working day. These areas are key to supporting good decision-making. However, these principles on decision-making are only as good as the team that is implementing the decisions. Residential care's history in Ireland has not been seen as one in which a healthy reflective culture existed. Residential care still carries a stigma both for the young people who are resident and for the social care workers who practise in the services. This is possibly due to constant ethical dilemmas that staff have to consider when dealing with vulnerable people on a 24/7 basis. Therefore, it is extremely important that social care staff who work in these areas are aware of their decisions and the impact these decisions will have on their client group. As discussed above, good decision-making is supported by good leadership. This leadership has to have a clear vision that both supports the client's rights and also focuses on the development of the staff member. In any ethical issue, social care workers must work through the ethical considerations to inform their decision-making. In summary, it is through reflection, ethical considerations, supervision and

inclusion of the voice of service user that we work towards excellence in social care practice.

Tips for Practice Educators

When making decisions I have found it very useful to discuss the potential decisions with a trusted colleague. In these discussions it was helpful to consider all possible actions, even the possibilities that might sound ridiculous, and then talk through the possible outcomes of each decision. It has been my experience that what starts off as a ridiculous suggestion often turns out to be close to the desired outcome with a successful conclusion for all parties.

1. Provide three examples of recent decisions made by you and your colleagues and explain the process, what was considered, what was rejected and why and how this decision was finalised.
2. If possible, allow your student to attend team meetings and give them the task of focusing on the decision-making process in the team, who made the suggestion, who spoke, etc. This can be the starting point for your next supervision session.

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Chapter 20 – Karen Mahon (DISOP20)

Domain 1 Standard of Proficiency 20

Be aware of and be able to take responsibility for managing one's own health and wellbeing.

KEY TERMS

Physical wellbeing
Mental wellbeing
Social wellbeing
Responsibility and management

Social care is ... about empowering and supporting people to achieve their full potential. It includes having an understanding and ability to meet people where they are at, to listen, hear and be their voice when they lose theirs.

Consider

What does health and wellbeing mean to you?

What does it mean for you to take responsibility in managing your own health and wellbeing?

How do we succeed in achieving this proficiency?

Introduction to Health and Wellbeing

Social care workers are acutely aware of the importance of health and wellbeing;

however their focus is often in relation to those we work with or care for. Leading by example is an effective tool in passing on appropriate lifelong skills.

First, we need to understand what the proficiency is asking of us in order to apply this information to improve our own health and wellbeing. In 1948 the World Health Organisation (WHO) defined health as a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity (WHO 2020). Using this definition we accept that our physical and mental health are intrinsically linked and we need to strive to achieve a balance of the two. The proficiency also draws our attention to the idea of a life well lived, through creating a balance between the private self and the work self (Keyes 1998). To be proficient is to gain advancement in knowledge or skill (Merriam- Webster), and to better understand the aims and objectives of this proficiency, this chapter looks at all three dimensions of health: mental, physical and social wellbeing.

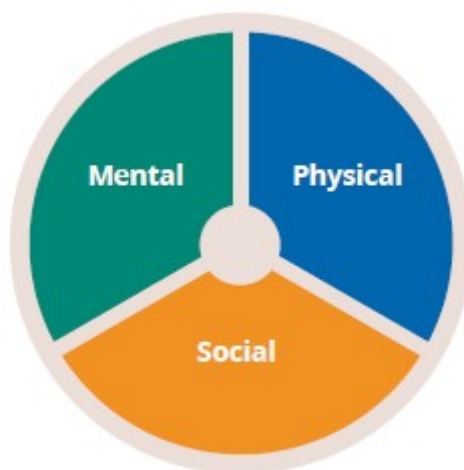
TASK 1

Draw a circle and divide it into three sections: physical, social and mental. In each section identify the proactive measures you take when striving to achieve a healthy balance. Think about:

All the physical activities you like to do

The positive relationships you have

The rituals you use to create a more positive mood.



*Author-created a Diagram about
Mental, Physical and Social
factors related to health and
wellbeing*

Physical Wellbeing

Maslow (1943) identifies our physiological need for food, water, shelter and sleep as basic requirements – these are our basic survival needs. Maslow believes that once these basic needs are met, we then move on to meeting our next need. This does not take away from the complexity of managing our physical health and the need to maintain it. For example, the food choices we make, the quality and amount of sleep we get have a significant impact on how efficiently our bodies are functioning. Monitoring and being aware of this is essential not only for ourselves but also in supporting the people we may work with. The Centers for Disease Control and Prevention (CDC 2020) identify tobacco use, excessive alcohol, lack of physical activity and poor nutrition as the main risk factors in preventable chronic diseases.

While being active has enormous benefits for physical health, the mental health benefits are equally important. Being active helps release chemicals in the brain which have a positive effect on our mood (Health Promotion 2020) – these are often referred to as ‘happiness hormones’.

Case Study 1

CrossFit West Dublin owner Lorna Heyes shares her thoughts on the power of exercise and training:

‘Being active has a ripple effect on our whole lives. When you exercise you are doing something you enjoy which makes you happy. Through the hard work you put into your training you build self-worth and confidence, you begin to look and feel better doing things you never thought possible. Being active will build a resilience inside you that you have never felt before, so when life goes wrong, as it always will at some time, you will be strong enough mentally and physically to handle it. Choosing exercise to reduce stress and anxiety has an incredibly positive effect on our overall health and wellbeing. Exercise is the superpower for mental health, that one hour you choose to move can change your whole life. I know I have seen it happen for thousands of people over the last 15 years.’

Mental Health – Emotional Wellbeing

‘Mental health is defined as a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’ (WHO 2014: para. 1). Mental health is multifaceted and is not static. It is important to differentiate between mental health and mental illness. Everyone

has mental health and current statistics show that one in six people have mental health issues (OECD/ EU 2018). In order to keep ourselves well and functioning at our best we need to take a holistic approach and find a balance.

The importance of self-care cannot be stressed enough; it is crucial that we look after and care for ourselves on a regular basis and not just in response to a sudden crisis.

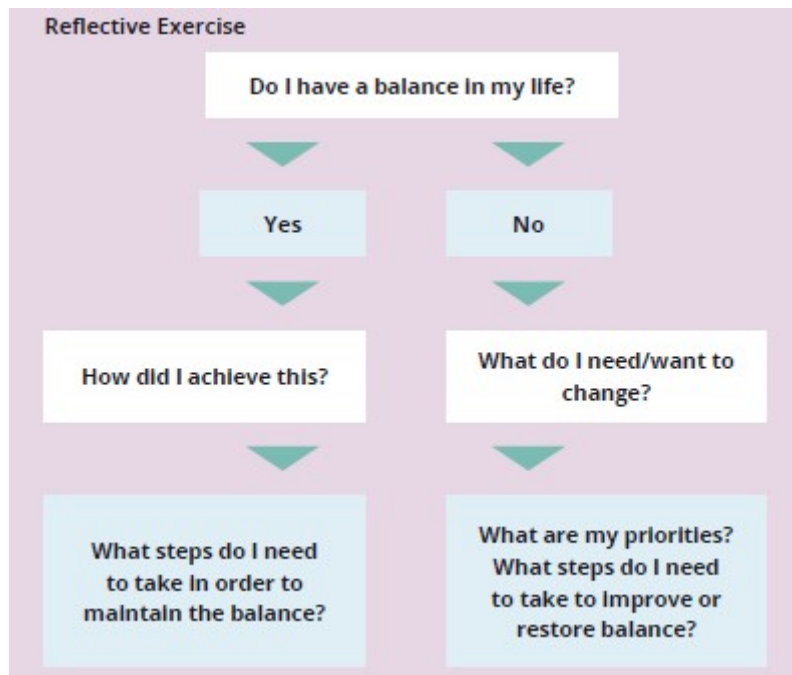
Take a car, for example; we look after our car by ensuring it has sufficient water, oil and fuel, and when it needs some extra care, we bring it to a mechanic. We do not expect it to run effectively without being looked after. If we apply that principle to ourselves and take a look at Cuba – which is well known for the love and care shown to vintage cars – we'll run a lot smoother. The attention they give their cars may have been born from necessity but it's a testament to how beneficial that maintenance is.

Mental Health Ireland (MHI 2020) promotes positive mental health. In its campaign Five Ways to Wellbeing it identified five key principles:

- Connect
- Be active
- Take notice
- Keep learning
- Give.

For more detailed information on the campaign please visit the Mental Health Ireland website.

When we talk about balance, we are referring to having a balance between work and life; that feeling of satisfaction we get when we feel balanced. The need to have a purpose in life and to be connected to others is not newly discovered; it heavily influences our sense of self.



Author-created diagram about self-reflection on life balance and steps for maintaining or restoring it.

Responsibility and Management

It is each individual's responsibility to take control of and manage their own health and wellbeing. This does not negate the responsibility and onus on employers, lecturers and practice educators to support and encourage the development of social care workers. Social care is a demanding profession and can be driven by the need or desire to help others. It's important to remember that not everyone seeks or is ready to accept help. In order to manage our health and wellbeing needs we also need to understand and adhere to the policies and procedures that have been put in place for the protection of employees and for the service users.

Supervision is integral in social care and in the personal and professional development of self. The role of a social care worker is varied and can be carried out across a range of services and settings, so it is important to be able to understand one's self and how that influences one's practice. Dr Pat Kostouros and Shannon Kearney presented at the 2019 Unity Through Relationships Conference on the need to address compassion fatigue and compassion satisfaction in supervision. The Professional Quality of Life Scale (ProQOL) Compassion Satisfaction and Compassion Fatigue Questionnaire is a useful tool and may be beneficial in providing further insight. Version 5 (2009) is the most

recent and is available on the ProQOL website at https://proqol.org/uploads/ProQOL_5_English_Self-Score.pdf.

The more we understand about ourselves the better equipped we are to manage our health and wellbeing. The nature of social care often draws those with lived experience into the field.

Studies are being undertaken to better understand the impact and prevalence of compassion fatigue in various settings. According to the Compassion Fatigue Awareness Project, up to 50% of healthcare workers can experience symptoms. They have similar characteristics, but It is important to be aware of the difference between compassion fatigue and burnout.

TASK 3

In pairs or small groups discuss the following:

- Signs of compassion fatigue and burnout – how do they differ?
- Is it possible to avoid and prevent compassion fatigue?
- How do you address compassion fatigue?
- What are the dangers of not actively addressing the signs and symptoms of compassion fatigue?

How do Social Care Workers Find a Healthy Balance?

It is important to remember that what works for one person does not necessarily work for another. What do I do to ensure I stay grounded and take time to support and encourage self-care? I am a planner, list maker and firm believer in having a soothe kit. A soothe kit is very personal, but there are endless ideas online for putting together your own kit. It is a wellness tool that can be added to on an ongoing basis. It may also be referred to as a wellness kit or tool box.

What belongs in a soothe kit? Here are some ideas:

Items that evoke special memories such as a shell from a trip, concert tickets or a card from someone special.

Reminders to take a break and what to do when taking that break, for example some bubble bath, a teabag, scented candle or a book.

Think about your five senses and choose items that elicit a positive feeling or thought for you, e.g., your favourite perfume, a soft toy, fizzy sweets, photos of family and friends.

I am aware that your own health and wellbeing should be a priority as you cannot provide an adequate service to the best of your abilities for a service user if you are unwell yourself. In order to stay well, I make sure to take care of my physical health by trying to get plenty of sleep, eat healthy food and by exercising. However, it is crucial to remember about your mental health which is equally if not more important than physical health. I do this by trying to stay organised, avoid stress by managing my own workload and trying to achieve the work/college-life balance.' (Katarzyna, social care student)

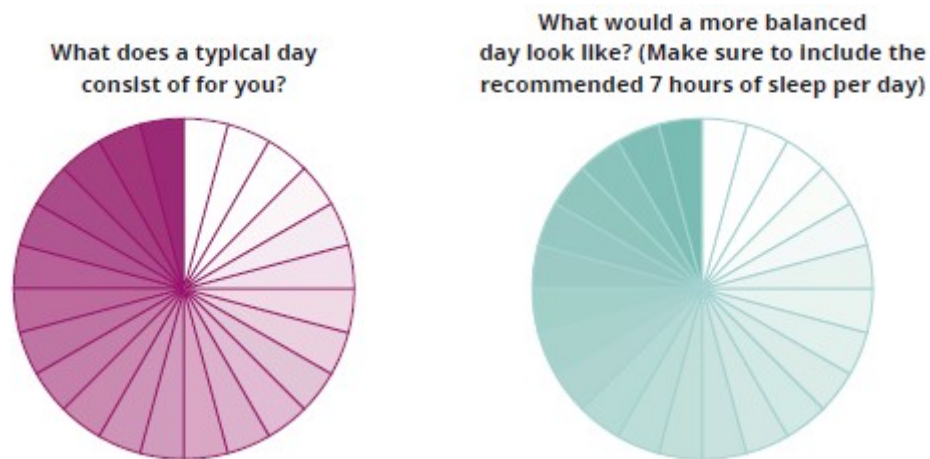
'Reflections: I look out to look in. To ensure I'm happy with my practice to ensure I'm happy in my head. Sometimes it leads to corrections.' (Elisa, social care worker in ID services)

'I like to take some time for myself where I don't think about anything other than the task at hand. When I swim I just think about counting the lengths, when I'm sewing I'm just focusing on making something. It's like a form of meditation for me.' (Katrina, social care worker in day services)

'With the demands and challenges of working with young people presenting with significant mental health difficulties I'm very aware of the need to mind my self-care, mental health and wellbeing. Maintaining wellness is my own personal responsibility. Eating well, getting exercise, prioritising good sleep hygiene are just some of the things I try to do. Managing my workload, seeking support and guidance from my workcolleagues regarding my clinical work is also important. Knowing my triggers and having a plan to manage same as well as engaging in my wellness tools can all help reduce stress and maintain positivity and productivity.' (Suzanne, social care leader in CAMHS)

TASK 4

Thinking of all you have read in this chapter, take a look at your typical day using a simple circle divided into 24 hours.



Author-created diagram comparing a typical daily routine with a more balanced schedule, emphasising the importance of time management and adequate sleep.

Take Note

- **Everything in moderation:** we're striving to achieve that balance.
- **Manage stress levels:** stress is a very real part of daily life and it has both physical and mental manifestations. The more resilient we are, the better able we are to manage inevitable stress. The 'science of bounceability' focuses on the ability to adapt to the challenges of work and life (Martin: website).
- **Get organised and plan your day:** having a sense of purpose to your day, no matter how big or small, can give a feeling of achievement.
- **Advocate:** social care workers are generally great in advocating for others but sometimes not for themselves. Remember, it is okay to say No and to ask for help when needed.
- **Time out:** time is precious and it is important to make it for yourself as well as others.
- **Take notice:** be present in the moment using your five senses to acknowledge and appreciate your surroundings.

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Chapter 21 – Jennifer Mc Garr (D1SOP21)

Domain 1 Standard of Proficiency 21

Be able to maintain professional boundaries with service users within a variety of social care settings and be able to identify and manage any associated challenges

KEY TERMS

Professional boundaries
Social care settings
Associated challenges

Social care is ... a profession concerned with meeting the needs of individuals, groups and communities through evidence-informed and strengths-based approaches to practice.

Social care work is grounded in building capacity, in empowering service users and in recognising the individual as the expert of their own experience (Byrne-Lancaster 2014; Branfield & Beresford 2006; Lalor & Share 2013). Much of the work happens in the life space of the individual, where everyday opportunities and events are used to maximise growth and development (Ward 2002). This work is relational; the relationship between the worker and service user is the key ingredient in mobilising change, and the social care worker must draw on the 'self' in creating a relationship which is authentic and meaningful (Ingram & Smith 2018; Lyons 2013; McHugh & Meenan 2013). In the delivery of this work, social care workers are mindful of the context in which such work occurs and are attuned to the wider social and political structures within society, which privilege some but exclude others (Byrne-Lancaster 2014; Thompson 2012). This means that social care workers walk a tightrope between adopting an individualised approach to practice while also recognising the wider social and cultural context in which the individual is embedded (McGarr & Fingleton 2020).

Professional Boundaries

Relationships are at the core of social care work (SCWRB 2019; Ruch, Turney & Ward 2018). However, relationships can be complex and messy. Building meaningful and authentic connections with service users requires an awareness of boundaries and a constant renegotiation of our personal and professional selves (Ingram & Smith 2018). Boundaries are not an exact science. They are “nebulous, elusive and difficult to define” (McCann James *et al.* 2009: 108) and change according to the context and the relationship (O’Leary *et al.* 2012). At a most basic level, boundaries are “the parameters of the self” (Fewster 2011: 9) and we navigate personal and professional relationships through these parameters. We all occupy different roles in our lives, for example father, sister, partner, mother, worker, child. Each role has its own unique boundaries and expectations which determine how we engage with that relationship. The boundaries of what we might share, our use of touch, how we interpret the actions of the other, are unique to that individual relationship (Davidson 2009; Fewster 2011).

When we refer to professional boundaries, in essence we refer to the parameters of our professional selves. Cooper (2012: 11) defines professional boundaries as “a set of guidelines, expectations and rules which set the ethical and technical standards in the social care environment ... (setting) limits for safe, acceptable and effective practice by workers”. However, personal and professional boundaries are not unrelated. Gender, culture, family background or religion shape our ‘limit-lines’ and how we engage in our personal and professional worlds (Cooper 2012). Furthermore, how we navigate relationships, including professional ones, can be a reflection of our internal working model (Bowlby 1969). How we engage and how we respond, particularly during times of stress, can be shaped by our own relational histories and the messages that we have received about what relationships are and how they function (Howe 2011). Therefore, the personal and professional selves are interrelated and boundaries can be dynamic and shifting. Workers are tasked with engaging in ongoing reflection to understand how values, attitudes, beliefs and personal histories shape their work, as the self is “the principal tool of the social care worker” (Kinnefick 2006, cited in Lyons 2013: 102).

In a professional context, boundaries provide ethical parameters to work that is often dynamic, contested and unpredictable. Inherent within any professional relationship is a power imbalance between the worker and the service user (Cooper 2012; Davidson 2009). Professional titles, access to information or funding, the ability to provide or deny access to a service, all confer authority

and can position the worker as the 'expert' in the situation (Cooper 2012) despite commitments to co-produced, participatory practice. Boundaries reduce the risk of abuse, exploitation and discrimination, and provide a sense of certainty for both workers and service users in relation to role and expectations (Cooper 2012). In addition, with relationship based practice at the core of social care work (Brown, Winter & Carr 2018; SCWRB 2019), boundaries provide "a safe framework for this relationship to exist in" (Cooper 2012: 32).

Professional boundaries protect both staff members and service users in the following ways:

- Boundaries help service users to feel safe (Cooper 2012). Consistent, trustworthy relationships create feelings of safety (SAMHSA 2014) and contribute to what Winnicott (1960: 591) termed the "holding environment". Service users often test these boundaries. Their behaviour may be communicating a need to feel safe, and they may be testing you to see if you can meet that safety need. Furthermore, some service users may struggle with interpersonal relationships. Through role modelling appropriate boundaries we provide relational safety while also supporting service users to work on their own boundaries and to navigate personal and professional relationships (Cooper 2012).
- Boundaries ensure the needs of the service user remain at the forefront of practice (McCann James *et al.* 2009). We all have our own needs, wants and desires, which can play out at a subconscious level. Understanding our motives, reactions and behaviours are key to practising in a reflexive way and ensuring that the care we give is person-centred and responsive to the service user's needs (Cooper 2012).
- Boundaries can reduce the risk of burnout (Cooper 2012). Through managing our responses and maintaining controlled emotional involvement we protect against compassion fatigue and minimise the processes of transference³ and counter-transference⁴ (McCann James *et al.* 2009). See Chapter 70 D5 SOP9 for a more detailed discussion of these processes.
- Transference occurs when the service user projects feelings about a significant person on to a worker, for example a service user who reacts aggressively to a worker because (s)he reminds them of someone from their past (Cooper 2012).
- Counter-transference occurs when workers project feelings about a person or experience in the past onto something that is happening in the present,

for example a worker who lacked parental attunement in childhood and feels rejected by a service user who will not engage (Cooper 2012).

- We work to support autonomy, minimise dependency and build capacity (Cooper 2012). Relationships in which workers are over-involved or are uninterested and detached can diminish resilience and undermine strengths-based practice (Davidson 2009).

Therefore, poor or mismanaged boundaries can contribute to both service user and worker stress and undermine the therapeutic potential of the relationship.

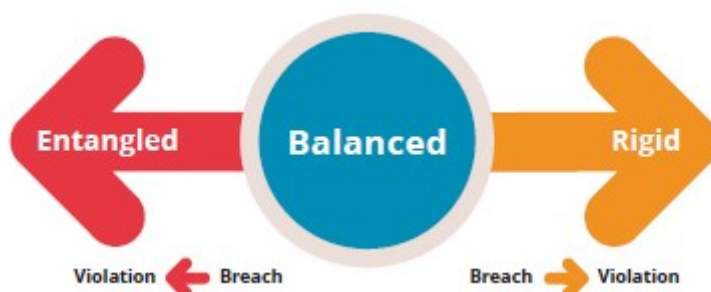
The Davidson Model

Social care practice is complex and nuanced, and knowing where to draw the boundary lines can prove challenging at times for even the most experienced worker. Davidson (2009) offers a framework for thinking critically about behaviour and understanding boundaries within professional relationships. Based along a continuum, she identifies three categories or boundary ranges: (a) entangled, (b) balanced and (c) rigid (see Figure 1) (Davidson 2009). Where boundaries have become compromised, workers may engage in boundary breaches or boundary violations (located at either end of the continuum). Boundary breaches refer to actions that have “transgressed a commonly accepted standard of behaviour for reasons that may be understandable”, whereas violations are actions whereby “a professional uses the relationship with the client to meet their personal need at the expense of the client” (Davidson 2009: n.p). According to Cooper (2012), boundary violations lead to the exploitation and abuse of service users.

Workers who display balanced boundaries adopt an authentic manner centred on meeting the service user’s needs (Davidson 2009). They are respectful, reflective in their practice, are aware of their feelings and motivations, and use their professional judgement accordingly (Davidson 2009; Cooper 2012). With entangled boundaries, the worker often subconsciously meets their own needs through the professional relationship (Davidson 2005). Boundaries become entangled when workers are over-involved in service users’ lives or when workers give too much of themselves to the detriment of their other relationships. For example, the worker who becomes upset or personally affronted when the service user does not attain a particular goal, or the worker who ‘gives it their all’ to the detriment of their own self-care and emotional

and physical well-being (Davidson 2009). Commitment, passion and empathy are admirable traits for those working in helping professions, however over-involvement can sometimes stem from a need to “fix things for people, to make things right or undo the impact of injustices...in the world” (Cooper 2012: 176) or a tendency towards co-dependence within relationships (Cooper 2012). Workers who have rigid boundaries deliver care which is inflexible and unresponsive to the needs of the client, often ploughing ahead with their own agenda (Davidson 2009), for example the worker who cannot use discretion when implementing the organisational rules, who gives nothing of themselves or struggles to create meaningful connections. Rigid boundaries “create substantial distance within the relationship” (Davidson 2005: 518) and amplify the power imbalance between worker and service user.

Boundary ranges are not fixed. Some social care workers may operate within the same boundary range for all their professional relationships; others may find themselves falling within a particular boundary range around a certain personality type, issue or situation (Davidson 2005). This is where reflective practice and supervision come into play, to create a space to identify triggers, unconscious motivations and patterns of behaviour.



Author-created diagram from Davidson (2005, 2009)

TASK 1

Reflective Task

Using Davidson’s model outlined above, where do you place yourself on the continuum in relation to your work relationships?

Consider your relationships with service users, members of your staff team and management.

Why have you placed yourself there?

What impact might your behaviour have on the service user?

If required, what changes can you make to your practice in order to achieve balanced boundaries?

Social Care Settings

Social care workers work in a multitude of settings, from addiction services to disability services, residential childcare, mental health services, homeless services and family support, to name but a few (Lalor & Share 2013). Prescriptive rules do not easily translate, as each setting is unique. Boundaries are contextual and dynamic; the profile and needs of the service user, along with the organisational policy, physical setting and wider societal and cultural context, will shape what is acceptable within each particular setting (Davidson 2005; O’Leary *et al.* 2012). Therefore, it is important to tune in to where your boundaries lie, to understand what you view to be acceptable, and to be open to revising these as you reflect on and grow in your everyday practice.

Associated Challenges

There are some behaviours that are clearly unacceptable, and are in complete contravention of CORU’s *Code of Professional Conduct and Ethics for Social Care Workers* (SCWRB 2019). While major boundary violations are easily identifiable (for example, having an intimate relationship with a service user), they rarely occur in isolation and have generally been preceded by minor boundary crossings (Cooper 2012). We all have a responsibility to safeguard service users and hold ourselves and our colleagues to safe and accountable practice. Students will have explored ethical parameters of practice in Chapter 1 D1 SOP 1, where the discussion centred on ethical practice being the balance between professional autonomy and accountability. Boundaries are also discussed in

Chapter 7 D1 SOP7, where graduates are expected to “be familiar with the provisions of the current Code of Professional Conduct and Ethics for the profession” (SCWRB 2017: 4). Chapters 1 and 7 contribute to our understanding of the nuanced nature of boundaries which, in day-to-day practice, can pose challenges for social care students and seasoned workers alike. Boundaries can be “difficult to identify but easy to cross” (Davidson 2005, p. 511) and “grey zones” are frequently present in the work (Davidson 2009: n.p). According to O’Leary *et al.* (2012) boundaries are about connection, *not* separation; therefore boundaries are fluid, not fixed. Students preparing for placement often find this fluidity frustrating, and lament the lack of a clear rule book.

Boundary Grey Zones

In social care work it is common to encounter “grey zones”, “circumstances where pre-scribed answers do not easily apply” (Davidson 2009: n.p). For example, physical contact is often a contested issue in social care settings: When is touch appropriate? What level of touch should I use? Should I wait for the service user to initiate this? Cooper cautions against the use of physical contact, suggesting that this should be kept “to a minimum and to a level appropriate to your role and your relationship” (2012: 45). He suggests that touching the hand or the lower arm may be safe way of using touch in the work. Byrne questions whether our current care context has led to a sanitised version of care that is devoid of love. He argues that, particularly in relation to working with children in state care, “the withdrawal of physical affection is arguably an abuse in itself” (2016: 154). This is an example of two valid yet conflicting messages, which can prove confusing for the social care student.

Sharing personal information is another area that often causes discomfort: What do I share? How much do I share? Could this information come back to haunt me at a later date? Relationships are fundamental to the work of the social care worker. Yet it is only through sharing something of ourselves that genuine and authentic connections are made. A student of mine offered this advice:

“For me it was important to carefully select which parts of myself that I wanted to share with both service users and the management team. I learned to use common conversation such as sport or TV programmes as a

way to form a relationship and to gather an understanding of the person's lifestyle" (3rd-year student).¹

Social care workers may be drawn to the work as a result of personal experience, for example a worker in a homeless service who had previously experienced homelessness, or a person who had struggled with addiction now working in an addiction service (Cooper 2012). Workers in these contexts sometimes share something of their own experience to connect with the service user, to encourage change and to create hope. In circumstances like this it is crucial to reflect on our motivation for sharing the information by asking: (a) What am I planning to share?; (b) Why am I sharing this information?; and, most important, (c) How will it *help* my service user? (Cooper 2012).

Cooper (2012) cautions against favourable treatment of some service users over others and that the giving and receiving of gifts can signify the marking of a special relationship. Yet key-working, a cornerstone of person-centered and relationship-based practice, could be considered a special relationship therefore definitive rules can be difficult to apply here. Through an attachment lens, one of the functions of the key working intervention is to provide consistency, continuity and relationship security (Payne 2009), and key workers sometimes give small gifts at birthdays or Christmas as part of this role. Aside from the key working relationship, in some organisations small tokens of appreciation are accepted but valuable gifts are not. In others, gifts are not accepted or are shared amongst the staff team. One might need to ask: What is the nature of the gift? Why was the gift given? What monetary value is attached to the gift? What is the organisational policy on giving and receiving gifts? A student recently shared this experience with me.

"On one occasion a service user brought me a gift. I was unsure about how to approach the situation and felt uncomfortable declining the gift. I explained to them that I was not allowed to accept gifts within the organisation. The relationship was not affected and I was able to maintain the trust and respect of the service user as I was honest" (3rd-year social care student).²

Other grey zones include bumping into a service user outside the service and

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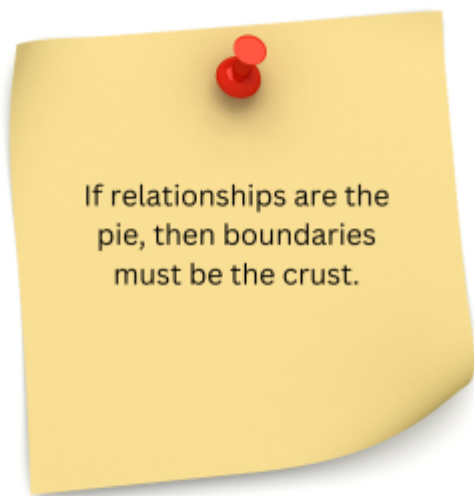
knowing how to respond, or beginning and ending the relationship appropriately. These scenarios are not always straightforward and require an individualised response based on the needs of the service user. A student shared how she supported a positive ending:

*“During my last week of placement in a disability service, a service user asked if they could have my phone number as he was not going to be there on my last day. I explained that it is not appropriate to give out my personal number. After being asked multiple times, I agreed to give my email to the staff and the staff could help them to type up an email to me. In other circumstances, I would have explained that maintaining contact after my placement was not appropriate. However, this service user was especially attached to me and found endings difficult. It aided in preventing feelings of abandonment by providing a sense of closure, while still ensuring any contact made was formal and regulated through staff” (3rd-year social care student).*³

Much of the work happens *in the grey* and working interpersonally with service users can present challenges. When working within these grey-zones, one must:

1. Pay attention to the power differential that exists within the professional relationship;
2. Engage in ongoing self-reflection to understand our own motivations, feelings and behaviours;
3. Remember that the relationship with each service user is different; and
4. Work within the parameters of ethical practice and sound professional judgement, including paying attention to organisation policy and context.

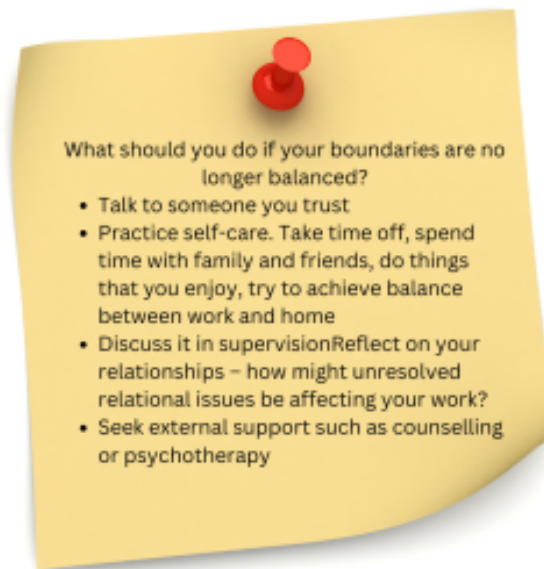
Maintaining Balanced Boundaries



Boundaries shape the type of relationship that is forged and the expectations and interactions attached to that relationship (Davidson 2009; O'Leary *et al.* 2012). Each pie might have different ingredients or look slightly different – for example, workers may have the same title or job description, but how they go about the work is unique to their working style. However, a crust that is too rigid holds the relationship in a way that is inflexible.

Conversely, a crust that is too soft lacks solidity and reassurance. Both compromise the “live adaptation to the [service user’s] needs” (Winnicott 1960:563), which is the essence of the holding environment.

There is no doubt that we all experience times where our boundaries are not well managed. Perhaps we overshared or became too invested in our service user’s goals or choices. Or the opposite; we experienced disconnection and apathy, or shared nothing of ourselves. According to Davidson (2005), this is most likely to happen when the worker is feeling vulnerable or is not maintaining good physical and emotional self-care. We cannot care for others if we do not care first for ourselves.



Case Study 1

Mary has been working in social care for approximately 10 years and is currently working in a family support service. Mary has recently been allocated a case; a mother, Joyce, who is parenting alone, and her two children, aged six and eight.

Joyce has mental health issues and is struggling to cope. Her situation is compounded by social disadvantage, poor housing and the absence of support. Joyce had come to the attention of Tusla, the Child and Family Agency, due to concerns around alcohol, and the level of supervision and basic care received by the children. Following an assessment completed by the Social Work Department, Mary had been assigned to work with Joyce to support her around parenting. As part of the Child Protection Plan, Joyce had agreed to start a rehabilitation programme to tackle her alcohol misuse, had been attending her appointments and keeping to her plan.

Mary has personally found this case very draining. Growing up with a parent who had problems with alcohol, Mary knows first-hand the impact this can have on young children. Mary is worried that Joyce has started to slip. When Mary rang the clinic for an update on Joyce's progress (with Joyce's consent), the clinic informed Mary that Joyce had missed a couple of her appointments. This left Mary feeling very frustrated. The most recent conversation with Joyce about this became quite heated and Mary felt she lost control. This resulted in Joyce yelling at her to 'Get out of my house and leave me alone.'

What is happening in this scenario?

Why did Mary react to Joyce missing her appointments?

What does Mary need to do next?

To conclude ...

Boundaries are not an exact science (McCann James *et al.* 2009) and due to the diverse nature of social care settings, prescriptive rules cannot apply. Each setting has its own unique expectations and requirements, while working within the bounds of ethical, safe and quality practice. Social care work is relational, therefore the role of self cannot be underestimated (Ingram & Smith 2018). However, we must consider what 'self' we are bringing to practice. The first step towards building meaningful relationships with others is to start building a meaningful connection with oneself. Tuning into our own emotional world is key, along with practising self-care and using opportunities to reflect, question and grow. This is no doubt a lifelong endeavour; however, in the words of Aristotle, "Knowing yourself is the beginning of all wisdom".

TASK 2

Activities Cooper (2012) 'How Tight Are Your Boundaries'. A self-assessment questionnaire to think about how you respond' in Professional Boundaries in Social Work and Social Care: A Practical Guide to Understanding, Maintaining and Managing Your Professional Boundaries.

Tips for Practice Educators

Pre-placement

Students often feel anxious before going on placement about maintaining appropriate boundaries. They worry about making a mistake, not 'getting it right', or worst of all, not making it through their placement. Creating a safe space within the classroom to explore these concerns and tease out the nuances of boundaries is very important. Activities such as case studies based on ethical and boundary concerns can be a useful starting point, as can role plays based around common placement experiences, such as:

- a service user asks to add you as a friend on Facebook or for your telephone number
- a service user asks you out on a date
- a service user confides something of concern to you 'as a friend' and asks you not to tell anyone
- a member of your local community/neighbourhood accesses the service.
- you meet a service user on the bus on the way into town

Furthermore, individual reflective activities based around the student's own experience and personal journey, for example listing what they feel comfortable sharing versus what they don't feel

comfortable sharing, can be valuable. These activities allow students to explore some of these issues within the confines of the classroom and to practise the skills that they will draw on in the placement setting.

During Placement

Students on placement should be able to provide their practice teacher with an example of boundaries within the workplace. Students could be asked to reflect on a time when they encountered a boundary challenge and how they resolved or addressed this. Practice educators do not expect students to 'get it right' all the time. However, it is important that the student has demonstrated some awareness of self, has engaged in critical reflection and can demonstrate the learning. My practice teacher used to say, "Once you stop learning, it is time to retire" and these words continue to ring true to me today. Students should also display a knowledge of whistleblowing and the Protected Disclosure Act 2014. Students may not have observed major boundary violations while on placement, however practice educators could present the student with a hypothetical scenario and ask them to identify the appropriate response.

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Chapter 22 – Danielle Douglas (DISOP22)

Domain 1 Standard of Proficiency 22

Be able to evaluate the effect of their own characteristics, values and practice on interactions with service users and be able to critically reflect on this to improve practice

KEY TERMS

Self
and
social
care
Values
Critical
reflection
Relationships

Social care is ... about working in partnership to support and empower individuals and groups at a vulnerable time in their lives through relationship-building and the delivery of personalised programmes and interventions

Self and Social Care

This proficiency requires social care workers to engage in continuous critical reflection to evaluate possible impacts of their own characteristics, values and practice on their interactions with service users. Reflecting on personal values and characteristics is an area of the human personality that has become known as the 'self' or sometimes the 'self-image' (Kidd & Teagle 2012: 65). This chapter has the dual objectives of conceptualising 'self' and suggesting ways of critically reflecting on the 'self'.

Social care is a relationship-based profession in which the social care worker and service user work in partnership to identify needs, achieve goals and enhance quality of life. Social care workers strive to support and empower their

service users and facilitate their voices at every opportunity. People who avail of social care services often have certain vulnerabilities or aspects of their life they are struggling with and require either short- or long-term interventions. Social care workers must always be acutely aware of the role they play in the lives of their service users and the possible impacts their values, characteristics and interventions have. To be able to evaluate the possible effects your 'self' have on the people you work with, you must first understand who the 'self' is and how it develops. Integral to this process is being aware of the values and characteristics that make up this self and the factors that contribute to the construction of self.

As a species capable of reflection and development, we have been asking 'Who am I?' for aeons, and despite the hundreds of thousands of academic articles and texts, and pop psychology self-help books, that attempt to address this question, a conclusive answer is yet to be determined. Rose (2012) offers four key characteristics that are useful for exploring the factors associated with self.

1. Self as Open to Change

It is important to understand that 'self' is not something that develops and remains static for the rest of your life. When we meet new people or experience new situations, we change and develop different ways of thinking, feeling and working. An awareness of this as a social care worker is necessary because you may find the relationship between you and your service user has the capacity to change how you both think about yourselves and each other. This is a two-way process and can lead to positive changes, but it can also raise some difficult questions about aspects of the self that have not previously been explored. This does not mean that all aspects of your self will inevitably change, but it acknowledges that personality is not something that is rigid and resistant to external influences. It is also important for service users to be aware of this in order to understand that they have agency and control over their lives. Reminding service users that people have the capacity to grow and, with the right supports in place, become the version of themselves they want to be is often related to the strengths-based approach that is used in social care work.

Practice Example 1

Self as open to change

Each year, as first-year students are deciding where to go on placement, I invite them to engage in a reflective exercise. I read the following statement: 'I'm sure they're grand, but I wouldn't like to live next door to them', and ask the students to think about the first person or group of people who popped into their head. Rather than share their answers, students are invited to reflect on where these thoughts come from and the possible impacts they may have on their practice and/or potential service users. Most students acknowledge that the view originates from preconceived ideas from family/friends or the media rather than personal experience or fact. Once we have discussed the possible consequences for their service users of such attitudes and/or biases, I encourage the students to challenge themselves to try at least one placement where they know people with similar issues or from those communities attend. The student should keep a journal to carefully monitor their views and/or values in relation to this person/people and observe if and how they change over time as the relationship develops. Students are also encouraged to reflect regularly and meaningfully on the possible impacts their values and beliefs may be having on their service users. (Lynda Monk has written a useful article to help students get started with journalling and highlights how it contributes to professional wellbeing (Monk 2011).) The majority of the time, students report being surprised by how fundamentally different they feel at the end of the placement and how their values have shifted through a combination of journalling/reflecting and the power of connection with service users. This proves that our selves are always changing and influenced by those we work with. The saying 'If nothing changes, then nothing changes' is pertinent here. Challenging assumptions and negative stereotypes will help students to develop healthier and more inclusive attitudes to those they work with.

2. Self as Contextual

According to González *et al.* (2004), identities can be enacted, constructed and/or ascribed by others and therefore are transient and develop within households, schools and communities. When addressing questions such as 'Who are you?' and 'What are your values?' people usually seek additional information in order to shape their answer. The context in which the question is asked is integral to the reflection that follows. Further questions must be considered, such as 'Who is asking the question?', 'What is my relationship with them?', 'What impact will my answer have on the situation I am in or the people I am with?' Having this contextual information is vital to the reflection and communication process. So too is the knowledge that it is impossible to separate ourselves from the communities, cultures, societies and times that we live in. Rose (2012) argues that if we are to reflect properly and learn about ourselves, it must be done within these contexts. At a macro level, this involves thinking about political systems, historical movements, physical environments, and cultural and economic contexts that shape our experiences. At a micro level, it is much more personal and requires reflection on the different relationships we share and the role we play within those. 'The bigger and smaller picture are intimately interwoven

in ways that are not always readily recognised, and this forms part of the exploration ahead' (Rose 2012: 5).

Practice Example 2

Self as contextual

Imagine you are a student who holds strong religious beliefs and regularly practises your faith. You begin a practice placement where there is a service user who holds different and/or opposing beliefs to you but with the same conviction. Part of their care plan involves addressing their spiritual needs, which requires you to accompany them to their place of worship. How do you think you would feel about that? What would happen if you refused to do it because of your values? How do you think the service user would feel? Knowing that this is a scenario you are likely to come across in this context will help prepare you to examine your values in relation to it and explore possible impacts it may have on your relationship with the service user. Thus, when preparing for practice placement, it is vital to find out as much as possible about the agency before you begin. Who are the service users? What are the key issues they face? What are their needs and the interventions used to address these? What are the values associated with the agency? What is the funding situation? Where is the agency located in the wider context of care? These are all questions that it would be beneficial to have the answers to either prior to beginning or certainly within the first couple of weeks of starting. Having contextual information from a range of sources (perhaps agency websites, agency literature, e.g., annual reports/ leaflets, up-to-date research) places the student in a position where they can already identify how they might think, feel and act on their placement. Of course, there is no way of knowing for certain how you will react in different situations, but identifying aspects of the work that may be challenging or rewarding through reflecting on this material will provide a better sense of your 'self' in the context of your placement. 'The more we can grasp of the context, the better our understanding of ourselves' (Rose 2012: 5).

3. Self as Multiple

Many people believe that individuals have a 'true' or 'core' self that is associated with a consistent pattern of behaviours, thoughts and emotions. Relationships are valued because we value the consistency of knowing how someone will act based on previous encounters with them. From this viewpoint, when we encounter new people or situations, especially if there is a conflict of values, it can destabilise our sense of self because it requires us to figure out who we are when we are with them. Others believe we should end the quest to find our 'true' selves and instead embrace the multiplicity of selves and the richness and complexity it brings to the human experience (Schaffer 2006). The term 'role' is often used as a way of making sense of this concept. We draw upon these different selves or roles depending on the context we are in and the interactions we have. Katsiaficas *et al.* (2011) expand upon this notion and introduce the term 'hyphenated selves' by way of explaining identity construction in young

people in shifting social and political contexts and in everyday interactions. For example, if I ask a person sitting before me in the classroom ‘Who are you?’, they might answer ‘A student’ because that is the identity they most associate with in that particular setting. If a stranger asked them the same question they might say ‘I am a parent’ or ‘I am captain of the football team.’ Each role will have certain characteristics and behaviours that are consistent with what is generally expected of that position. Esteban-Guitart and Moll (2014) put forward the idea of *identity funds* as a way of understanding how we can draw from the different selves we need in order to behave and/ or communicate effectively and appropriately in different situations. Think about the language you use when you talk to your friends versus when you talk to your parents, grandparents, a boss or small child. In general, it is unlikely the same words are used because we deem some language to be inappropriate or disrespectful to certain people, or at least that it might be interpreted that way. Regardless of the reason for not using that language, the awareness that it is not conducive to a positive outcome in an interaction requires the individual to draw on an alternative more appropriate self.

Practice Example 3

Self as multiple

It is essential to consider the multiplicity of self when establishing and maintaining boundaries in practice. Knowing that it is not only probable but necessary to display different aspects of ourselves when in a professional setting helps establish clear boundaries and appropriate ways of being. Consider the following scenario: You are a nineteen-year-old student on practice placement in a youth setting. It is Friday and you are stacking away chairs after the last session of the day. One of the young people, who is eighteen, asks if you have plans for the weekend. You reply that your favourite band is playing that evening, but you cannot go as all your friends have plans. The young person says that they also like that band and will go with you if you like. If you viewed the self as a unitary concept you might agree to go along with the service user as the facts are: (a) the person is over 18; (b) you like the band; and (c) you want to go – which all satisfy your personal self. However, through your training in college and awareness of policies relating to the agency, you should also be developing a ‘professional social care worker self’ or ‘social care identity’ and it is this self who will guide you in situations where your boundaries are tested. Drawing from this professional self and acting accordingly will also have a ripple effect on the service user, who will be influenced by your behaviour. Reminding the young person of professional boundaries will also help them to develop a suitable self for the youth club (a self who knows it is not appropriate to ask a worker out for a drink or to a concert).



Viewing the self as a unitary concept is particularly problematic in terms of the risks associated with service users internalising the labels assigned to them. In a study I conducted on the link between resilience, outcomes and children in foster care, I asked some of the care-leavers to comment on their identity. One young person replied, 'growing up I was just a foster kid I guess' (Douglas 2012). This description of himself was despite the fact he was also someone's son, brother, friend, uncle, a

hockey player and a good student, but his memories of the time did not reflect these multiple roles. The potential to label individuals and have their identity solely associated with that label is a risk that social care workers must be aware of. Labels such as 'foster child', 'addict', 'homeless person' and 'autistic child' can be internalised by the service user and can play an integral role in the construction of their identity or sense of self.

4. No Self without Other

The proficiency that this chapter is focusing on is proficiency 22 (Domain 1): 'be able to evaluate the effect of their own characteristics, values and practice on interactions with service users and be able to critically reflect on this to improve practice'. The final characteristic in Rose's (2012) typology that is useful to consider in order to be competent in this area is that there can be no self without other. Rose uses the example that every single baby is born into particular social groupings based on their family, class, society, race and culture. All these factors contribute to the individual's value system and understanding of who they are and who they ought to be according to a learned set of norms and rules. When we encounter individuals or groups with different values or priorities from our own, we can sometimes view them as less developed or less important. This is where the significance of critical reflection becomes apparent. If a social care worker is working with an individual from a different culture or with different priorities, they must ensure they are actively reflecting on what impact any conflict of values may be having on the service user, on themselves and, most important, on the practice. Although reflection on the self is often a

personal exercise it relies on thinking about others too. To become self-aware requires the individual to be aware of others who are and have been instrumental in their lives. It is through reflecting on these interactions and relationships with others that a greater sense of self emerges. Giddens (1991) notes this as 'the reflexive nature of self-identity' which is consistently revised according to life events, circumstances and interactions. Reflecting critically on who we are through our own and other people's eyes is one of the key principles of the Johari window method. This is a simple yet effective tool that incorporates similar concepts of self as laid out thus far in this chapter. Fisher-Yoshida (2003) offers an interesting discussion on the use of the Johari window in becoming self-aware and attuned to the role individuals (influenced by their values) play in the co-construction of conflict. It also explores other methods useful for the critically reflective social care worker.

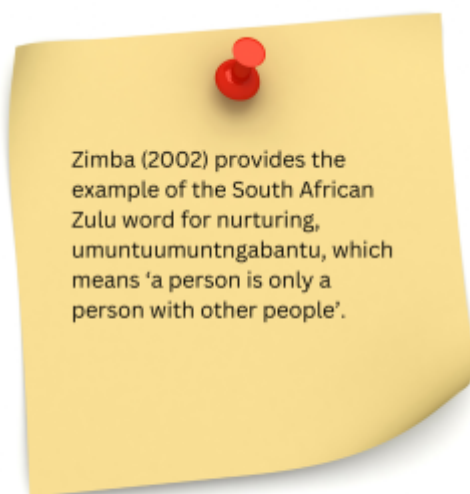
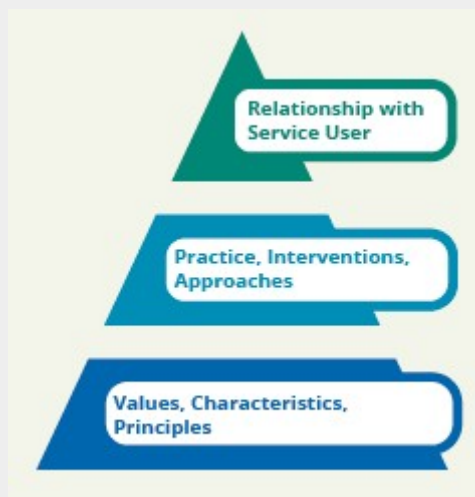


*Figure 1:
Author-created
diagram based
on the Johari
window
method of
reflection
(Included with
permission
from Alan
Chapman).*

Practice Example 4

No self without other

The pyramid below highlights how our personal and professional values often influence the interventions we use, how we approach our practice and how this in turn impacts on the relationship with the service user.



Author-created pyramid diagram illustrating the foundational role of values, practices, and interventions in building effective relationships with service users.

As you have undoubtedly read in many other chapters of this book, the foundations of social care work are based on the relationship between service user and social care worker. It is important then to engage in self-reflection regarding values and their possible impacts on the relationship. Accurately interpreting and assessing the values of service users is an equally important activity that is central to social care work, but it is something that we don't always get right. One example of this comes from my 2011 research on outcomes and foster care. Young people (in and from foster care) and professional stakeholders (foster carers and social workers) were asked to list what they felt were indicators of successful outcomes for young people in foster care.

All the young people (n=8) referred in some way to feeling 'happy' in their answers. Contrastingly, all the professionals (n=87) listed 'doing well in education' as their number one or number two indicator of a successful outcome. The implication here is that the professionals placed a strong value on education and therefore interventions designed were often associated with improving educational engagement and attainment. The young people also mentioned education as an indicator of success, but given the traumatic background many of them had lived through, they felt that interventions should also be aimed at celebrating other definitions of success, such as a young person feeling genuinely happy. During the follow-up interviews with young people, I asked them about this and the consensus was not that they did not value education or wish to attain certain levels of education but the majority felt that if they were happy then it would increase their confidence and therefore the likelihood of wanting to further their education.

TASK 1

Interpretation of values

This exercise will help you to assess your own value system and to examine how your values compare with others'. It will also highlight the importance of language, interpretation and experience when reflecting on the possible impact values can have on practice.

Values for discussion: *Achievement, Fame, Family, Freedom to Express Opinions, Friendships, Helping other People, Intellectual Status, Keeping Ireland Irish, Looking out for Number One, Religion, Truth, Wealth.*

(Note to Facilitator: some of these values have been deliberately phrased in ways that are open to interpretation and to prompt discussion. The facilitator should change or adapt the particular set of values according to needs. This exercise works best as a visual piece, so I recommend printing each value on an A4 page and getting students/ members of the group to lay out the different lists. Halfway through the exercise the groups can walk around and look at how other groups are doing. If they decide to change the order of their list as a result of this, a discussion on how easily influenced we can be by others might be useful.)

1. Instructions

- Look at the list of values and think about how important each one is to you. List the values in order of importance. Think about what each one might mean and why you are putting it in a particular place. How influential are your previous experiences and/or relationships to this process?
2. In groups of four or five, agree on the overall order of the list and place in a way that is visual to all (on the floor or desks depending on space available). Everyone must agree on the order, and values cannot be placed side by side. Generate discussion on what the different value statements might mean and how easy or difficult it is to come to an agreement on where the different statements should go.
3. As a group, reflect on how decisions were made. Were there any disagreements? If so, what were the reasons for this? What were the statements that groups found easy to place? Why? What were the statements that groups struggled to agree on? Why?
4. Think about how these values might apply to social care practice. What impact might the value you put on any particular statement have on your relationship with service users? What would happen if you and the service user had conflicting values about certain issues?

Personal Values

Now that you have an understanding of how presentations of the self emerge through relationships, interactions and values, let's take a look at how you can analyse your own values. In my years as a personal and professional development lecturer and, more recently, a Year 1 tutor, I have had many opportunities to chat with students regarding their motivations for doing the course and ultimately becoming a social care worker. What is apparent is that most of these students'

decisions come from a place of personal experience that is now rooted in their personal value system. The values of wanting to help vulnerable people, celebrate diversity, reduce inequality and be part of a team that supports individuals and groups to reach their full potential are often cited as being central to the decision-making process. These values are valid and in line with the professional values we strive to promote in social care work.

However, what students sometimes struggle with are the more personal values that can influence how we think and feel about certain situations. Once we start to peel back the layers of meaning and interpretations associated with aspects of life that hold varying degrees of importance to different people, the impact of personal experience in shaping those values becomes clearer. Let's look at the example of family. Most students cite family as being the most important factor in their lives and the thing they most value or hold dear. The reasons for this are often related to the feelings of belonging, security and support that being part of a family often affords. However, if we look at the family situations of some of the vulnerable people who avail of social care services, this definition often does not apply to the same degree. For some individuals, the mention of family conjures up feelings of stress, loss or rejection. It is important for students to reflect on how their value on family may differ from that of their service users and any impact this may have. If a social care worker has a strong connection to their family and believes that 'family should stick together' there might be a temptation to allow this belief to impact on their relationship with a service user. Someone who holds this belief may, for example, struggle when working with a parent whose child is in the care of the state because of neglect or inability to cope.

Non-judgemental practice requires individuals to consistently examine any preconceived ideas, biases or past experiences that may be affecting the relationship and approach taken with the service user.

TASK 2

- Using the template provided at <https://wehavekids.com/family-relationships/find-create-family-crest-coat-of-arms-heraldry> or <https://www.therapistaid.com/therapy-worksheet/coat-of-arms-family-crest>.
- Design a crest that identifies the people, beliefs, attitudes and things that are most important to you in your life, now and in the past, and that contribute to your sense of self.
- You can use words, quotes/lyrics, draw pictures, use collage or other creative methods. This is a personal exercise for you so you should use methods that make most sense to you.
- Reflect on why these things are important to you and where they come from. What have

been the influences/experiences in your life to bring you to this point?

- Think about the following social care settings: homeless services; intellectual disabilities; residential care for young people; and members of the Traveller community. Do you think your values would be similar or different? What positive points/challenges might this have on your relationship with that person/people?

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Chapter 23 – Lynn Leggett (DISOP23)

Domain 1 Standard of Proficiency 23

Be able to see the world as others see it; be able to practice in a non-judgemental manner and be able to understand another's feelings and be able to communicate that understanding

KEY TERMS

Perception and empathy
Non-judgement
Active listening
Advocacy

Social care is ... supporting people to live their best lives and reach their full potential through meaningful, person-centred interaction; supporting people to empower themselves through non-judgement and advocacy; encouraging and respecting the choices people make; and ensuring respect and dignity for the people we support at all times.

TASK 1

"Where would you sit?"

You board a bus and look for a seat. There are three empty seats, each next to a person. One seat is next to a male teenager. He's listening to loud music and is wearing a hood over his head. One seat is next to a well-dressed middle-aged woman carrying several shopping bags and looking at her mobile phone. The final seat is next to an older man who looks dishevelled and appears to be talking to himself. Where do you sit, and why?

This short task may help you to gain an insight into how you see the world, find out if you harbour any unconscious prejudices and prompt you to be aware of others' feelings

Perception and Empathy

Social care workers rely on perception and empathy every day in all sectors of social care practice. How we respond to service users is key to forming therapeutic relationships and having the ability to understand an individual's needs. Two factors are important here: emotional intelligence (EI) and social competence.

The study of emotional intelligence is complex, with many theorists applying different meanings to and ways of measuring intelligence. However, it appears that there are 'both genetic and social determinants of EI' (Carthy & Jameson 2016: 20). Salovey and Mayer (1990) define EI as 'the ability to recognise and monitor one's emotions and to use this information *'to guide one's thinking and actions'*' (in Carthy & Jameson 2016: 13). Bar-On *et al.* (2000) define EI as 'an array of emotional, personal and social abilities and skills that influence an individual's ability to cope effectively with environmental demands and pressures' (cited in Zijlmans *et al.* 2015). Both definitions suggest that our emotions are strongly linked to our behaviours. Therefore, our own emotions and subsequent behaviours alongside the emotions and subsequent behaviours of service users are undoubtedly going to affect any interactions we have with those people we engage with and support in our social care roles. Interestingly, Rose *et al.* (1998) found that within residential settings 'where staff reported low levels of stress, higher levels of support and more positive staff-client interactions were found' (cited in Zijlmans *et al.* 2015). This suggests that people, i.e., staff, when managing their own stress levels well, are better able to focus on and empathise with others. Here, wellbeing matters. The National Economic and Social Council (NESC) says that wellbeing relates in part to 'having a sense of purpose in life' and is enhanced by 'meaningful and rewarding work' (2009:4). It also says that 'the importance of care, both unpaid and paid, and its impact on the well-being of individuals and society is now coming into sharper focus' (2009:17). Self-care is also a crucial component of wellbeing and self-awareness and is therefore a key component of effective social care. For more on self-care see Chapter 18. In her excellent TEDx Genova event, Louise Evans details how to become more conscious of our own behaviours, how they can directly shape our world and how they impact on those around us. Here, self-awareness is key. Louise details how she brought her partner's daughter to a jazz club in Milan to help build a relationship with her.

Louise was enjoying the music, but when she glanced over to see her partner's daughter looking at her phone, she was faced with a choice in how she could

interpret and react to the situation. She attributes animals' personalities to five human traits in order to cleverly demonstrate the possible reactions and outcomes she could have to the situation. Louise says that 'our choices make a direct impact on the relationships we form', and that 'work can be a place where we make some of our most questionable and sometimes toxic behaviours' (2017).

Social competence is an important concept in social care as it is a skill which, if underdeveloped, can make it difficult for service users to make sense of their emotional world. Seemingly small things we may take for granted, such as social cues, can have quite a negative impact on their lives. For example, if service users lack the capacity to understand and regulate their own emotions, it may be fair to assume that they may have difficulties interpreting the emotions of others. In their study, Owen and Maratos (2016) investigate the importance of social competence, stating that 'understanding the facial expressions of others is critical, as emotion recognition is a prerequisite to empathetic responding and an essential factor in social functioning' (2016: 344). Adults with intellectual disability (ID) have difficulty discerning the facial expressions of others, which is a crucial point to consider when trying to convey empathy or concern (Owen & Maratos 2016:352-3). People with ID also have difficulty communicating their emotions, and as social care workers we use our observation skills to note changes in the emotions of the service users we support. In other words, we need to use as many means as are necessary and relevant to the individual to show service users we empathise with them. This again highlights the importance of person-centredness. For example, staff might use a tool such as the disability distress assessment tool (DisDAT) (East Sussex NHS Trust 2017) to guide them in supporting the individual in relation to pain management. Here the person's appearance, vocal signs, habits and mannerisms, posture and observations would be monitored over a period of time in order to draw up a summary of signs of when the person is content versus distressed so that the most likely cause of distress can be managed for the person. In order to develop meaningful relationships, it is vital to be able to see the world as others see it, to practice in a non-judgemental manner, to understand another's feelings and to be able to communicate that understanding. Relationship-based care is an important concept here as it is based on the power of relationships. In her book *Relationship-Based Care*, Koloroutis acknowledges that '[w]ithin health care organizations, profound human experiences happen every single day' (2004:1), and the book gives more information on the benefits, healing and transformative power of building relationships with the service users we support. It is also worthwhile acknowledging that at times, 'health care staff often feel demoralised when they find themselves in the middle of a health care delivery

system that seems to have lost touch with the very reasons they've chosen health care as their profession (Koloroutis 2004:2). However, showing that we care doesn't have to be complicated and can be achieved by the simplest of means.

The Hanging Out Program (HOP), developed by Sheridan Forster (2008), is an excellent example of this. It highlights the importance of interaction and focuses on looking at the environment from the service users' point of view. 'The approach is to spend 10 minutes with a person giving them 100% of your attention' (Forster 2008:1). In my experience, spending time with people over a cup of tea while having a meaningful and conscious conversation has proved invaluable in developing relationships and helping to identify necessary supports.

Many problems have been shared and solved over a cup of tea!



Drawing by Aoibhinn Leggett and reproduced with permission.

Non-Judgement

A non-judgemental attitude is arguably one of the first principles of social care practice as judgement has the potential to violate equality.

In his article 'Valuing equality in Irish social care', Hanlon presents 'an equality perspective on practice', stating that 'emancipatory practices, that is, ways of helping that provide egalitarian solutions and outcomes ... begins with an appreciation of the nature and relevance of inequalities on the lives of diverse social care users' (2009:6). Hanlon asserts that social care workers 'who do not have at least an implicit appreciation of the nature of inequalities, and of how they impact on the lives on social care users, are lacking a basic knowledge required to do this work' (p. 9). Therefore, working toward equality is two-fold – it is vital that social care workers work on building respectful relationships while also challenging prejudice and judgement (pp. 10-11).

Case Study 1

An example of non-judgement and respect in practice:

In terms of equality within the area of disability, the United Nations (UN) Convention on the Rights of Persons with Disabilities (CRPD) has provided 'legislative structures' that protect the rights and dignity of people with disabilities. Article 23 of the UNCRPD states that people with disabilities have the same rights as anyone else in the areas of marriage, family, parenthood and relationships (UN 2006). An example of where staff should work on shedding their own misconceptions and maintaining a non-judgemental and respectful approach would be when supporting two service users who have decided to have an intimate relationship. Here, both service users should be respected and offered supports in relation to initiating and/or maintaining a relationship. Remember, in practice we should always work towards questioning our preconceived notions about the lives of people we support. What kind of supports might you offer two service users in this situation? Some examples might include contacting a psychologist to meet with the service users in order to determine what each person is seeking within the relationship or perhaps asking an advocate to meet with the service users to clarify issues in relation to consent.

TASK 2

Reflect on your own values and how they impact on your practice.

Case Study 2

While working in a residential service for people with disabilities, social care worker Tom encountered the following situation. The service users living in the house Tom worked in had decided that they would like to go to the circus. Circus tickets were booked and paid for on an evening that suited the residents who wished to go. The staff on duty on the evening of the circus outing refused to accompany the residents to the circus as she felt the circus conflicted with her values. The residents didn't have the ability to go to the circus on their own and were reliant on the support of staff. The person in charge (PIC) contacted Tom at short notice to ask him if he would work for the evening and take the residents to the circus. Tom agreed to do so. The PIC met with the staff member who refused to go to the circus to resolve the issue and ensure that a similar situation didn't occur in the future.

Often times we may be faced with situations which challenge our values; however, the service users' needs and choices should always be at the forefront of decision-making.

Case Study 3

The following case study outlines the difference between our expectations and those of the people we support and the importance of non-judgement and respect in relation to those expectations.

Joanne* was a service user attending a day service. She had a mild learning disability. She was a very sociable lady and loved to spend time with her partner and friends in the day service she attended. She volunteered three days a week in a charity shop and spent two days a week attending the day service and participating in her preferred activities, which included a craft group and cookery class. Joanne was always quite an active lady; however, as she aged, and her mobility naturally began to decline, she began to put on an increasing amount of weight. At her annual medical check-up with her GP she was advised to lose weight. Having received this news, Joanne confided in her key worker, Rose,* that she felt embarrassed and upset in relation to her appearance. She said that she had realised that she had put on weight but didn't feel that anybody had noticed until the GP mentioned it to her. Rose reassured Joanne and together they began to implement measures in order to assist with weight loss, such as having Joanne assessed by the physiotherapist so that she could use the exercise equipment in her day service. A volunteer began going for walks with Joanne once a week and Joanne also decided that on the days she did cookery she would have some of the meal prepared in class instead of bringing in her lunch as well. Joanne's wellbeing meeting was scheduled and her mother and sister attended. During the course of the meeting Joanne's weight was discussed. Her mother began by saying 'You're getting awful fat altogether ... look, those clothes don't even fit you any more ... what am I going to do with you?' Rose could see the colour rise in Joanne's cheeks and the tears begin to prick her eyes. Joanne's sister said, 'Yes, we'll have to sort you out before you have a heart attack.'

Question: How do you think Joanne might feel? How would you support Joanne at this stage of the meeting?

Rose passed Joanne a tissue and reminded her of all of the great work that she has been

doing and asked her if she would like to tell her family about her healthy eating choices and use of the exercise equipment. Joanne and Rose had prepared some visual support plans, which Joanne showed to her family. Rose made the decision to steer the conversation in a more positive direction so that Joanne might enjoy the remainder of her wellbeing meeting as she had worked so hard to prepare the agenda and content of the meeting. Rose decided that she would chat to Joanne later about how she felt the meeting went. It may have felt like the right thing to do to jump to Joanne's defence directly after the comments in relation to her weight were made; however, Joanne's family didn't visit the day service often, and family relations were already strained. It's important that we don't make judgements or assumptions about how families interact, or care for their loved ones, as they too may have things going on in their lives that we are unaware of.

* Names have been changed to protect identities.



Thus, judgement has no place in social care and only serves to hinder relationships with those who are already marginalised. Social care workers have many opportunities, especially when accessing the community, liaising with families and multi-disciplinary teams, to help to change people's attitudes towards marginalised groups within society. As social care workers it is crucial that we don't judge a service user based first on their disability and second on the decisions they choose to make.

Active Listening

Being present with people is a core concept which stems from our ability to be self-aware and practice in a mindful manner. It means continually looking for subtle cues in relation to how an individual presents themselves on any given day. One of the most valuable lessons I have learnt throughout my social care career is the importance of active listening. Rogers and Farson first coined the term 'active listening', claiming it to be a 'growth experience which can [build] deep, positive relationships and tends to alter constructively the attitudes of the listener' (1987:1). Two components are important here: 'the content of the

message and the feeling or attitude underlying this content' (p.3). As social care practitioners we aim to understand both components in order to understand the total meaning the person is trying to convey. Rogers and Farson also argue that '[in] some instances, the content is far less important than the feeling which underlies it' (p.3). This is perhaps even more important in social care as often times the service user won't have the skills to clearly articulate how they might be feeling. It is therefore crucial that we develop relationships with the service users we support and begin to recognise the non-verbal cues that may indicate how the person is feeling. This can help to offset any emotional upset or episodes of behaviours that challenge. It's important to know how the people you support communicate and helping a person to develop a communication passport or support plan can be very useful here.



Author created diagram based on Rogers and Farson (1987: 3-4) illustrating key components of active listening, including verbal and non-verbal cues.

Rogers and Farson (1987:3-4) outline the following important cues to be mindful of when listening to a person:

Rogers and Farson also note that 'Active listening carries a strong element of personal risk [as] we risk being changed ourselves', for example, we run the risk of seeing the world from another person's point of view (p. 5). They claim that 'It is

threatening to give up, even momentarily, what we believe and start thinking in someone else's terms. It takes a great deal of inner security and courage to be able to risk one's self in understanding another' (p. 5).

It is vital to have a genuine interest in the speaker. Any pretence of interest will be picked up by the person and as a result they may 'no longer express [themselves] freely' (p. 5). This is so important in the area of social care, in particular; being willing to invest yourself emotionally will undoubtedly come as a result of actively listening to a person. If you chat with somebody you support for longer than a minute or two you are no longer engaging in idle conversation. Instead you should see this time as a valuable opportunity, one in which you can

actively seek ways of gaining information which might translate into future goal-setting, problem-solving or advocating on behalf of the person.

TASK 3

Research positive behaviour support to better understand the link between non-verbal cues and behaviour and supporting the person in an individualised way.

Case Study 4

All About Me

The organisation I work for has an excellent person-centred planning system, part of which facilitates a service user and member of staff to embark on a process of discovering the person. Together, the service user and staff member compile meaningful information which the service user would like to share with those he/she chooses and in a format which is accessible to the person. For example, the All About Me could take the form of a photo album, memory book, video recordings or a combination of visual and audio. The finished product is a document entitled 'All About Me'. It's the journey and not just the finished product which makes this process so special. An All About Me offers an invaluable insight into the person's world – everything meaningful to them. The All About Me process is an example of active listening in action and the resulting actions and positive outcomes that can result from the process in order to better the lives of those whom we support.

TASK 4

In social care we talk about 'what is important to and for the person'. In your place of work, how is 'what is important to the person' recorded and communicated to others?

Advocacy

According to Mind (2018), advocacy can be described simply as “getting support from another person to help you express your views and wishes, and help you to stand up for your rights. Someone who helps you in this way is called your advocate.” One of the key roles of social care workers is advocating on behalf of those whom they are supporting.

- Judith Snow is an example of an advocate. In particular, she was an advocate for inclusion and has also been described as a 'remarkable leader, philosopher, teacher, artist, creator' (Inclusion). She believed not in disability, but in 'giftedness and capacity' (Inclusion). Inclusion provides many resources to gain a deeper insight into Snow's work and life.
- The Wellness Recovery Action Plan (WRAP) is an example of a mental health recovery tool which allows a person to advocate for themselves. The self-designed plan is created when a person feels well and documents exactly how the person would like to be supported should they become unwell (AHP online).
- The HSE provides details of nationwide advocacy services for many groups in society (HSE online)
- The Citizens Information Board (www.citizensinformationboard.ie) is also a great resource for information, advice and advocacy.

TASK 5

Think about how you would like to be supported if you needed somebody to advocate on your behalf.

To conclude, social care is based on the development of inter-personal relationships with vulnerable people. It requires empathy, strong communication skills, self-awareness and an ability to use self-reflection.

Finally, never be afraid to invest yourself in another person in the pursuit of truly understanding the world of another. Snow's writing is testament to the notion that if we can try to understand an individual who has been marginalised or needs to be supported in some way, we may be gifted with a deep connection to the individual, whereby our lives are enriched with a better understanding of the meaning of life. She said, 'Walk into the daily activities and environments of life with this person as dream and reality interact in a creative dance that expresses the meaning of life. Try this and may you rejoice in all that you create together' (Snow 2015:63).

Tips for Practice Educators

It is important for the student to really try to place themselves into the shoes of the service user. A few key aspects are important here.

Respect an individual's life choices and lived experiences. Enter into a relationship with the individual, not solely in a caring capacity, but one based on acceptance that the service user is the expert. For too long in the caring professions the service user and their families were disempowered and handed control of their loved one over to professionals who, it was assumed, knew best. The person-centred planning process, including the All About Me, is invaluable in this respect. The time spent on this process is always well worth the investment.

All too often service users are labelled and treated in a certain manner in line with whatever attributes they are deemed to possess. For students entering placement it is vital that they invest the time in getting to really know an individual instead of treating the service user as perhaps others do. In this way the service user will be at a greater advantage in relation to having their needs accurately communicated.

Advise the student to complete relevant recognised online courses that may enhance their skills and learning; for example, the online learning and development site HSEland (www.hseland.ie) provides online learning courses including Communication with Consideration and Putting New Directions into Practice.

Finally, don't make the fundamental attribution error and presume a student isn't capable of engaging in tasks, projects or interventions. The new perspectives that students bring are often invaluable. The learning gained through placement and the opportunities given to students during this time will help to shape their future practice. Guiding students through placement allows social care workers a considerable opportunity to impart their knowledge and skills so that the students learn to become competent social care workers.

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DOMAIN 2 - COMMUNICATION, COLLABORATIVE PRACTICE AND TEAMWORKING

Effective communication is central to social care practice. Workers should tailor their communication to meet the needs of individuals, including those from diverse backgrounds or with communication challenges. They must document accurately, collaborate within teams, manage conflict professionally, and foster strong, respectful relationships with service users, families, and professionals.

Domain 2: List of Contributors

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

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

Vicki Anderson is a social care worker currently lecturing in the Institute of Technology Carlow. Prior to lecturing, Vicki had practice experience in children's residential care services and in disability services. She was Vice Chair of the Irish Association of Social Care Educators (IASCE) from 2011 to 2013, during which time she was a board member of Social Care Ireland.

Deirdre Berry qualified as a social care worker with a BA (Hons) in 2006. She has practice experience in mainstream residential and after-care services and has worked in the area of domestic, sexual and gender-based violence for over thirteen years. Deirdre has a keen interest in human rights and gender-based violence. She has vast experience working with the family court system, child protection, mental health, homelessness, family support and addiction services. She holds a master's in Advanced Social Care from Athlone Institute of Technology and a special certificate award in Team Leadership and Supervisory Management.

Bernie Breen has over twenty years' experience working in the field of social care. She holds a BA (Hons) in Applied Social Care and an MA in Social Care Leadership and Management. Bernie is one of six professionally accredited therapeutic crisis intervention trainers in Ireland and her MA research focused

on 'Social care managers' perspectives on factors which support or impede the implementation of therapeutic crisis intervention (TCI) systems in children's residential care services in Ireland'. Bernie is Director of Services with TerraGlen Residential Care Services, which provides mainstream and disability residential and respite services.

Marian Connell is a lecturer in Applied Social Care in Technological University Dublin, Tallaght Campus. She lectures across the programme in Applied Social Care, Creative Group Work and Facilitation Skills, and Facilitating Arts in Social Care. Prior to becoming a lecturer, she worked in a variety of residential care settings, in family support as a social care worker and in management. She has fifteen years' experience as a child psychotherapist and 28 years' postgraduate training as a social care worker. She has a degree in Social Care, postgraduate diplomas in Child Art Psychotherapy and Practice Based Play Therapy, and an MSc in Child Art Psychotherapy.

Natasha Davis-Dolan is a social care worker currently working in partnership with children, young people and families who are at risk. Natasha holds an ordinary degree in Social Studies in Social Care and is currently undertaking her honours degree in Athlone Institute of Technology. Natasha's focused interest is in the area of care and aftercare, particularly the effect on children and young people who enter the care system of separation and loss, and attachment. Natasha is a qualified financial adviser, having spent sixteen years working for a large Irish financial provider before making the decision to return to education in 2016.

Maeve Dempsey is a social care lecturer with Limerick Institute of Technology and has over eight years of teaching experience. She has previously worked in mainstream residential care, youth and community work, and the disability sector, and continues to work as both a facilitator and consultant for supervision in social care and developing effective communities of practice within organisations. Maeve holds a BA (Hons) in Applied Social Studies (Professional Social Care), an MSc in Criminology and Criminal Justice from University College Dublin and is currently undertaking a diploma in Clinical Supervision.

Diane Devine is a social care worker for over seventeen years, and her experience includes management in day services. Diane specialised in the education and training of adults with additional needs in day services; earlier in her career she worked with children in the specialised care sector. Diane is a lecturer in the Department of Lifelong Learning, Institute of Technology Carlow. She lectures across Social Care and Childcare programmes. Diane also holds a B.A Degree in Arts – Community Studies, an MA in Child, Youth and Family Studies,, a Diploma in Local and Community Studies from National University

of Ireland Maynooth, a certificate in Supervision, Theory and Practice, and qualifications as an adult literacy tutor and a Teaching English as a Foreign Language (TEFL) tutor.

Paul Hogan is a lecturer in social care in Athlone Institute of Technology. As well as his social care degree, he holds an MA in Child and Youth Studies and is currently undertaking postgraduate research on family homelessness. Paul co-ordinates practice placements for students. He was involved in politics for fifteen years and has a particular practice interest in homelessness, youth, direct provision and community development.

Dr Ailish Jameson, a social care lecturer in Technological University Dublin, is also a relief social care worker in homeless services. Her PhD, which she completed in 2019, explored emotional intelligence (EI), graduates and employability. Part of this PhD was the design and delivery of an EI coaching programme for final year students, tailored to the specified needs of employers. Ailish completed the Applied Social Studies in Social Care degree in 2010. She has a major interest in wellbeing, in particular mindfulness interventions to address stress and burnout, and is a trained mindfulness teacher. She facilitates mindfulness sessions on a voluntary basis in educational settings, to individuals deemed at risk and to members of the public.

Gillian Larkin is a lecturer in Applied Social Care at Technological University Dublin, Tallaght Campus. She lectures across the programme in Professional Practice, Management and Supervision in Social Care, Leadership and Organisational Change in Social Care and Strategy and Governance in Social Care. Prior to becoming a lecturer, she worked in family support and residential care settings for fifteen years, and for the last ten years has worked on a voluntary basis coaching and mentoring people experiencing difficulties with addiction and mental health. She is currently completing a MA in Applied Psychology (Positive and Coaching Psychology).

Eleanor Lyons is currently working as a social care worker/deputy manager in a residential house for adults with intellectual disabilities. Eleanor graduated from the Institute of Technology (TU Dublin) Blanchardstown with a degree in Applied Social Studies in Social Care. Eleanor's family were foster parents for children in emergency care and she grew up with a keen interest in social care. She also worked with Dublin City Council on their student activity programme, which aimed to empower young people from the inner city.

Garreth McCarthy is a social care worker currently working in an addiction community service as part of a multidisciplinary team in Dublin's North Inner City region. Garreth previously worked in numerous residential homeless services including a family hub, supported temporary emergency

accommodation and one night only emergency hostels for five years. Garreth completed his honours degree in Social Care at Technological University Dublin, graduating in 2020 and completed a master's degree in Social Science (Rights & Social Policy) at Maynooth University in 2021.

Des Mooney is a social care leader working with children in residential care in Dublin South. He also teaches and writes about the practice of social care. He holds a BA (Hons) in Social Care and an MA in Higher Education. His research interests include social care practice, therapeutic care and communities, supporting recovery from trauma and negative early life experiences, and lifelong learning. Des was a member of the Social Care Workers Registration Board from 2015 to 2021.

Evonne Mushonga is a social care worker who began her career with the Ana Liffey Drug Project (homelessness and addiction). She is currently working in the community with HIV Ireland as a support worker. After graduating in 2017, she has continued her studies in the area of counselling and psychotherapy. Evonne is currently serving as a board member with Rooted in Africa and Ireland (RIAINetwork), an initiative that aims to tackle and promote anti-racism in Irish society.

Shauna O'Regan is a social care worker currently working in day services for adults with intellectual disabilities. Shauna has also worked in adult residential care and residential services for children with autism. She graduated from Technological University Dublin, Blanchardstown Campus with a degree in Applied Social Studies in Social Care in 2019 and has been working in the disability sector since then. Shauna is currently completing a course in Positive Behavioural Support with the Open Training College.

Collie Patton has worked in social care for the past fifteen years, in both frontline and academic roles. His practical work has primarily been in residential and day programme development and delivery, with a special focus on therapeutic work in the outdoors for those living with an additional challenge. Collie currently works for Active Connections Inc and was instrumental in creating a therapeutic outdoor programme for children and adults with additional needs, which currently runs in seven counties in Ireland. He delivers Continuing Professional Development (CPD) programmes with CARA that focus on sports inclusion, and teaches on Dublin Business School's and Limerick Institute of Technology's Social Care degree programme. Collie holds a BSc (Hons) in Chemistry, graduate degrees in Applied Social Studies (Professional Social Care) and Business Administration, and an MSc in Behaviour Analysis.

Gráinne Powell, a graduate in Family Support/Social Care, has a range of expertise in the areas of community development, drug education and

parenting. Gráinne has worked for many years as a health promotion officer with the Health Service Executive delivering health and wellbeing initiatives in line with national policy priorities. Prior to this she was a youth and community worker. Gráinne is a trained parenting practitioner and is currently undertaking research in this area.

Tanya Turley has worked with and continues to manage organisations involved in the social care arena such as crisis intervention services, child protection, residential care, youth services, community development, and therapeutic and family resource work for the past twenty-three years. Tanya holds an MA in Therapeutic Childcare, a BA (Hons) in Applied Social Studies and Combined Management, an HDip (Hons) in Adult Education and Community Development, a Diploma in Psychology (NUI Maynooth) and a Teaching English as a Foreign Language (TEFL) qualification. Tanya has lectured in the Faculty of Lifelong Learning and full-time daytime courses across the Early Years Education and Social Care programmes in the Institute of Technology Carlow since 2005. Her ethos of work is a person-centred approach with areas of special interest that include trauma-informed practice, adverse childhood experiences, polyvagal theory, resilience, and attachment.

Chapter 24 – Evonne Mushonga (D2SOP1)

Domain 2 Standard of Proficiency 1

Be able to communicate diagnosis/assessment and/or treatment/management options in a way that can be understood by the service user

KEY TERMS

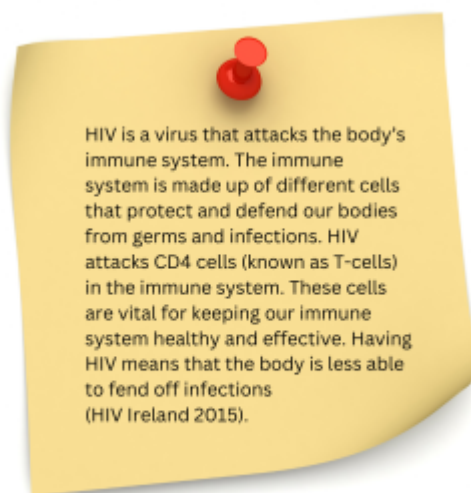
Assessment
Diagnosis
Treatment options
Communication

Social care is ... the ability to empower others to speak up for t

This proficiency can be specifically applied to various social care contexts. The importance of communicating treatment interventions in a way that can be understood by the service user is one of the central elements of social care practice. Social care workers provide a broad spectrum of care with diverse people in response to the political, economic and social demands occurring globally. The practice sphere of the social care worker has expanded greatly because the competencies and skills of social care professionals can be positively transferred into different areas of care and support, for example working with older people, domestic violence support, homeless services and addiction services. This chapter is based on my experience as a social care worker in one of these new practice settings, a service for people diagnosed with the human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS). In order to help you, the reader, understand this proficiency, I decided to base the chapter around how this service communicates the diagnosis/ assessment and/or treatment/management options available to people with HIV or AIDS. The case studies presented here are fictional but are used to demonstrate an

effective and supportive way to communicate information on the diagnosis, assessment and treatment options for people receiving an HIV positive result (Jamison *et al.* 2006).

The organisation I work for operates under an ethos of equality and is committed to making a positive contribution towards a humane and just society (HIV Ireland 2015). This service strives to ensure that all staff, volunteers and service users are always treated with dignity and respect in an environment that promotes equal opportunity and prohibits discrimination. The main aim of the organisation is to raise awareness and provide training, support and advocacy; it also provides free community HIV and sexually transmitted infection (STI) testing, free counselling, a free resources service, as well as disseminating free condoms in the community. In this service, social care workers are referred to as support workers and the service users as clients.



The assessment interview is the initial opportunity afforded to a social care worker to start building a working relationship with a client. Through the interview process the client's past experiences and coping strategies are discussed, along with their goals for treatment. At the same time, the client's strengths and unique needs are identified, which helps the service ascertain the best intervention strategy for them. The assessment is a long process that begins with the initial interaction with the client and continues throughout the duration of the intervention (HIV Ireland 2015). The assessment process establishes the social care worker as one part of the client's support system. Therefore, it is important for the worker to be patient and sensitive to the

client's needs in order to gradually find out from the client how they can be of support. It is necessary to aid the client to build their own support network, in addition to the service, to have better and longer-lasting outcomes. As a worker, the support you provide is social, emotional and, most importantly, empathy.

The ability to display empathy is vital in validating the client's feelings. Empathy assists in the acceptance of the client's plight, and enables them to realise that they are being genuinely listened to. Empathy in practice means accepting and understanding the client's feelings, which may help you to become better equipped to facilitate the service user to help themselves. This requires learning and experience and can be achieved through practice (Gilbert *et al.* 2017). During the assessment phase it is vital not to be judgemental about the client's circumstances, but rather to adopt a neutral position. You can achieve this by keeping an open mind and by not imposing your own religious, political and personal views on the client. It is also important to read and learn the social care workers' code of ethics to guide one's judgement (SCWRB 2019).

The first case study illustrates the background information that is shared during the initial assessment process. This case study is fictional but is based on the type of assessment process people who have received a diagnosis of HIV/AIDS may experience.

Case Study 1

Assessment Stage

The fictional client is a male called John, and he is in his late 50s. John was once married, and has two children, who are in their 20s. John has been unemployed for more than five years. John stated that he lived a happy life before he lost his job. He worked as a security man for a long time and provided for his family well. The second tragedy he discussed was the breakdown of his family. This was precipitated by his heavy drinking tendencies that became worse after losing his job. During this time, his wife left him, taking the children with her, and John remained in the family home. In the beginning the children visited him regularly, but John was unable to keep up with the mortgage repayments and the family home was repossessed. John now lives rough on the streets. John stated that he comes from a strong family and his mother, three sisters and two brothers are all still alive. He described how his family looked up to him as a father figure after the death of his own father.

Since last year John has come out as gay to his family. He met a young man in a homeless shelter and they began dating. Although his family know he is gay, he has concerns about their acceptance of him as they hold strong Catholic beliefs. In the final part of the initial assessment, John discussed how he suspects he has contracted HIV.

John does not know much about HIV and AIDS. He considers HIV a death sentence. He does not know about medications or if they will work very well if taken as prescribed. All this confusion is expressed during the assessment meeting, as it is not confirmed at this stage that he has contracted HIV.

Trust-building skills were employed during John's assessment phase. A strong therapeutic relationship with the client is developing, through helping him identify a support system, accurately assessing his needs, and empathising with his own unique situation in a non-judgemental and value-neutral way.

Because John felt safe, he opened up about his life and volunteered information to the support worker. He stated that he felt comfortable and looked forward to the next meeting. It is important to note that if the social care worker does not feel that John is able to process all this information, they can refer him to a counsellor to provide additional support at this time (Kabir 2017).

Diagnosis

Diagnosis can be referred to as the process of helping the client to make sense of their medical condition. It can also be part of the assessment process. In the case before us, the client is worried that he may have contracted HIV. As a result, there is a medical diagnostic process that needs to be performed. However, the diagnostic process must be supported with clear and accurate verbal communication, patience and empathy.

Case Study 2

Diagnostic Stage

Meetings continued regularly between John and me. After two months, John could not be found. I suspected that it was a result of our last discussion, in which I suggested that there was a need for him to know his HIV status. At the time, he was not too keen to know. He gave me the impression that he did not want to know; however, John promised me that he was going to think about it. I was committed to help John and work at his pace, but I felt it was important to reach out to him.

A week elapsed without yielding any results. At the end of the second week, I came into contact with him. He was very surprised that I was looking for him, but he appreciated the care

and concern. He stated that he did not come to our meetings because he still had not made up his mind whether to check his HIV status. I told him that he will never be forced to know his diagnosis. However, I explained the advantage of knowing early, especially if he was HIV positive. I discussed the benefits of early intervention. The following morning, I was surprised to receive a phone call from John. He told me that he wanted to meet me as soon as possible and we made an arrangement to meet the following day. He told me he was ready to know his HIV status. I further explained that diagnosis can happen in two ways: self-diagnosis by home testing with kits provided by HIV Ireland; or through hospitals and/or clinics. He suggested we go to hospital, and we did. The hospital staff were very respectful and provided a private room for the consultation. I continued to assure him that everything would be alright regardless of the outcome. He was shaky but still wanted to go through the process. His diagnosis was HIV positive, and I stayed with him to help him understand the information provided by the clinician.

When John found out his HIV status, he did not want to discuss anything further that day. He told me he would be in contact as soon as he was ready to talk. I respected his wishes, at the same time encouraging him to consider early intervention. He promised he would be in touch before long. After a few days John phoned again and said he was in a position to meet me. This time I decided to meet him in a hotel setting. I bought him lunch just to make him feel loved and cared for. It was important to show him I cared so much about him. After lunch we sat in the lounge, far from everyone else for privacy. John told me he had not been in a hotel for some time and expressed his gratitude to be there. Before long, we got into a serious conversation. He told me he did not understand how I could say things were going to be okay when he was HIV positive. That question gave me a chance to explain to him all the treatment that is available for people living with HIV. This was the next step of my journey with him after diagnosis, to explain the following points so that he could ask questions and take his time to digest the information.

- HIV is no longer a potentially terminal illness; it is a chronic illness and people can live long and healthy lives if they adhere to their HIV medication, attend hospital appointments, and take care of their general health.
- If someone is taking their HIV medication and has 'undetectable' HIV viral load (as will be determined by their physician), HIV cannot be passed on to their sexual partner(s).
- Even women who are living with HIV and who are adhering to their HIV medications can give birth to HIV negative babies (WHO 2007).
- A person living with HIV (PLHIV) who has a good immune system may not need to take medication but will have regular check-ups.
- A PLHIV will regularly attend hospital every 4-6 months to have their viral load and CD4 count checked.
- Ongoing counselling and support are crucial at this stage.

Towards the end of the meeting John burst into tears, telling me that he had wasted his life. He was in despair and did not know how he could get back to his old self again. I assured him I would be there for him and would do my best to help him start a new life. At the end of the meeting, I was happy that John had expressed the desire to turn his life around. The next day I made an appointment for him at the hospital, and he started treatment.

The role of the support worker is to support the client with their diagnosis, provide accurate information and guide them in their HIV journey. Also vital to a person living with HIV is peer support; Positive Now is a national peer support

group that runs support/social groups, workshops, forums and conferences for people living with HIV (HIV Ireland 2015). The newly diagnosed can benefit from peer role models who can identify with the shock of a positive diagnosis while also explaining that HIV is no longer a terminal illness. Peers can also help orientate and support people living with HIV around the important issues of medication compliance and disclosure (Rouleau *et al.* 2019). As HIV-related stigma is still prominent in society and is equated with sexual activity and/or drug use, it is important for the social care worker to be open-minded and non-judgemental. Social care workers need to educate themselves on how HIV is and is not transmitted. It can only be passed on through unprotected sex, from mother to unborn child (if the mother is *not* on HIV medication), and through infected blood products (which, in Ireland, is extremely unlikely) (WHO 2016).

Someone living with HIV might not return or engage further with the service if he or she feels judged, or if the social care worker, fearing possible infection, treats the person living with HIV differently from others. Such actions and attitudes will further compound the vulnerability of the client. Often people living with HIV feel a lack of control over their lives, particularly around the issue of choosing to disclose or not to disclose their HIV positive status. In respecting the service user's wishes, and in considering their feelings, service providers can help them regain a sense of control over their circumstances. Additionally, social care workers have the responsibility to educate themselves about the rights of service users who are living with HIV and to ensure that service users know and understand these rights. This can help to empower service users to ask questions, especially about the decisions being made on their behalf.

Treatment Options

HIV treatment is also known as antiretroviral therapy (ART), or highly active antiretroviral therapy (HAART) (WHO 2016). Treatment with anti-HIV drugs is often called combination therapy because people usually take more than one drug, usually three, at the same time – often combined into one tablet. Current HIV treatment is not a cure for HIV (WHO 2016). It can keep HIV under control, but it does not eliminate HIV. HIV treatment works by stopping the virus from reproducing in your body. It can reduce the amount of the virus (your viral load) to very low (undetectable) levels (Rouleau 2019). If you are taking HIV treatment regularly and have an undetectable viral load, this lets your immune system stay strong, and, if the virus has damaged it, allows it to recover. Since antiretroviral

therapy first became available in the mid 1990s, enormous progress has been made in the treatment of people living with HIV such that, for many, life expectancy is similar to that of the general population (WHO 2016). If you are taking HIV treatment correctly, and achieve and maintain an undetectable viral load, there is effectively no risk of passing HIV on to others. HIV treatment is beneficial from an individual perspective, in that it keeps your immune system strong, prevents illness and improves your life expectancy. HIV treatment is also beneficial from a population perspective in that it prevents HIV being passed on to others. This is known as treatment as prevention (TasP) (WHO 2016).

Communication

Case Study 3

Treatment and Living with HIV

It is six months now since John started medication. He has been very consistent in taking his medication. As a result, the doctor has told him that the HIV is no longer detectable in his body. John is keen to turn his life around. He has paid frequent visits to his brothers and sisters. He makes sure he is sober and clean during the visits. He wants to win their trust again. His siblings are extremely happy about him. One of the brothers has been arranging meetings between him and the children.

However, John is faced with the challenge of communicating with friends and family about the HIV diagnosis. He wants to be honest, but at the same time he is not sure about his loved ones' reaction. Following discussions with the family, a meeting was arranged at which John was going to let his family know what had transpired in his life, including the HIV status and the gay relationship. I helped him to prepare what he was going to say to his family. At first, they were horrified about both issues. I gave them some comprehensive education on HIV and the fact that the virus is now not detectable. At that point the family became relieved and had the opportunity to ask questions in a safe and non-judgemental environment. At the end of the meeting, we discussed the importance of their family as John's support network in living with HIV.

Communication is key when dealing with service users who are HIV positive. The newly diagnosed are often given a lot of information by practitioners and is important to determine whether the service user has understood the information relayed by the medical practitioner (HIV Ireland 2015). While social care workers are not medically trained, there are World Health Organisation-endorsed key messages which social care workers should ensure people living with HIV understand (WHO 2016).

This is the most important first step in the process of communicating important information to the service user. The following are the key steps to consider:

- Establish a relationship with the service user. This is paramount because you need to make sure they are comfortable telling you everything that is going on, which will be better for them and their health.
- Communicate with the service user. Explain the issues to them in a language that they understand and check with them whether they understood what the consultant said.
- Meet the service user where they are at and listen to them in a non-judgemental way.
- Assure the service user that HIV is a chronic illness, not a terminal illness, and the treatment will enable them to live a long life.
- Develop trust with the service user by having open and honest communication.

For many people living with HIV, counselling and support is a vital service for them and their significant others. Often service users who are newly diagnosed request support around disclosing their HIV positive status to family, friends and, particularly, partners. Communication is key, and part of the role of the social care worker is to support the service user to communicate information on their diagnosis to their friends and family (HIV Ireland 2015). They may need to develop coping mechanisms in relation to their diagnosis and living with a chronic, and stigmatised, illness. Those living with HIV for many years can also benefit from counselling as HIV-related issues arise in their lives. This is another example of the importance of establishing a relationship based on trust and respect, achieved through checking back in with the service user on how they are living and coping with this diagnosis (HIV Ireland 2015).

The story of John above is a good example of how much a trustworthy relationship between client and support worker can achieve. In the case study the social care worker did not relent on visitations. She realised the client wanted to turn his life around and she helped. Similarly, when the client wanted to communicate his HIV story, the social care worker was present, and she helped the client to reach out to his family for support.

Conclusion

Through support, advocacy and training, social care workers can help to improve the lives of PLHIV and those affected by HIV. The agency I work for values the rights of service users and seeks to ensure that service users understand and exercise these rights and that they do not experience HIV-related stigma in society by promoting HIV and STI testing, educating communities, and empowering people living with HIV to self-advocate. Living with a stigmatised illness such as HIV can be very difficult for those affected by the illness and they may feel hesitant working with service providers. However, by ensuring there is good communication from the beginning of engagement, by remaining compassionate and non-judgemental, the service provider and the social care workers can optimise service user engagement and be able to communicate diagnosis/assessment and/or treatment/management options in a way that will be understood by the service user.



Tips for Practice Educators

Trust-Building Skills

The ability to display empathy is vital in validating the client's feelings.

During the assessment phase, it is vital not to be judgemental of the client's circumstances, but be neutral at all times.

Remember that the assessment is to help the social care worker develop the best intervention strategy to meet the client's unique needs.

Social care workers need to be sensitive and supportive of their client, and this comes in the form of social support, emotional support and empathy.

It is imperative not to be judgemental of your client's circumstance but be able to keep an open mind without imposing your own religious, political and personal views on your client.

Identify factors that can diminish a client's acceptance of a new person in their life. Deal with them, then you will be able to support the client.

Communication Tips

Listen more than you speak.

Understand the client first before making a comment and never interrupt.

Understand the needs, wishes and values of the client.

Begin with empathy.

Take responsibility for your own feelings.

Make requests that are practical, specific and positive.

Use accurate, neutral descriptions.

Be willing to hear 'No'.

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Chapter 25 – Shauna O'Regan (D2SOP2)

Domain 2 Standard of Proficiency 2

Be able to modify and adapt communication methods and styles, including verbal, non-verbal methods to suit the individual service users considering issues of language, culture, beliefs and health and/or social care needs.

KEY TERMS

Language
Culture
Beliefs
Health and social care needs

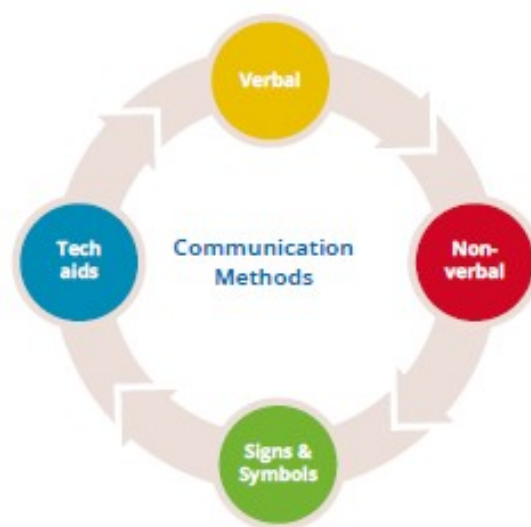
Social Care is ... using skills you have learned, your professional development to influence the lives of people you work with. Through a person-centred approach to enable people to live a full life, unhindered by societal barriers. It is the proud feeling when witnessing someone accomplish a new skill that will forever benefit them in their day to day life with tools you have helped them to master.

TASK 1 Can you remember a time when you, or a service user, did not receive a service or support as a result of challenges in communication methods or styles?

Communication Methods and Styles

When many people think of communication and communicating with others, they think of the most common form of communicating, speaking. People forget that there are many more forms of communicating through language than just spoken communication. Language can be spoken or written but can also be signed. Sign language is a skill mostly taught to people who have impaired

hearing and those in their immediate circle, i.e. their family. As a social care worker who may be working with service users with hearing impairments it would be useful to learn basic signs that would allow you to open up a line of communication with the service user. This is just one simple way of how you can adapt your communication style within the social care environment. Although this is a great way to open up lines of communication with service users, it is important to further develop your professional skills by going to courses and seeking training in this style of communication. The many different areas of social care will affect how as a practitioner you will adapt and change your method of communicating; for example, an office-based position will involve using written and technological methods of communicating. It will also change depending on the demographic you are communicating with, i.e. clinicians, floor staff, families of the service users or the service users themselves. Floor staff will be in direct contact with the service users, which will entail face-to-face communication. Below I will detail the different methods and styles of communication that can be used in the social care setting. I will then go into detail about the key terms highlighted above; language, culture, beliefs, and health and social care needs.



Author-created diagram illustrating different communication methods, including verbal, non-verbal, signs & symbols, and tech aids.

TASK 2

Question: Can you identify a time in your personal life when you adapted your method of communication?

Answer: Every day. We change how we communicate whenever we speak or text someone of a different age or nationality, e.g. we speak to our grandparents differently from how we speak to our friends and we speak to lecturers in college differently from how we speak to fellow students.



Author-created diagram illustrating the six-stage communication process, from idea formation to message understanding.

Verbal Communication

Service users who communicate verbally to staff and to others will do so in their own way and to the best of their ability. Some service users may use their own way of speaking. Verbal communication involves more than just speaking to someone and them responding. The communication cycle demonstrates this (see diagram). Effective verbal communication involves six steps; however, when working within a social care setting it is important to recognise that this process may take longer for some people than for others. If you are working in the disability sector, it is evident that the decoding stage may take longer to process. Thus, it is vital as a social care worker to allow the service user time to decode

the message before they respond. In practice you must not rush service users or overload them with more information than necessary, as this may impact on their ability to decode and understand the verbal cues. It is important to give service users time to complete the communication cycle before they are expected to respond.

Non-verbal Communication

Non-verbal communication includes a multitude of different ways in which someone communicates, for example body language, eye contact and gestures. It is necessary for a social care worker to familiarise themselves with service users' non-verbal communication methods in order to maintain a pathway to communication. An example of this would be that if you are to sit down and discuss with a service user what they would like to do for the day, depending on their communication style the conversation might be you suggesting activities, allowing time for them to process the verbal prompt and then respond. This may be by how they position themselves – if they don't want to do the activity, they may move away, turn their back on you or simply shake their head; if they do want to do the activity they may nod their head in approval or even move towards where the activity is happening.

Signs and Symbols

Service users may associate certain objects with different things, i.e. a lunch box may indicate it's time for lunch or a picture of a bus may mean that it is time to go home. These are objects of reference. These are signs and symbols that service users use as visual aids to communication. Another example of this form of communication is a visual schedule designed around a service user's day so that they understand what is going to be happening throughout the day and they will always have a visual representation to refer back to so that they do not have to remember everything. A visual schedule can also be used alongside a 'now and then' chart to help with transitioning between activities.

Picture Exchange Communication System (PECS) is a form of communication using signs and symbols. 'PECS is a type of augmentative and alternative communication that use visual symbols to teach the learner to communicate with parents, carers, teachers and peers. The aim is to teach intentional,

functional communication and to allow users to communicate their wants and needs' (Integrated Treatment Services 2021).

Technological Aids

'Technological aids, such as electronic communicators, hearing aids and videophones are designed to help people who have difficulty sending or receiving 'messages' as part of the communication cycle' (Collins Resources 2010). Service users may also use their mobile phones as a method of communication; they can use them to text their parents/guardians, family, carers or friends.

When working in a social care setting it is important to have patience and understanding when communicating with service users while they communicate with you. Rushing a service user or ignoring them because you 'don't have time' simply because you may be in the middle of another task is one way to make a service user feel you are not providing an adequate service that suits their needs. A simple conversation may take time as the method used by the service user may involve typing out words and sentences on electrical devices. This should never be an 'inconvenience' to you as a staff member as it will most likely break down any relationship with the service user as they feel you do not care about their thoughts and needs.

Language

As a social care worker it is vital to know that your use of language will need to be altered and edited depending on the group of people or specific individual you are communicating with. An example of this is that you will likely talk to a clinician in a different manner than you would to a service user. A multi-disciplinary team is a different cultural group from the service users you support. At meetings about the needs of service users' personal plans there may be pages upon pages of information that might be too complicated or overwhelming for a service user to understand. This can be adapted and modified for them by transcribing the most important information into an easy-to-read copy that might include pictures for reference.

Ireland is home to people of many different nationalities and cultures, so as social care workers we will meet service users and families who use different

languages. We must be equipped with resources to facilitate adequate lines of communication. Service users under the age of 18 and who are residing at home will be advocated on their behalf by both their parents/guardians and their service staff. In order to successfully fulfil this the family and staff must have an equal understanding of each other, language barrier included. If necessary staff may need to use an independent translator if the family do not have fluent English. It is important to not make the family feel excluded at meetings or in decision-making when it comes to care plans. Staff might learn simple and useful words and terms that are in the first language of the service user and their family. This will open up lines of communication and will build a rapport with the family so that they will understand that the staff team are putting effort into co-operating with and including the family.

In social care, language and culture are closely interlinked: 'when you learn a new language, it may not only involve learning its alphabet, the word arrangement and the rules of grammar but also learning about a specific society's customs and behaviour. When learning or teaching a language, it is important that the culture where the language belongs be referenced, because language is very much ingrained in the culture' (Day Translations 2018).

Culture

'Every time you interact with another person, you do so in relation to patterns of communication that you have learned from the many different cultural groups of which you are a member. The vast majority of those patterns will be invisible to you, and that lack of knowledge means that whilst you and others like you may judge your communication to be good, some of the most vulnerable people in health and social care settings may find it to be poor' (Roebuck 2017: 30). This may mean that when you are communicating with service users you will need to adapt your language for them to understand. 'Language and culture are intertwined. A particular language usually points out to a specific group of people. When you interact with another language, it means that you are also interacting with the culture that speaks the language. You cannot understand one's culture without accessing its language directly' (Day Translations 2018: np). An example of this would be that you may have to learn certain words of the language in which your service user is fluent or recognises primarily.

It is important to know that culture can define a person's level and understanding of communication. A service user may not understand certain

jargon if they are from a different cultural background from staff. When dealing with someone who may be new to a service it is beneficial to assess their level of comprehension and understanding so as to provide them with a service person-centred to them, and using jargon-free language can aid this. Involving a service user in devising and implementing any support plans can make them feel as though not all control has been taken away from them. In order to do this, it is important that staff understand the way in which the service user communicates, and adapt their way of communicating to support the service user. As mentioned above, this may mean changing the language you use and being mindful of not using colloquial speech that you may use in another cultural group. You must also be able to read the service user's body language and facial expressions to determine whether or not they are following you or if they are afraid to disclose that they are having trouble understanding you. In this case, you may have to modify your language or the way you are explaining things, such as using more visual ways of communicating.

Beliefs

'Beliefs are things in life that you feel strongly about, that guide you in your daily life and are linked closely to your morals and values, beliefs might not necessarily be based on facts but our opinions and beliefs are not just formal ones, such as, what we regard as right or wrong' (Active Social Care 2010: np). Being able to communicate your beliefs with others is important and as social care workers it is important to be non-judgemental when a service user is expressing theirs.

In many ways, it can be difficult to support a service user as the staff may have no knowledge about, for example, their religious faith. If a service user wishes to actively practise their faith, staff should ensure that they have an appropriate knowledge in order to facilitate an open thread of communication with the service users around their religion. Staff may need to adapt religious literature for service users, and if staff do not have adequate knowledge it may make the service user feel that they are not being supported. Many religions are taught through a language other than English, and this can be an additional barrier that staff need to work through to be able to give the service user access to material. Staff may have to use online resources, translate them and then adapt them to the communication style of the service user. It is important to exhaust every option to solve any problems that exist due to a communication difference.

Being able to communicate right and wrong with a service user can be

challenging. A non-verbal service user may use aggressive or destructive behaviour to try to communicate how they are feeling. This behaviour can all too quickly be labelled as behaviours that challenge, and plans implemented to manage these behaviours may be useless if the real cause of the behaviour is frustration because staff are not able to recognise what they are trying to communicate. In this case staff need to know the service user well and be able to correlate certain behaviours with an outcome of a demand or request. If a service user is trying to say they want a drink or they are in pain and staff do not understand, this may lead to a service user displaying certain behaviours. Staff may see this as challenging but to the service user it is their way of communicating a need or want. An ABC chart or scatter plot may be implemented to try to identify the cause of the behaviour and through this staff can identify a pattern, e.g. when the service user bangs on the counter, it is after they have held their hand out towards the press with the cups in it. This could be their way of saying they would like a drink. Work can then be done to open up a better level of communication, but the main thing to take from this is that something you see as challenging and unnecessary may be the only way a service user has to communicate.

Health and Social Care Needs

Through working within the health and social care sector it will become evident that each service user will use a different form of communication. As a professional working in these sectors it is important to familiarise yourself with each form of communication. As a key worker to service users it is important to create a communication passport for them so that no matter who they wish to communicate with, be it relief staff, new staff or family and friends, that person will have an understanding of their preferred way of communicating and also will allow the person to adapt their communication in a manner that will open the lines of communication with that service user.

A communication passport is a folder devised by the service user and their key worker.

Communication Passport

The purpose of the communication passport is to provide information on how the service user communicates.

Each communication passport includes the name of the service user and a photograph of them. By having all service users by name, they can quickly identify the right communication passport.

The communication passports include a list of important contact numbers such as the service user's family and important numbers.

The communication passport is written from the perspective of the service user, so it has a personal touch.

The passport will include the way in which the service user communicates. For example, if John is non-verbal, his passport will include information about how he communicates.

It would also include information such as his favourite activities and how he likes his tea. Another example is a woman who is non-verbal, her passport will include information about what the vocalisations indicate and how to help when she is distressed.

If you are new to a service and have never met the service users before, the passport will give you important information about the way they communicate, whether that is verbal or non-verbal. If the service user is non-verbal, the communication passport may have information such as how they like to be spoken to, e.g. slow and concise words, or for staff to use objects of reference. It may also contain information such as making sure to speak slowly and clearly and give plenty of time for the service user to process the information and be able to respond. If a service user uses Lámh, their communication passport may contain a sheet of their most used Lámh signs and ones you would need to know. It is important to learn and use these when communicating with a service user. The more you work with a service user the more you will get to know them and will be able to identify facial expressions and body movements as a form of communication.

Communication is so important when it comes to supporting the service user's needs and wants. Involving a service user in decisions about their care is vital in putting that service user at the centre in all planning and they may be able to challenge some decisions about their care that, without modified or adapted communication, would have just been implemented on their behalf. Depending on the service user and their ability to comprehend certain aspects of their care, a decision may have to be made without their input, such as decisions on medications assigned by doctors, but staff can still keep the service user

informed and up to date by having key working sessions in which they communicate the information in a way the service user will understand.

To be able to provide effective services, it is imperative to be able to communicate with service users to build a strong working relationship, but to also be able to advocate for their needs and wants. This will essentially mean having a basic knowledge of many forms of communication to be able to support a range of different service users' needs in a variety of different settings and situations.

Make a service user feel important by giving them the time they need to have a conversation with someone who knows their method of communication. In a busy unit it can be very difficult to always give each service user your undivided attention for long periods of time. This is through no fault of the social care workers; there may be more service users than staff and certain service users' needs may be higher than others, which may mean that they receive more attention. However, you must be able to make it clear that if a service user approaches you to communicate they will have your undivided attention and that you will make them feel that they are being listened to. This is essential when a service user uses an alternative method to communicate.

Effective communication is essential because it supports the social care relationship. Communication is not only speaking, writing or nonverbal, it is also centred on active listening. Active listening may appear a simple task, but active listening requires engagement at all levels: socially, emotionally and psychologically. Through active listening we can identify if we need to modify and adapt communication methods and styles for each service user.



Tips for Practice Educators

Make a communication passport for your service users if the service does not already do so and involve them in the process.

Research different methods of communication online, e.g. Lámh, ISL, PECS, Rapid Prompting Method (RPM), etc.

Identify an opportunity to help a service user to develop and enhance their way of communicating, such as using an electronic device, to enable them to be more independent when in the community.

As part of a learning task, get students to gain mastery over their own non-verbal cues
Communicate ethically sensitive practice.

In supervision, review with the student their communication styles and methods.

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Chapter 26 – Vicki Anderson (D2SOP3)

Domain 2 Standard of Proficiency 3

Recognising service users as active participants in their health and social care and be able to support service users in communicating their health or social care needs, choices and concerns.

KEY TERMS

Active participation
Human rights-based approach
Everyday practices and relationship-building
Environment – emotional, cultural and structural

Social care is... the profession that has the most potential for impact on the lives of people in crisis. That is why it is so important to make that impact a positive one.

TASK 1

Describe a time when people did not seek or take on board your input in a decision that impacted your life. How did that make you feel?

At first glance, this proficiency appears to be straightforward: simply ask for service users' input and take their views on board. In asking for input, we need to consider and make allowances for communication difficulties, disabilities, language and cultural barriers. However, such a simplistic interpretation is problematic and lies at risk of 'tick box' practice. Does offering a choice of three activities from which to choose satisfy the requirement? Will hiring a

translator suffice? Such gestures may contribute little to supporting active participation unless they are built on strong foundations that embed specific values and approaches into all aspects of the service delivery. In the absence of a human rights-based approach that respects service users as autonomous individuals with rights of self-determination, measures such as these will fall short of ensuring active and meaningful participation or decision-making on the part of the service user. These foundational approaches and values must be at the base of all service delivery, including planning, consultation, relationship-building, practice culture and everyday interactions. To effectively support active participation, consideration must be given to the power balance in staff-service user relationships. We as practitioners must fully adopt non-judgemental attitudes and relinquish control over actions and outcomes. In asking for service user input we must not only listen but must also create an emotional, cultural and structural environment where individuals are free to communicate their needs and feel safe to raise concerns.

Active Participation, Self-determination and a Human Rights-Based Approach



The concept of active participation marries well with a human rights-based approach to service delivery. Both a human rights-based approach (HRBA) and the concept of active participation focus on the inherent dignity of the human being. The individual is placed at centre stage of all decisions affecting them and, most important, they play a key role in service planning and delivery (Quin et al. 2002).

The slogan popularly used in disability rights advocacy comes to mind on thinking about this proficiency: 'Nothing About Us Without Us' (Charlton 2000). Emerging from decades of struggle against oppression and treatment that did not recognise and respect those with disabilities as equal citizens, this slogan neatly sums up a call for control. It represents the request for respect and recognition for the rights of people with disabilities to make their voices and their

choices heard and to have sufficient control over decisions that affect them in all areas of life. Though concise, the phrase highlights clearly the impacts of power imbalance, the very basis of oppression. As Charlton states, 'The needs of people with disabilities and the potential for meeting these needs are everywhere conditioned by a dependency born of powerlessness, poverty, degradation and institutionalization. This dependency, saturated with paternalism, begins at the onset of disability and continues until death' (2000: 3). Although with unique experience, people with disabilities are not alone in their encounters with oppression, both historically and currently. It is a situation all too common among social care service users that they experience powerlessness, their opinions and choices are not what determines their outcomes, and they have little control over what will happen in their lives. This is a reality that must change and as social care workers we play a key role in influencing this change both through advocacy and in careful reflection and adjustment of our practice.

What may seem like mundane and inconsequential everyday practice plays a key role in fighting or reinforcing oppression. We as a profession must adopt practices that recognise and respect the rights of service users. We must remain aware of the conditioning and paternalism that potentially exists within organisations and structures and strive to equalise power imbalance in all decision-making. We must encourage practice that facilitates service users to identify the 'problem' for themselves and to determine their needs in relation to the situation. Furthermore, individuals must be respected and supported in their decisions in utilising services and overcoming their problems, whatever the opinions of the professionals involved. A right to self-determination is recognised, allowing individuals to select their own goals and work towards them in a manner of their own choosing.

Easier said than done – discussion of self-determination

Respecting people's right to self-determination can be challenging and may force us to put aside our views or even our personal values. It is easy when service users make decisions and goals we agree with, but what happens when a homeless individual decides that they do not want to engage in a programme of education and training or secure a job despite the continuing impact that it will have on their living situation? Or what if a mother decides she does not want to engage in a drug treatment programme despite her children being taken into care? How easy is it for us to facilitate active participation and self-determination at that level?

Incorporating concepts of active participation, respect and a rights-based approach into practice is complex. Practice that is in line with these ideas cannot be directed and followed in a step-by-step manner; neither can their

requirements be met in a half-hearted way. They are constructs that must be understood and fully embraced by the social care work team and the wider service in order to efficiently impact practice. They represent an epistemological standpoint that determines professional social care workers' practice approaches, their viewpoint on situations and, crucially, how they regard service users. This proficiency links closely with Proficiency 11 under Domain 5 (see Chapter 75), which considers active and meaningful engagement on the part of the service user. What is considered to be meaningful engagement and participation can only be determined by the individual service user involved. What is important to them? What approaches are in line with their ability and wants? What is their interpretation and understanding of the situation? It is not the role of the social care worker to determine what actions meet the requirement of active participation. It is the role of the social care worker to facilitate the individual service user to determine that, to create an environment in which they are safe and supported to express their views and are respected in their decisions as much as possible.

The role of the social care worker must also be supported by the team, managers and the wider organisational structure. Human rights values must be embedded throughout the service and easily identifiable in all areas of service delivery. It is vital that the culture and structure that surround the service users reflect these values, allowing and encouraging service users to actively participate in their own social care service.

Supportive Environments

Respecting individual service users, their rights, choices and opinions must be an aspect of the organisational culture running from the top levels of management to every person involved in the service. The relevant values must be adopted throughout the service and reflected in policy and practice as well as in planning. Only where these values are intrinsic in the service will the correct environment be provided for the service user to effectively communicate their preferences and to actively engage. Evidence of these inherent values should be visible in the visions and mission statements of the organisation, in its strategic focus and, crucially, in its planning and organisational processes. Good practice in this regard is seen where service users are recognised as key stakeholders, where they are an integral part of the review and planning process and thorough consultation is carried out in seeking their opinions and feedback. Facilitating

this practice requires a division of power unusual in governance structures. While customer consultation is common in most non-care services, attributing decision-making power to customers is not. What is required is that the traditional model of top-down service delivery is flipped to allow for a bottom-up approach. Adopting this partnership approach for strategic design is a difficult process and requires that all involved are dedicated to the values at the heart of the change. Power division must be structurally embedded, with clarification of roles and processes to support continued active and meaningful engagement. Clear lines of communication for feedback, review and raising concerns or complaints must be in place. Service users must know the ways in which they can get their message across and feel comfortable and confident to do so. All service staff must actively seek out opinions, views and feedback from everyone in the service. Representatives of service users should be active in planning and review teams.

TASK 2

Consider different environments that you encounter. Which of those environments encourages you to speak up for yourself and communicate your choices? What about that environment helps that to happen?

For these efforts to be successful, respect for active participation must also be a cornerstone of the organisational culture. Reflection in organisational visions and missions will support this, as will the modelling of good practice by management. However, further efforts must be made to ensure that appropriate values are adopted among staff teams through training, education and supervision. These aspects of practice culture should be protected through continuous review and reflection. In the absence of these cultural and structural supports, the individual social care worker will be challenged in incorporating them fully into practice and the service users will not feel the full benefit. Being proficient in supporting active participation is therefore not only associated with service user interaction, it also requires the social care worker to be able to identify the absence of necessary structural aspects and to advocate for change.

Everyday Practice and Emotional Culture

Recognition of service users as active participants in their health and social care is not only relevant in direct planning situations, it must also be an aspect of everyday practice and inherent in all interactions and communications with the individual. In fact, when facilitating active participation and consultation, these practice domains are not mutually exclusive. This proficiency requires professionals to support service users to engage in planning processes, to contribute meaningfully to determining their care plans, their goals and, as much as possible, the frameworks of their health and social care. Efforts in this regard will be minimally effective in large planning operations if they are absent from smaller-scale planning and communication. The necessary recognition and respect must be at the base of the service user-social care worker relationship and must be present in the seemingly meaningless interactions of everyday practice. To be effective, this proficiency must not only relate to the determining life goals, it has to be present in deciding on the plan for the day or in deciding what's for dinner. Furthermore, these smaller decisions must be respected, the rights of the service user to make these decisions must be respected and this respect must be communicated consistently. The reasons for this are threefold.

Everyday actions: it must be recognised that life is not made up solely of long-term and large-scale planning; life is determined by the small everyday actions and interactions that each of us has. If service users are not participating in decisions daily, they are not sufficiently active. Unlike many other professions, the impact of social care work is not reserved for scheduled appointments or meetings, it is carried out through everyday activities and interactions that from the outside may appear insignificant.

Have an Impact: it must be appreciated that the purpose of this proficiency is not solely that a professional has the relevant recognition of the service user, it is that that recognition is felt and observed by the relevant person or persons. It is important that the recognition on the part of the social care worker has the necessary impact on the life and experience of the individual service user. As stated above, the relevant respect for and recognition of the service users' right to participate cannot be portrayed in a half-hearted manner, it cannot be faked. If transmission of this proficiency is reserved only for a formal planning environment, it will not hold sufficient weight. It can only be meaningful where it is communicated to the service user in small, everyday interactions. These interactions are the site for professional relationship-building, where the

parameters of trust and respect are built, and where the majority of the social care work is carried out. It is through the small daily interactions, the shared meals, chats over tea or seemingly meaningless trips to the community that the emotional environment of the service is established. It is vital that this emotional environment is one that respects each service user and supports them to express themselves and to communicate freely without fear of rebuke or judgement. Honest communication about needs and wants, and particularly concerns, requires a sense of emotional security, which takes time to establish. For this reason, showing recognition of the service user as an active participant in their health and social care must be ingrained in all areas of practice and service delivery.

Supports Service User to Communicate. The third aspect of this argument links into the second section of the proficiency, directly addressing communication. The proficiency requires that the social care worker supports the service user to communicate their needs, choices and concerns. Communication can be a challenge in several social care sectors. This may be due to inhibited communication skills, disabilities, language or cultural difficulties, among others. In these circumstances, communications are strengthened through informal everyday interactions. Both the ability to communicate and the confidence in communication are improved where the social care worker takes the time and effort to listen and to effectively support communication. Time and energy must be invested in maximising lines of communication through small, casual and everyday interactions. Only then can social care workers sufficiently support communication for active and meaningful participation.

In summary, despite the apparent simplicity, practice in line with this proficiency is reliant on understanding, appreciation and adoption of a range of inherent values, not only by the social care worker but by the service as a whole. Being proficient in this regard requires more of the social care worker than simply asking questions and using communication supports. It is the responsibility of the social care worker to understand their role and that of the service in either changing or reinforcing the systematic oppression that their service users experience and that so many have fought to change. This proficiency requires the adoption of an intrinsically human rights-based approach that recognises the value of a person, that respects their right to self-determination and places them at the centre of all decision-making. These values must be incorporated into everyday activities, they must be communicated to the service user in all interactions and must be a cornerstone of the practice culture. It is the job of the social care worker to create the appropriate emotional environment through

everyday practice that supports the service user to feel safe and respected in communicating their opinions, choices and concerns. Furthermore, it is the role of the social care worker to recognise the importance of surrounding cultural and structural environments in influencing the ability of service users to actively participate in their health and social care. Where these environments are inadequate, it is the job of the social care worker to advocate for change in the best interest of their service user.



Tips for Practice Educators

Developing the necessary skills and knowledge for this proficiency requires different layers of learning for the student. While they will have knowledge of the proficiency and will have considered practical application before they come to the placement, a true appreciation of the meaning of active participation and an adoption of the relevant values into practice requires real life experience. What active participation means will be different across various social care settings, as well as between different individuals. It is paramount that the student has the opportunity to witness real life examples of this proficiency in action, to observe the adoption of the underlying values and assumptions and, most important, to see the limitations and barriers to application.

My advice to practice educators would be to start early; talk to the students about this proficiency from the beginning of their placement, as reaching the adequate level of understanding may take time. Begin with supporting them to develop a baseline understanding of how they see service users being supported to make and communicate their choices day to day. This could be as simple as choosing activities or choosing the clothes that they wear. Encourage the students to identify these things and ask them what structures they see that support or limit these types of choice.

Once you are satisfied with their understanding of the everyday practice, move to supporting them to develop a more critical awareness. Perhaps, when they know the service users a bit more, ask the student what they think active participation means to the different individuals. It may be suitable in your setting to have them look at one or two service users as case study examples. Focusing on individual circumstances will facilitate the students to critically explore the concept of active participation and how they as practitioners can support it to happen, even where limitations are in place. Whether restrictions to active participation be circumstantial or resource-based, it will benefit the student to see how limitations can be minimised through professional practice that seeks to support the service users to communicate their choices and that respects their choices. Don't be afraid to challenge the student, ask them some difficult and thought-provoking questions to guide them towards a deeper level of understanding and appreciation. It is important that you use your own insight into the concept and your experience of its application in your setting for these discussions.

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Chapter 27 – Eleanor Lyons (D2SOP4)

Domain 2 Standard of Proficiency 4

Understand the need to empower service users to manage their well-being where possible and recognise the need to provide advice to the service user on self-treatment, where appropriate.

KEY TERMS

Active participation
Human rights-based approach
Everyday practices and relationship-building
Environment – emotional, cultural and structural

Social care is ... The ability to guide and help an individual fulfil their goal with the best possible outcome. Nothing is perfect, but within social care we can help promote change and ultimately support the individual towards success in life.

What is Empowerment?

Empowerment is a human right (Smith 2018) which is achieved through increased service user involvement, where they are supported to become independent, confident individuals in control of their own life. This chapter is written from the perspective of empowering individuals within a disability setting. Empowering any one individual brings a sense of achievement or accomplishment to the person involved. One of the many objectives as a social

care worker is to empower the individual to fulfil their dreams or goals for the year. These goals may not be achievable immediately, so it the role of the social care worker to help implement a step-by-step planned process that will empower the service user to meet their needs and attain their goals in a gradual and achievable way. In the disability sector, this process is called person-centred planning.

TASK 1

How would you empower your service user to make an effective decision?

Person-centred Planning

The Health Service Executive (HSE 2018) advocates for creating empowerment cultures within health and social care settings, based on a belief that each individual should be treated with respect and dignity and should be an active participant in their own life choices and experiences. In *New Directions* (HSE 2018: 14) empowerment is one of the core beliefs of person-centred planning, along with equality, respect, dignity, independence, choice, inclusion and active citizenship. 'Empowerment; person-centred planning supports the person to take control of their life. Each person is supported to have their say and their views are respected' (HSE 2018: 14). During the course of making a care plan or a person-centred plan, the individual will work with their 'key person' to document what goals they would like to achieve during the course of the year.

The main aim of the person-centred plan is to get to know the service user and understand their needs and wishes for the future. Throughout the meeting, the key person and the individual will design these goals in achievable steps. This process will support the individual to successfully develop new skills based on their wishes and desires. The diagram illustrates the three themes that are discussed during the planning stage. The individual is supported to communicate what they enjoy and what hobbies and interests are part of their identity (MY SELF). MY WORLD is an opportunity for the service user to describe all the people, places and experiences that are important for them now; and MY DREAMS is all the wants and wishes they have for their short-term and long-term future. According to Sanderson (2000), the key features of person-centred planning include active listening (in order to learn about the person), so people

are encouraged to say what they want; and gathering key people together to put the plan into action. The following table, adapted from Sanderson (2000), lists what person-centred planning is and what it is not.

Person-centred planning is about:	Person-centred planning is not:
Listening to and learning about what people want from their lives	The service
Helping people to think about what they want now and in the future	The service
Family, friends, professionals and services working together with the person to make this happen	Owned by the service
A commitment to keep learning about the person	Just a plan
For everyone who wants one	One size fits all

Different social care organisation will have alternative approaches to person-centred planning. Whatever the title used, a person-centred plan places the individual at the centre. So who attends the person-centred planning meetings? The individual will write a list of who they want to invite to the meeting, who may include a parent/guardian, sibling, family friend and any professional that works with them and is important in helping them to put this plan into action. Family and friends are partnersPlan helps build the person’s place in the communityPerson at the centrePlan reflects what is important to the personOngoing listening, learning, and further action.



Source: *Person at the centre* (Sanderson, H. 2000)

During the course of the meeting, the individual is given an opportunity to express what they want, explain how they are feeling and discuss how they want to fulfil their goals. For the non-verbal service user, creativity is used as a way of supporting them to express their goals and wishes in alternative ways. The person-centred planning process also aims to improve the service user's self-efficacy and increase their self-confidence. Towards the end of the meeting, each individual who was invited communicates what they have understood from the meeting and shares how they can support the service user to meet their needs and achieve their goals throughout the coming year. As well as achieving goals and meeting needs, an empowerment culture (HSE 2018) can help service users gain confidence to manage their own wellbeing, where appropriate, through the support of social care workers, the staff team, family and friends.

In day services such as training centres, the staff would work towards employment for the service user to achieve independence and empower them to work in the community base. Working in the community helps the service user to feel involved and gives them a sense of belonging. To begin with, they would have someone working one-to-one with them during their working hours. Once the individual has been trained, they will continue to have a worker alongside them, to help them if they have any issues. It is important to note that the whole process of the service user attending work should be designed during their person-centred meeting. Any areas that may need improvement or what may be a concern should be highlighted and discussed, along with the supports to be provided.

TASK 2

For more information on person-centred planning, please read the HSE's New Directions: A National Framework for Person-centred Planning in Services for Persons with a Disability (2018).

Wellbeing

The proficiency in Chapter 20 focuses on the responsibility of social care workers to take responsibility for their own health and wellbeing. In her chapter, Karen Mahon presents the WHO (2014) definition of health as including physical, mental and social wellbeing. This chapter is focused on how we can empower our service users, where appropriate, to play an active role in managing their own

life and health, including their physical, mental and social wellbeing. Heslop and Hebron (2020) also adopt the WHO definition, presenting happiness as related to their view of health and wellbeing for people with an intellectual disability. This view of wellbeing acknowledges ‘a relationship between an individual and the social and environmental factors that determine their health’ (Heslop 2020: 4). Based on my practice experience this can include making the individual physically and emotionally comfortable by helping them to feel safe and loved, and promoting their good health by supporting them to make healthier choices. Other factors that can contribute to wellbeing and happiness include social contact, level of loneliness, how easy it is to get outside and be in open spaces or have opportunities to connect with people (Heslop 2020).

Working in social care, self-awareness of our own wellbeing and a knowledge of wellbeing strategies can help us to empower the individual to have a balanced outlook, to help them make healthier choices, to increase their happiness and help them through experiences such as physical or emotional trauma. As professionals, we have a duty of care to make sure the needs of the individual are met to a high standard of care and that they play an active role in managing their own health. Empowerment is only achievable through a relationship of trust developed between the service user and the worker. It is the role of the worker, through this relationship, to provide advice to the service user on strategies and ways they can improve their health and happiness. The HSE’s New Directions policy (2014) discusses consent as an ongoing process in which the service user is asked for their consent to be supported, when possible and appropriate.

TASK 3

Please read Chapter 16 on the current legislation and guidelines related to informed consent for individuals with a lack of capacity.

Consent/Self-treatment

Part of social care work is to provide advice to the service user on strategies and self-treatment options to improve their overall health and wellbeing. Guided by the HSE’s National Consent Policy (2019), when they have capacity to sufficiently understand the information and consequences of any decisions they make, their consent is needed. The individual can express their consent in writing, orally

(speech) or non-verbally (nodding or hand gestures). Social care and health professionals must give the service user enough information in a way that they can understand and decide whether they do give consent. The service user's decision must be voluntary and made without undue pressure to agree or disagree. Also, the service user must be mentally capable of communicating their decision to the social care professionals or any other health care professional, as per the Assisted Decision- Making Capacity Act 2015. This Act set out a system for adults who may have difficulties with making an important decision to have the support to make an effective choice (Inclusion Ireland 2021). In some situations, a ward of court is appointed to guide and outline consent for an individual making an important decision. The relationship between the services (health and social care) and the service users should be developed on the basis of trust and good communication. Good communication requires all parties to recognise and acknowledge the service user's goals, their values and choices, along with guidance from the health and social care professionals (Inclusion Ireland 2021).

If the service user needs to attend treatment outside the service, the social care worker should outline to them what the appointment is for and why it is important to attend. A recent Health Information and Quality Authority (HIQA) inspection outlined the importance of the service user having a consent sheet to sign to confirm that they understand why they are at the appointment and that they can stop at any time. Before any medical treatment, such as attending hospital or the local GP, the service should ask for the service user's consent. Depending on the situation, the service user's next of kin or social care worker will be present at all times.

Case Study 1

John is a 35-year-old man living in a residential house in Dublin. He has mild Down syndrome and over the last year has developed a lung concern. Staff called his local GP for an appointment as John's breathing has deteriorated. When John arrived at the appointment he refused to go in as he was not sure what the appointment was for and wanted to speak to his brother Sam. Staff explained to John the importance of the appointment and explained to Sam (John's next of kin) that staff were concerned about John's health. Sam asked to speak with the manager of the residential house to get a clear picture of why John did not have an explanation of the importance of the appointment before attending. The manager apologised for the lack of communication and John not being informed of the medical appointment taking place. A policy was drawn up that all

residents in the house would sign the consent form and be informed about the medical appointment before attending.

Adults with intellectual disabilities, depending on their mental capacity, can orally consent and express how they feel. Children and adults with an intellectual disability could use 'easy reads' to help explain the appointment and help the service user to feel empowered in the process of taking responsibility of their own health and well-being. Supporting the service user to become an effective decision-maker in their own health and well-being is another important role of social care work.

So how do we empower the service user to manage their wellbeing and provide advice to the service user around self-treatment?

As social care workers we have a role, through person-centred planning, to empower the service user to build meaningful relationships, be empowered, and give informed consent. This chapter has explored the different elements that we face every day working on the frontline and dealing with the ongoing issues that the service users will face. We do not have all the answers, or the best strategies to use, but we have the ability to sit and listen to the service use and to advise them on the best actions to take.



Tips for Practice Educators

During the student's time on placement, a discussion group could help ease them into their new role in the social care setting. The discussion group will help release nerves and tension and break the ice, helping all involved to build a professional relationship.

Beginning placement: At the beginning of a placement, it is important to give the student different jobs to undertake and make them feel involved in the social care setting. The jobs could be small, but this allows for casual chats between the service users and the student on placement. From here, a relationship can develop over a cup of tea or coffee, along with building common interests between the student and service user.

During placement: Once the relationships have begun to develop, the student can take on more responsibilities, based on the abilities that they have shown over the previous weeks.

1. Undertaking an activities that would benefit the service user. For example, designing a wall area about what interests the service users, e.g. a television programme or music.

2. Use a computer to choose colours and work out how the design will be placed on the wall. Each service user has their own part of the wall and their part of the wall will represent their own ideas.
3. The wall design is a talking point for each service user to express how they see life and allow conversation to develop.

How can the social care worker guide the individual student on placement?

First, sit down with the student and get to know them over a cup of tea or coffee. This will give the student the opportunity to ask questions about the service and what their role will be for the next 12 weeks.

Outline what the social care role is within the service, what their job will be and how their role is important in empowering of the service users.

Explain that service users learn by watching the social care workers and being shown how to complete a task.

No question is a silly question – so ask the question! For example, ‘How can I help the service users manage their wellbeing and grow?’

The smallest impact can bring great achievements and empower the service user, with support, to fulfil their goals.

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Chapter 28 – Deirdre Berry (D2SOP5)

Domain 2 Standard of Proficiency 5

Be able to recognise when the services of a professional translator are required.

KEY TERMS

Cultural diversity
Cultural diversity in domestic violence services
Gender-based violence
Lost in translation
Who should translate?

Social care is ... the provision of care to vulnerable and marginalised groups of individuals in our society. Social care workers advocate, guide and support their client groups. Social care incorporates a wide range of service provision, based on the principles of respect, dignity, inclusion and empowerment. To achieve the best outcome, social care workers must apply a meaningful and genuine interest in working towards better outcomes for a person. Social care work is not about just providing care but also being caring. It is the skill of developing relationships while maintaining boundaries.

Cultural Diversity: The Changing World We Work in

The people of Ireland are scattered all over the world; many Irish people have migrated to other countries during times of famine, war and economic crisis. Irish society has become increasingly diverse, as many other nationalities have migrated to Ireland to live. In April 2020, there were an estimated 644,400 non-Irish nationals resident in Ireland, originating from 200 different countries, and accounting for 12.9% of the total population (CSO 2020). This creates a vibrant melting pot of cultures, languages, religions and experiences. In Ireland, unlike countries such as Australia that have specific written guidelines in place for

the provision of interpreting and translation, there is a lack of written policies for government departments and agencies and a lack of guidelines for staff on when and how to use interpreters. This is not to say, however, that there is a complete absence of policy, as there are obligations under the European Convention on Human Rights, which must be adhered to for legal process; the Refugee Act 1966; and, more generally, the Equal Status Acts 2000-2004.

Social care, in its essence, is a body of trained professionals who plan and provide quality care and support to vulnerable individuals and groups of all ages experiencing marginalisation, disadvantage and/or special needs, irrespective of their culture or language. Social care work utilises problem-solving and task-centred approaches, which guide and advocate for service users to support, empower and sometimes challenge them to overcome diversity. This can become more complex when service users speak a different language. To do this work, social care workers use a suite of tools and communication skills including body language, tone of voice, eye contact, touch, the written and spoken word. Providing accessible information in a range of user-friendly formats to all service users is an integral approach to service delivery in every social care setting. Such information assists those who may not be functionally literate, may have hearing or sight impairments, may not be competent in the English language, or who may need information presented in plain English. The principal objective of the social care worker is to support service users to reach their full potential and sometimes this might include knowing when to enlist the services of another professional. Speaking a different language, or lack of access to a professional translator or interpreter, should not be a barrier to people getting the support they need.

SOME TOOLS AND TIPS THAT CAN HELP WHEN LANGUAGE IS A BARRIER

Google Translate can be used for immediate translation in a crisis response or to translate a message.

Some services have translation services: hospitals/the Gardaí/courts have interpreters they can access. Women's Aid has a translation service, which can be accessed through its helpline: 1800 341 900

HSE Multilingual Resources and Translated Information can be found on the HSE website, with many translated leaflets available.

TASK 1

Talk to someone in your class, workplace or community for whom English is not their first language. Use Google Translate to translate a sentence from English into their first language and ask about the accuracy of the translation, and what information is lost in the translation.

INTERPRETERS

An interpreter converts information from an oral or sign language into another language, as a means of enabling communication between two parties who use different languages.

A TRANSLATOR

A translator carries out the same task with written information.

Interpreters and translators can help us understand our service users, accurately ascertain their needs and appropriately communicate professional opinions and relevant information about their care. An interpreter speaks more than one language and can help to communicate with service users when English is not their first language.

Cultural Diversity in Domestic Violence Service

I have worked predominantly in frontline and management roles, in the area of gender-based violence (GBV), within a domestic abuse support service for women and children. It is mainly a crisis intervention service. I will draw on my experience of this setting throughout this chapter to give practice scenarios of working with families when English is not their first language. If you are unfamiliar with the work we do, I have included the following short segment.

Case Study 1

Background to a Domestic Violence Service

The service I work in provides a 24-hour helpline, emergency refuge accommodation, outreach and court services and a specialised children's service to women and children. However, as well as supporting women and children directly we also provide specific expertise in safety planning; connect and accompany women through medical, legal, financial, immigration, employment, educational and social services; and provide direct care to traumatised women and children in refuge and other residential settings. We also work to challenge organisational policies, institutional values, and/or public attitudes to improve system responsiveness to women in abusive relationships. We provide training to partners such as gardaí and other civil service personnel, design public relations campaigns, and talk to students in local education systems. Logical reasoning and problem-solving is at the core of our practice every day. It is a service user-led service, which essentially means that every person who enters the service gets a bespoke service. This is key to our work as every person is unique and has had unique experiences and needs. Historically, most of the domestic violence and abuse services in Ireland have been developed from a grassroots response to the needs of women and children in communities to a nationally organised response. The services were developed as survivors and advocates lobbied for responses, services and pathways to safety for women experiencing violence in their home. In recent years Ireland has evolved in its provision of responses for people experiencing domestic violence with the Domestic Violence Act 2018 replacing the Domestic Violence Act 1996 and the Domestic Violence (Amendment) Act 2002. This brought positive and significant changes, many of which have been petitioned for by domestic abuse advocates for a long time. Changes in guidelines, such as extension eligibility for orders and intimate relationship being considered an aggravating circumstance in sentencing, were introduced, ultimately improving the protections available to victims of domestic violence under both the civil and criminal law. Moreover, from January 2019 coercive control became a criminal offence in Ireland. This development gave recognition and grounding to the destructive patterns of abusive behaviours. The standardisation and professionalisation of the domestic abuse sector has also opened the door to the social care sector, with many services modelling their service on the social care model. In fact, social care is the discipline that is most sought after in the domestic, sexual and gender-based violence (DSGBV) sector.

Social care workers are part of the multi-disciplinary team within domestic abuse support services. Over the past 15 years I have supported many migrant women. Coming to live in a new country is filled with many hopes and challenges; a new language, opportunities, different social policies, little or no family or social support systems, status, to name a few. Facing everyday challenges without a support network can easily lead to difficulties. This is where the social care service (care homes, homeless services, family support, addiction supports and mental health services) will meet many migrant persons facing adversity. Some migrant women may not have travelled willingly, may have been trafficked or misled into a false promise of marriage, employment or a life free of war and hardship. Those who seek asylum in another country may have experienced war, conflict-based rape and/or rape, abuse and terror in their country of origin or during the migration journey. I have witnessed women arrive to the refuge door,

some with small children, some older women, some women who are still in their teens, who are afraid, upset, hurt, confused; they are traumatised. Their situation becomes a lot more challenging when they have little or no English.

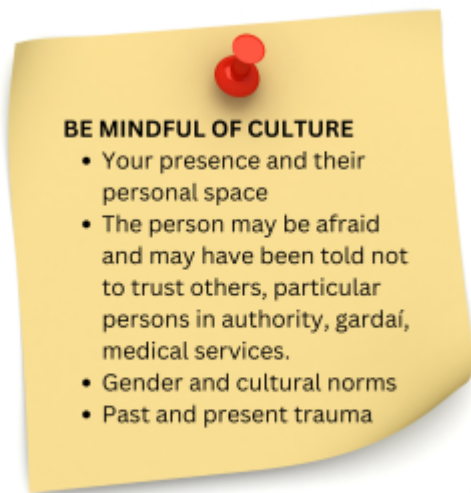
Gender-based Violence

All genders can experience domestic abuse. I work specifically, in a gendered approach, with women and children, therefore my practice reflection will be through a gendered lens of my work with women and children. Gender-based violence (GBV) is one of the most prevalent social problems in the world. Not only is it a violation of women's human rights, but it also has devastating physical and psychological health consequences for victims/survivors (WHC 2007). It is complex in its various forms (physical, emotional, financial, sexual, social and coercive control); additionally, other difficulties can add to its complexities, such as mental health, addiction, cultural and religious beliefs and socio-economic background. All of which can be barriers to safety. European research suggests that one in three women (33%) have experienced physical and/or sexual violence (FRA-EUAFR 2015). Women's Aid reports that one in four women in Ireland who have been in a relationship have been abused by a current or former partner. While all women are at risk of experiencing it, a range of factors place minority ethnic women at higher risk than the rest of the population. They include the twofold discrimination of gender and ethnic origin, migrant status, increased isolation and social norms that are defined by patriarchal values. Some minority ethnic women come from cultures where harmful traditional practices are carried out, such as female genital mutilation (FGM) and forced marriage.

While services in the DSGBV sector provide specialised services, domestic abuse and violence will, due to its prevalence, commonly present as an issue in most social care settings. For example, in residential care, domestic abuse could have been a presenting issue in the child's family of origin; in youth work, patterns of abusive or unhealthy relationships may surface and support or educational programmes may be necessary. The double discrimination of gender and racism has created a situation in which minority ethnic women are not always able to access the services they need. In addition, their economic and social circumstances, as well as migration and residence laws, may militate against their ability to access services. Additionally, living in a home where there is domestic abuse and coercive control can make a person feel extremely isolated and afraid. Not being able to speak the common language and an

absence of interculturally competent services exacerbates this and leaves the person in a very vulnerable situation. For many migrant women, when they reach out for help, it is when things have come to a very difficult and dangerous point.

Lost in Translation



As social care workers we rely on our humanity to connect with people. We then deploy our skills and knowledge to support the people accessing our services. In those moments of crisis, when a person reaches out for help, we must respond by de-escalating the situation enough to act

effectively.

De-escalate the situation:

- Show empathy and provide reassurance
- Remain calm
- Help them self-regulate (sit, breath)
- Offer caring gestures (tissue, drink of water/tea)

Assess the situation:

If the person is traumatised, the social care worker must assess if the trauma is a factor in their ability to communicate. Trauma can impact people in different ways. A person may present stunned, non-verbal, withdrawn, distant, confused, upset or crying, rambling, confused, shouting, talking rapidly, frustrated. Once

the person is somewhat calm and can start to communicate, the social care worker must figure out if they can understand some English. Establishing names, country/ language they speak is a good starting point. It may not be possible to get an interpreter in that moment so using other communication tools can help provide reassurance. Google Translate/ translation apps on mobile devices are helpful. As there are so many language variations, even within one country, Google Translate can help identify the specific language spoken, which will assist when arranging an interpreter.

Within many social care settings, for example a refuge environment, assessing health and wellbeing may need to be the first response. If a person presents with visible injuries medical assistance should be provided. However, in the context of domestic abuse some injuries may not be visible, if the person has been sexually assaulted or assaults are intentionally not carried out on obvious or visible areas of the body. Be cautious if offering other services; this may frighten the service user, especially if they do not understand the context of the conversation or if their status in the country is linked to another person.

Who Should Translate?

If there is any doubt that the person does not fully understand the conversation, a translator should be enlisted. Some people who are frightened and unsure may give the impression that they know what you are saying. Clarity and understanding should be sought. Be aware that service users may not want to use an interpreter and may prefer to use a family member or friend. Children can often become language brokers for their non-English-speaking parents. Using children to interpret should be avoided. Children must be protected from harm, as outlined in Children First guidelines, and interpreting may cause distress and trauma for the child. Using adult family or friends has its advantages and disadvantages; additional information may be shared if family members interpret for one another; service users may mistrust using an unknown professional interpreter (Lucas 2014). Nevertheless, issues of collusion and accuracy have been identified when informal interpreters have been used in public services, resulting in errors and compromised meaning (Lucas 2015; Dorner *et al.* 2010). In the case of domestic abuse disclosures, some service users may not want to disclose details of their abuse, to protect the friend or family member or because they feel ashamed. There are also concerns about interpreters' availability and confidentiality breaches (Sawrikar 2013). This may

present in small tight-knit communities. One example of this occurred when the court interpreter was known to a woman I supported. This woman was applying for a domestic violence order. The incident caused huge distress for the woman, and resulted in her withdrawing from accessing the court order for protection. This also left her in an unsafe situation, worrying if the interpreter would tell her partner of their encounter.



Interpreters contribute to assessment and intervention processes by facilitating communication, and by doing so, they gain insight into service users' experiences, perspectives, wishes and feelings. Discrimination and oppression are common experiences for emergent bilinguals, thus facilitating communication is an anti-racist and anti-oppressive practice issue. Ensuring that services are provided in a suitable format and facilitating communication is helpful in recognising people's language, history, culture, traditions and religion (Keating 2000). Using an interpreter when language is an issue is important to ensure understanding and gain clarity. This is particularly important when completing risk assessments, informing service users of their rights, in child protection issues, for consent to engage in services or share information to other services, and in line with General Data Protection Regulations (GDPR).

For example, information for a woman accessing a refuge in crisis:

This is a refuge, women and children who are hurt or afraid at home can stay here. You are safe here. I work here, and it is my job to help you. If you are afraid, we will not tell anyone you are here. Can you tell me how I can help you ...Engaging the services of an interpreter can be time-bound. Whether over

the phone or in person, the interpreter will have a set time with you to provide their services. Preparation for this will ensure the time is used effectively. Write down the information you need to provide to the service user and write down the questions you need to ask them.

Be mindful that you can enlist an interpreter again, at a later stage, so do not overwhelm the service user with too much information. Keep the information specific and deal with the most pressing issues.

It may help to clarify at the start of the first meeting that the interpreter is a professional doing their job, has no decision-making powers and is bound by the confidentiality policy of the agency. Speak directly to the service user, rather than to the interpreter. Many more sessions may be required as the service user's needs are identified. Once the crisis point has passed, communication will increase as trust and the feeling of safety grows. For more practical tips for using translation services see the resources listed at the end of this chapter.

Funding and access to translation services or an interpreter must be considered. Some partner services have access to these services; however, all services should work towards having their information translated into the most used languages. Services should also have guidelines for staff detailing when and how to enlist translation and interpreter services.

Conclusion

Our society is growing rapidly and with this growth diversity blossoms. Our social services must be able to support all persons in our society. Communication and Language is the seed that must be present in order to assess and meet the needs of all persons. Every person has the right to have their voice heard; it is up to us to enable this process, to support and ultimately assist them to overcome the adversity they are facing. Engaging and working with other cultures can create learning and new experiences that enrich services and the people in them. Having services that are accessible to all persons ensures inclusiveness and diversity. Training staff in diversity, equality and inclusion can help build awareness of unconscious bias, cultural competence, or other barriers to diversity, equity, inclusion and belonging. It can also motivate positive behaviours and attitudes. Reflection and sharing learning can also add to this growth.

Useful recommendations for interpreting and translating services:

1. The National Consultative Committee on Racism and Interculturalism

(NCCRI) report, 'Developing Quality Cost-effective Interpreting and Translating Services for Government Service Providers in Ireland' (2008), <https://www.atii.ie/publications/articles-reports/page/2/>

2. HSE Multilingual Resources and Translated Material Information, <https://www.hse.ie/eng/about/who/primarycare/socialinclusion/about-social-inclusion/translation-hub/multilingual-resources-and-translated-material/>
3. Lost in Translation? Good Practice Guidelines for HSE Staff in Planning, Managing and Assuring Quality Translations of Health-related Material into Other Languages, <https://www.hse.ie/eng/services/publications/socialinclusion/lostintranslationreport.pdf>
4. On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services, <https://www.hse.ie/eng/services/publications/socialinclusion/emaspeaking.pdf>



Tips for Practice Educators

Working in the DSGBV sector can be both challenging and rewarding. Student placements in this setting can yield rich learning not only about domestic abuse but also in many interconnecting areas of social care, such as social policy, as we support the service users through social welfare, housing and immigration issues. It also exposes students to the legal and justice processes, navigating working with the Gardaí, legal aid and court procedures. Students may also learn and practise risk assessing, care planning, reflection and child protection. Building meaningful relationships is the essence of our work in DV services, and within all social care settings. Students can certainly have an opportunity to practise this.

Preparation for placements

In my experience, students starting a placement in a GBV service may become overwhelmed. Walking into the setting, which is normally buzzing with families and small children, and meeting the team is the first taste of the reality of women and children fleeing their own home due to fear, violence and abuse at the hands of those who should provide love and care. Taking some time to process this before starting placement will prepare the student.

Knowledge of the law, particularly the Domestic Violence Act, and in relation to coercive control and other types of violence, is also essential.

Most GBV services will have student handbooks and student placement co-ordinators and mentors. Students should seek them out.

In our service, we accommodate students on placement from third and fourth year. We

have found at this stage in their studies students have a broader learning base and the maturity needed to complete the placement successfully.

As the GBV sector grows it is opening many more employment opportunities for social care professionals, and new research and publications also allow for rich learning for students.

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Chapter 29 – Paul Hogan (D2SOP6)

Domain 2 Standard of Proficiency 6

Be able to produce clear, concise, accurate and objective documentation.

KEY TERMS

Purpose
Effective report
writing
Writing in
practice
A model
for report
writing
Holistic
needs
assessment

Social care is ... a broad profession, characterised by the delivery of quality care and support to individuals, families, groups, communities and societies that experience challenges, adversity, disadvantage, marginalisation, isolation or any form of discrimination or oppression.

Introduction

Social care workers write reports and record information every day and in various formal practical situations. Report writing is a skill that we are expected to have from the beginning of our placement or employment, and yet there is little training or direction available, and many social care workers struggle with the challenge of writing reports.

This chapter aims to address this gap by providing an overview of report writing and record keeping for the social care worker in Ireland. The chapter is not prescriptive, but it endeavours to enable social care workers and students to understand and develop the proficiency to write effective, objective and accurate reports and records.

The ability to write clearly, accurately and objectively is an essential skill for all social care workers. It underpins quality service delivery, effective inter-agency collaboration, and best practice in terms of professional development.

This chapter will support students and social care workers to understand this proficiency and develop skills in preparing factual, structured and concise reports to serve various needs and groups. The first section will detail the purpose of effective report writing, followed by the application of a skills model before concluding with a case study. The last section gives some tips for practice educators.

The Purpose of Effective Report Writing

The purpose of report writing is to provide a permanent and evidenced account of a service user's development while in care. Reports can also be a tool for staff in person-centred planning. While supporting continuity and cohesion of practice by meeting regulatory and statutory requirements, report writing and record keeping also promotes accountability and transparency in delivering interventions. Effective report writing and record keeping also fosters a lifelong learning environment and contributes to the continuing professional development of social care workers. The Standards of Proficiency for Social Care Workers (2017) set out the expected standards for social care professionals who are regulated by CORU. This comprehensive report determines the standard to maintain competence and performance in producing clear, concise, accurate and objective documentation under proficiency six of the Communication, Collaboration and Teamworking domain.

The ability to produce clear, concise, accurate and objective documentation is a key social care work proficiency, but one in which students receive little formal training and preparation (Webber 2015). Reports and records that social care workers need to produce include assessment reports, daily case reports, family communication plans, access reports, care plans, daily diaries and reflective practices, etc. The social care sector is developing a growing reputation for increased administration, resulting in greater demands for social care workers to master the skill of writing reports. It is also important to be familiar with the organisation's in-house policy on key tasks such as report writing, safeguarding, data protection and referrals to other statutory, regulatory and professional bodies such as Tusla, HIQA, An Garda Síochána, and members of the legal profession.

Although this chapter does not expand on legislative requirements in relation to report writing, it is important to be mindful of the statutory provisions under, for example, the Freedom of Information Acts 1997, 2003 and 2014; the Data Protection Acts 1988 and 2003; the General Data Protection Regulations 2018; and the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012. Effective report writing involves good communication skills, having an active rather than passive voice and learning to write objectively. These three important skills are essential for effective report writing.



Author created diagram illustrating three essential components for effective report writing: good communication skills, use of active rather than passive voice, and objective writing.

Good Communication Skills

The ability to communicate effectively is an integral element of the ability to write good reports and it is an essential part of the role of the social care worker. There are various methods of communication, including oral, non-verbal, and written. The accuracy of the written report is essential as it may inform future interventions and resources for the service user. There is a requirement for social care workers to ensure that what they write is legible, accurate, clear and objective.

When writing reports, it is important to be aware of non-verbal communication and the need to document these in report writing. These may

present as shrugs, nods, crossing arms or legs or both, grimaces, gestures, tone of voice and eye contact (Griffiths 2010). Learning to take account of these reactions is part of developing the skills of report writing and record keeping.

A report can be understood as a means of communicating an account, information or advice from a person who has collected the facts to a person who has requested the information for a specific function or the performance of a particular task (Stanton 1990). It is a short, concise document that is written for a particular purpose and a specific audience or multiple audiences, and which generally sets out and analyses a particular situation. There are three basic elements to writing reports in social care: a rights-based and service-user focus; a sound understanding of the values and principles that underpin social care practice; and competence and proficiency in compositional, rhetorical and technical writing skills (McDonald *et al.* 2015). Reports should be underpinned by social care values and principles such as social justice, partnership and equality while deploying anti-discriminatory, objective and non-judgemental language, which clearly details fact rather than feelings or opinions.

Social care workers must ensure that nothing contained in a report can be interpreted or construed as insulting, abusive, prejudiced, racist, sexist, ageist or discriminatory in any way. Social care workers' reports must be anti-oppressive, concise, specific and written in plain English to enable greater understanding by multiple readerships. Report writers must ensure that what they write is not only accurate, objective and correct but that it will be understood by various audiences, such as service users, families, service providers, regulatory bodies and, in some cases, the courts. In this regard, it is important to keep the language simple and reader-friendly.

Active Voice versus Passive Voice

Essentially, there are three main components in a sentence – the subject, the verb and the object. The subject is sometimes called the 'naming part' of the sentence. It identifies the person, group or thing performing the action. The subject is most often a noun, pronoun or noun phrase. The verb, or dynamic verb, denotes the action or doing word. It describes what the subject has done or is doing. The object describes the person, place or thing that receives the action of the verb.

'Active' and 'passive' voice refers to the use of the verb in a sentence. One of the

most common mistakes in report writing is using the passive voice, which makes sentences verbose, less concise and less clear.

In the active voice, the action comes before the object. In the passive voice, the object comes before the action. The active voice emphasises the subject, i.e. the person who is performing the action. The passive voice emphasises the object, i.e. the person or thing the action is done to.

Sentence	Active or Passive	Con
Mary identified a goal.	Active	Sub O
A goal was identified by Mary.	Passive	Sub V
A goal was identified.	Passive	It is acc

The Challenge of Writing Objectively in a Caring Role

Writing objectively in reports means writing about facts, not opinions. Many social care workers find it challenging to write objectively in a caring role. It is good practice to write reports in an impersonal tone and avoid using judgemental, prejudicial or emotional language. Social care workers should also ensure that they are aware of their own perceptions and biases when compiling reports.

As social care workers are motivated by the emotional, relational, interpersonal and social dimensions of their work, it can be challenging to write documentation that disengages these subjective aspects of the social care role in order to prepare an objective account about a particular occurrence. There is also a fear that an objective account of an incident could be misinterpreted. This is a challenge. Even when we all see the same thing we can each interpret it differently.

To ensure objectivity and clarity, it is important to plan the content of a report and to use correct grammar, spelling and punctuation. Unnecessary details should be omitted. The report writer should not offer diagnoses (unless qualified

to do so). Inaccurate or misinformed reports can have consequences for the service user in terms of subsequent decision-making and other interventions.

Effective Report Writing

A report can be viewed as a reflection on professional credibility. Therefore, it is imperative that a social care worker writes effective reports and documentation.

When writing a report:

- Organise your thoughts.
- Make sure you know the purpose of the report.
- Lay out the information and determine the format.
- Decide on your writing style.
- Use clear, simple English that is easy to read.
- Keep sentences brief and concise.
- Avoid words that are open to interpretation.

Barriers to effective report writing:

- Lack of understanding of the organisation's policies.
- Being unsure or unclear about what information is relevant or necessary.
- Varying levels of competencies, abilities and expertise among staff.
- Ineffective time management.
- A tick-box culture.
- Rushing to complete reports after a long shift.
- Perception and interpretation.

Reports are necessary for a range of reasons and it can be difficult to ascertain what a good report looks like in all situations (Bogg 2015). However, there are some universal points that a social care worker should apply:

- The purpose of the report is clear.
- The report is written in appropriate language.
- The report is concise.
- The report sets out relevant frameworks and criteria being adhered to.
- The report is proofread to check for any errors.
- The report is signed and dated. (Bogg 2015)

Effective report writing should answer the following:

- Date and time?
- Who was present?
- Where did it occur?
- What happened?
- Did you observe triggers?
- What actions were taken?
- Who conducted the debrief?
- What follow-up, if any, was identified?
- Was the in-house policy referred to?
- Was it necessary to seek advice from line management?

Effective report writing should never contain the following:

- Humour or jokes.
- Colloquialisms such as 'lost the plot', 'went berserk', 'had the craic'.
- A diagnosis of the service user – unless you are qualified to make one.
- Discriminatory language.

Useful verbs, terms and phrases:

- It appears
- It seems
- It was decided
- It was recommended
- In particular
- After
- Subsequently
- Consequently
- Although
- Even though
- Displayed
- Became
- Noticed

A Model for Report Writing

Good planning underpins good report writing. You will write a clear, concise and objective report if you take the time to plan what will be in the report and why. It is important that there is a clear sequence of information and the paragraphs are presented in a cohesive and coherent manner with clear links from section to section. The formal nature of report writing for assessments, case reports, access reports, care plans and reflective practices means that reports should be written clearly, concisely, accurately and objectively. Using the GAS (Goals and objectives, Audience, and Structure and style) model will help you plan the report, record or other document before you begin to write (Bogg 2015).

Goals and Objectives	Audience	Structure and Style
What is the aim of the report? What are the objectives? What is the context of the report? What is the report trying to achieve? What is the purpose of the report?	Who will read the report? Service user? Colleague? Line manager? Supervisor? Court?	Is there an in-house policy/ template that governs how the report should be written? What are the main headings that need to be addressed? What style will you adopt? Will the report be in plain language?

(Source: Bogg 2015)

Holistic Needs Assessment in the Homelessness Sector

In the homelessness sector, national policies such as the National Quality Standards Framework for Homeless Services in Ireland (2019) provide that a support plan addresses the housing needs of the service user by achieving housing-related goals and considering personal preferences and tenure options. In addition, the holistic needs assessment records the service user's key information, their housing history and needs, family and current relationships, early life and childhood experiences, education, work and job history, legal issues including offending behaviour, income and finance, general physical health, mental health, alcohol use, drug use, independent living skills, equality issues and the service user's own assessment of need. The holistic needs assessment

is an important tool that facilitates care planning for people experiencing homelessness that is person-centred and offers the potential to map pathways out of homelessness. The support plan must also detail preferred areas, level of support required and include a risk assessment. In addition, a social care worker in the homelessness sector must prepare daily reports which provide a brief overview of the resident's day, such as appointments attended or a synopsis of key working or significant conversations.

When filling in the holistic assessment form, it is good practice to detail as much information as possible from previous records and to check the accuracy of the information with clients. It is important to become familiar with the information to encourage a fluid conversation. Many of the subject areas are inter-related, such as addiction and the impact on financial resources. Sometimes this can present inconsistent or contradictory information as everyone has different interpretations of life experiences. If this occurs, you may ask for clarification, but if the client is not comfortable talking about a particular aspect, you can move to the next question. The main aim of the holistic assessment is to identify and prioritise areas for action and the supports to enable them. The holistic assessment form may take up to an hour to complete with the client, so it is important to allow sufficient time and to find a quiet location where the confidentiality of the service user is protected and where they feel comfortable and at ease when sharing information with you.

Case Study 1

Alice is a 25-year-old single parent of two children. Alice was in a relationship immediately prior to experiencing homelessness and has reported the cause of her homelessness being experiences of domestic violence, for which she received medical treatment. Alice reports leaving all her possessions in the house and has limited financial resources. This has been very traumatic for Alice and she complains about anxiety, panic and problems sleeping at night. For the past year, she says, she had spent some time with friends, but the living environment was not conducive to rearing two small children. There were experiences of engaging in drink and drug use in the house.

Alice sought help to provide a stable home for her and her children. She came to the attention of homeless services after presenting as homeless to the local authority. She was referred to a regional homeless provider and you have been tasked with completing the holistic needs assessment with Alice.

TASK 1

Apply the GAS Model to this case study of Alice.

Goals and Objectives

- The goal and objective of this report is to provide an objective and factual insight into Alice's situation.
- The holistic needs assessment also sets out the strengths, needs and risks in Alice's life.

Audience

- The report is person-centred and therefore Alice will be contributing and reading its contents.
- Your line manager may read the report.

Structure and Style

- The holistic needs assessment will be available in template form and you will need to provide a clear, concise, accurate and objective report based on the information provided to you by Alice.
- The main topics are outlined in the template.
- The assessment also provides an opportunity for Alice to identify her own assessment of needs.
- This report should be written in a formal style.



Tips for Practice Educators

This proficiency will enable students to produce clear, concise, accurate and objective documentation.

- It is important that sufficient time is afforded to the student to develop this proficiency.
- It is also important for practice educators to provide constructive feedback to students and facilitate regular debriefings for students in an enhanced collective learning environment. Examples of best practice in report writing would supplement the learning experience of students in developing this proficiency.
- Students should be equipped with the knowledge and skills of how to produce quality and effective reports.
- Students should be given the opportunity to practise report writing and reflect on any aspects of their work that could be improved for future tasks.
- Practice educators should ensure that students receive both task-based learning and one-to-one tuition where the need arises.
- Relating theory to practice with exemplification is a cornerstone of learning for students. The 360-degree performance appraisal might be a useful theoretical framework for practice educators to provide constructive feedback to students on developing their proficiency in producing clear, concise, accurate and objective documentation.

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Chapter 30 – Ailish Jameson (D2SOP7)

Domain 2 Standard of Proficiency 7

Be able to apply digital literacy skills and communication technologies appropriate to the profession.

KEY TERMS

Digital literacy

Homeless services: pass system

Alternative and

augmentative communication

Technology to promote independent living

Technology for those who experience communication difficulties

COVID-19 and communication technologies

Social Care means connection at a human level with those who are vulnerable and often marginalised by society. Social care involves using a diverse range of skills to support, safeguard and empower service users to improve and enhance their quality of life. It involves compassion, empathy, critical analysis, communication, relationship building, assessment and intervention, all centred around the holistic needs and the strengths of the person. Social care incorporates the principles of social justice and advocacy, being the voice for those who are disadvantaged by the inequalities in society and, most importantly, working with service users to empower them to use their own voices to address injustice

TASK 1

Reflect on how you use digital literacy skills to complete your work as a social care worker. What are the advantages and disadvantages of digital technologies and digital literacy skills?

Digital Literacy

At the core of all social care work is the ability to build and maintain relationships. One of the key skills in relationship-building is communication. Over the past number of decades the way in which we communicate has evolved and changed from primarily paper-based methods to online and the increased use of information technology. Information and communication technologies (ICT) are used both in how we deliver social care services and our routine day-to-day interactions with service users. We are required to be digitally literate, but what does this mean? How can we utilise ICT to improve our systems of care provision and the experiences of those accessing social care services? This chapter will examine digital literacy and communication technologies and how they work to promote and enhance communication in social care. It will discuss different systems of social care provision, systems in use in the homeless sector, use of technology in intellectual disability and autism services and with respect to children and young people in care.

According to the American Library Association, digital literacy is the ability to use information and communication technologies to find, evaluate, create, and communicate information, requiring both cognitive and technical skills. Digital literacy and technology has led to significant changes in how social care work is delivered and the interactions with service users in our care. In 2016, the UK's Local Government Association published a report entitled 'Transforming Social Care through the Use of Information and Technology', which highlighted the important role of information and technology in the delivery of social care services. Among other improvements, the report held that digital literacy and technology has resulted in the integration of services and information for children, families and adults, has led to improved interactions with care services and promoted independence and wellbeing. In Cumbria, for example, an electronic referrals and matching system called Strata has been implemented across all adult and children's services, resulting in over 1,000 referrals a month. It has enabled organisations to automatically make referrals to social care organisations and has resulted in reduced form-filling and significantly cut the time needed to make a referral (LGA 2016).

TASK 2

Read the Local Government Association (UK) (2016) report 'Transforming Social Care through

the Use of Information and Technology'. Examine the five key themes (pages 6-16) for improving services through the use of digital literacy and technology. How might you incorporate some of the ideas into your workplace to improve the communication process?

Download the report from www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/informatics/transforming-care-through-technology

Homeless Services: Pathway Accommodation and Support System (PASS)

Case Study 1

Joe (pseudonym) is an 18-year-old boy who has recently become homeless. Joe was spotted on the streets by Gardaí and brought to the station. Joe informed the guards that he could not return home due to current living conditions and poor relationships there. The Gardaí have contacted your service enquiring about bed availability for Joe.

What is important here is that Joe feels secure and that his needs will be met. Through the use of a centralised database system, communication between the different homeless services is streamlined and homeless agencies can access information on bed availability and service providers who can ensure Joe achieves a placement.

PASS is a shared online system used by every homeless service provider and all local authorities in Ireland. This system enables the four Dublin local authorities, the Health Service Executive (HSE) and all homeless services to communicate through one unified system and provide an integrated system of service provision and effective case management to those who are experiencing homelessness. The PASS system provides 'real-time' information on numbers presenting as homeless as well as bed occupancy, ensuring the most up-to-date statistics on homeless figures.

However, this shared system also uses the information shared on the system to improve service delivery and monitor, co-ordinate and plan the delivery of services (DRHE 2020). For example, agencies working with people who are homeless can record and share the work they conduct with clients. This means that resources are utilised more effectively, there is less duplication of work and a continuum of care is provided to those accessing homeless services, resulting

in an integrated delivery of care. Through monitoring the delivery of services, individual organisations can track outcomes of the work conducted with clients, compare with other providers and evaluate the effectiveness of services. The PASS system enables services to be co-ordinated more effectively through information sharing and targeted interventions. Through having one unified system for homeless services, planning and development of services can be more seamless as information can provide important data on the homeless population profile, any emerging trends in the sector and detail on how services are being utilised.

Alternative and Augmentative Communication

As social care workers, we often encounter service users who have difficulty communicating verbally. In recent years, augmentative and alternative communication have become the norm in social care services in order to assist service users to have a voice and communicate their needs. For some service users, speech may be limited, so many devices have been introduced to improve (or augment) their speech. Other service users may not have any speech, and many devices can be used as an alternative to speech, thus ensuring that service users are autonomic and are heard in relation to their care. Some of these devices are explained below: the list is not exhaustive.

Technology to Promote Independent Living

One key aim of social care work is to promote independent living and afford greater choice to service users in their own lives. Through the use of digital technologies, an increased number of service users have been supported to live independently in their own home (LGA 2016). This brings reassurance to carers and families, who may not always live locally to those they are supporting. The 'traditional' method of service delivery is changing, however, with a greater emphasis now on how technology can support people through proactive alert monitoring rather than reactive response calls. In order to facilitate independent living, discreet monitoring devices have been installed in care homes, sheltered housing or privately owned homes to support passive remote monitoring (LGA 2016).

Just Checking

One example is the Just Checking initiative introduced in Liverpool which reduces the requirement to provide 'sleep-in' support to service users in supported accommodation, affording the individual an increased sense of independence as well as reassurance for family members and other carers via wellbeing electronic notices (Just Checking website). It has been found to be very effective for those with learning disabilities and/or autism. Key to this technology is the idea of supported living, so the technology is not a replacement for the workers, but it augments the support given to the service user in order to promote safe independent living.

Just Checking works by means of movement and door sensors which are placed around a property, on walls and skirting boards. These sensors create a chart of activity; for example, sensors show when a door has been used and how long it has been open. It can track when an individual enters or leaves a property and how long they have been out. A Plug and Go Hub is plugged in and information from the sensors go to the hub. Support workers can log into the Just Checking hub to view the activity charts, add new users and set up notifications on any smart device with an internet connection.

See Greg's story: <https://vimeo.com/173928293>

Just Roaming

Just Roaming is a real-time system for people in supported living. Again it is used to augment rather than replace the role of the social care worker. It is a flexible, responsive overnight support system which uses sensors to send live alerts to a mobile phone. If an alert is received, a roaming support worker responds. Alerts are personalised to the needs of the individual, so that the right support is provided at the right time. This could be reassurance and guidance for someone who has been to the bathroom, is now in the kitchen and has not returned to bed, or immediate attention if, for example, someone is having a seizure. Just Roaming is proving more personalised and timely than sleep-in support, and has transformed the independence, choice and control of those who are being supported.

Technology for those who Experience Communication Difficulties

Talking Mats

Talking Mats are a visual framework to help people express their views using a selection of communication symbols that cover a variety of topics and are used in a wide range of health and social care settings. They are available in an original low-tech and digital resource. At the core of our work is person-centred care and, most important, the inclusion and participation of service users in every aspect of their lives. Talking Mats assist service users in their decision-making process in relation to the care planning process and facilitate meaningful participation in setting personal goals with respect to education, health and social care plans. In children's services, transitions form a large part of a child's life and Talking Mats have been found to assist in the preparation for transitions and investigating sensitive or difficult issues. See a video on Talking Mats on <https://www.youtube.com/watch?v=SzAgGmLYpE0#action=share>

Communication with Children and Young People: Emotions

For many young people, and particularly those in the care system, communicating emotions can be very challenging. Many young people in the care system have experienced a great deal of trauma in their lives, which can often be internalised and lead to difficulties in communicating feelings and emotions (Buckley *et al.* 2016). This can impact on relationship building with key workers and the social care team. As social care workers we need to be creative in how we reach these young people and facilitate expression of emotions in a safe and trusted environment. Using technology is ingrained in young people's lives, so it is important that we as social care workers meet young people where they are at in terms of their communication. The traditional means of communication across a table simply does not fit in with how young people communicate today. One organisation, Mind of My Own in the UK, has designed many apps to assist in the process of communication for young people in the care system. One form of information and communication technology used with young people is apps.

Apps and Young People

Apps are providing new ways for young people to stay in touch. Mind of My Own (MOMO) makes it easier for children and young people to communicate with their care team and make more frequent and coherent contributions to their reviews, conferences and other care-related meetings. For an explanation of how it works, see the website www.mindofmyown.org.uk. For how it is used, go to the video in the link below that promotes active participation by children in the delivery of services provided to them and has been preferred to previous methods of engagement by a significant proportion of young people. <https://mindofmyown.org.uk/social-care/>

Smiling Mind

Smiling Mind is a free app for young people which helps build an understanding of mindfulness and meditation. One key aim of social care work is to build resilience and wellbeing in young people, and mindfulness and meditation have been found to help them build confidence and calm. This app can help young people become calm, be clear about their emotions and feelings and be more contented in their lives. If introduced at a younger age, this can assist with stress management and help mitigate mental health risks and issues in later life. The app includes reminders for users to complete different daily activities and could easily be used in social care organisations with children and young people. It can be downloaded from the app store or Google Play. See <https://www.smilingmind.com.au/> for further information and for free download.

See also <https://www.teachthought.com/technology/5-ipad-apps-for-social-and-emotional-learning/> for details of other apps for building social and emotional learning in children and young people, which range from \$0.99 to \$3.99 to download.

COVID-19 and Communication Technologies

The COVID-19 pandemic has presented significant challenges for the delivery of social care services across all sectors. The lockdown in March 2020 resulted in many day services being closed and links with service providers being curtailed

for service users. The need for social distancing in order to reduce the transmission of the virus has resulted in an increased use of information and communication technologies in the sector. Many have enabled virtual appointments and key working sessions to take place, providing some degree of continuity of service for service users. The following are some of the platforms being used to deliver virtual support and services. Staff should ensure that any of the platforms being used are approved by the service providers and in line with the organisation's IT policies and standards. In addition, platforms being used should meet data protection legislation.

MS Teams

MS Teams provides a platform for video and audio conferencing. If the service has a business account, staff will be able to schedule meetings with service users and use other features, such as recording or using channels if small groups are required. It contains a scheduling assistant which assists with organising meetings, with an automatic link being generated and sent to the recipient. It also has a chat facility. For service users, the MS Teams app is free to download and they simply click 'Join Now' to enter a meeting room once the invitation has been set up. It is free to set up a personal account on MS Teams, but some of the advanced features are not activated but are being constantly updated by Microsoft. MS Teams enables users to share content such as presentations or documentation, so it is collaborative in nature. This might be particularly useful in care planning reviews or multi-agency meetings. Follow this link for a short tutorial on how to use MS Teams:



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://tus.pressbooks.pub/standardsocialcareworker/?p=160#oembed-1>

<https://tus.pressbooks.pub/standardsocialcareworker/?p=160#oembed-1>

Skype for Business Basic

Skype for Business Basic is free to download and offers users instant messaging, audio and video calls and online meetings. A charge applies for more advanced

features. It differs from MS Teams in that it was primarily set up to support video calls and video conferencing, whereas MS Teams is a more collaborative platform.

WhatsApp

WhatsApp is a free download primarily used for messaging, but it also supports audio and video calls. It is particularly popular with young people as it is easy to use and calls and texts are free.

Zoom

Zoom offers a video conferencing, web conferencing and webinar facility. A basic plan is available for free which offers unlimited meetings; however, there is a time limit of 40 minutes. When a meeting has been set up a Meeting User ID is generated and a password is forwarded to recipients. They click on the link to the meeting and are prompted to enter the ID and password to gain access to the virtual room. The host must admit attendees to the meeting area.



Tips for Practice Educators

An important element in ensuring that a student achieves this proficiency is for practice educators to alleviate any anxiety felt by students with respect to using information and communication technologies during their placement. First, if a centralised database is used in the service for updating service user engagement and attendance, training could be given to the student on arrival on placement. As part of their duties, students, if permitted under data protection and GDPR legislation, could be permitted to enter and update records in order to develop competence in this technology.

As a key element of social care work is building and maintaining relationships with service users, the ability to communicate is an essential skill for all students to develop while on practice placement. Depending on the service user group, the communication needs may differ. It is important that students learn and use the technology to communicate effectively with service users. So, for example, a service user with autism may use a tablet to communicate their activities of daily living, their preferences and wishes. If students are allowed access to a tablet and given guidance on the meaning of the different signs and

symbols, they will very quickly understand the needs and wants being expressed by a service user. This will help create a bond between the student and the service user and may alleviate any challenging behaviour that may occur if a service user's needs are not been met. This should be regularly reviewed at supervision sessions to ensure that the student is being given the opportunity to learn the technology required for communicating with service users in the service.

Similarly, it would be useful for students who are placed in children's residential centres to learn about the technology used for expression of emotions, for example. This would, of course, need to be supervised and managed as it could potentially be a very sensitive areas for service users. It may be the case that the keyworker should demonstrate to the student how apps are used with young people who have difficulties in communicating, particularly around emotions. This will demonstrate to the student that there are different ways to communicate than the traditional means of sitting down at a meeting table with a young person, asking questions and taking notes. The use of technology in expressing emotions is often an important first step for young people in care to identify their feelings. It can be a safe means and a starting point for subsequent in-person meetings about emotions and feelings. Again, allowing students access to technology such as apps and allowing them to observe them in action will help them be confident in using them and in incorporating them into their work with service users and enable them to build strong connections. Students can build on this work with service users and provide a safe place to meet and discuss issues and challenges.

COVID-19 has changed how many social care organisations work, and they have moved to a more virtual space. Digital literacy and information technologies are core to communication, not solely with service users but also with staff. As far as possible, students should be given opportunities to utilise the different platforms for communication. Allowing students to attend virtual staff meetings would greatly facilitate their learning in many areas such as teamwork, task delegation, multi-agency working and inter-disciplinary work. Of course, it is important that students understand policies on IT usage and using technology in accordance with data protection and GDPR legislation. Asking a student to create and host a meeting with a serviceuser and with an external agency would be of huge benefit in terms of meeting this proficiency. Having an understanding of databases and their use for cross-communication between different agencies would also be of use to students in terms of e-referrals and occupancy rates.

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Chapter 31 – Garreth McCarthy (D2SOP8)

Domain 2 Standard of Proficiency 8

Be aware of and comply with local/national documentation standards including, for example, terminology, and signature requirements.

KEY TERMS

National documentation standards
Local documentation standards
Terminology
Signature requirements

Social care is ... about meeting people at a particular stage in their lives and supporting them overcome their challenges and assist them with reaching their goals.

TASK 1

Describe one relevant National Quality Standard Framework and discuss how this policy relates to a particular care setting. (Think of your last placement or previous social care position.)

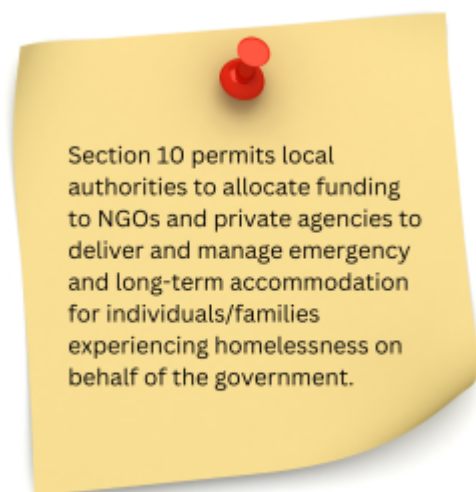
Introduction

Social care workers in Ireland work with a diverse range of service user groups and/or individuals. They are therefore required to have an awareness and understanding of a variety of national standards. This chapter will focus on the

National Quality Standards Framework (NQSF) that was devised for homeless services in Ireland. The themes and standards in the National Quality Standards Framework were predominantly adapted from those used by the Health, Information and Quality Authority (HIQA). The relevance of the HIQA standards in relation to homeless services will also be briefly discussed. There are many families with dependent children currently experiencing homelessness, so the 2017 Children First Guidelines will also be discussed; social care workers working with children have a statutory responsibility to comply with the guidelines. Challenges that social care workers experience when adhering to both the national standards and guidelines will be highlighted.

National documentation standards

The aim of the NQSF is to ensure that services that support individuals experiencing homelessness are well organised and are of a high standard. It also aims to accomplish appropriate co-ordination and integration between services, to ensure that services and practitioners are focused on supporting individuals and families to secure suitable long-term accommodation in a timely manner (within six months) (DRHE 2019).



Section 10 permits local authorities to allocate funding to NGOs and private agencies to deliver and manage emergency and long-term accommodation for individuals/families experiencing homelessness on behalf of the government.

Interpreters contribute to assessment and intervention processes by facilitating communication, and by doing so, they gain insight into service users' experiences, perspectives, wishes

and feelings. Discrimination and oppression are common experiences for emergent bilinguals, thus facilitating communication is an anti-racist and anti-oppressive practice issue. Ensuring that services are provided in a suitable format and facilitating communication is helpful in recognising people's language, history, culture, traditions and religion (Keating 2000). Using an interpreter when language is an issue is important to ensure understanding and gain clarity. This

is particularly important when completing risk assessments, informing service users of their rights, in child protection issues, for consent to engage in services or share information to other services, and in line with General Data Protection Regulations (GDPR).

Homelessness has become a major social concern in Irish society, with both adults and children living in emergency accommodation (Hearne 2020). In 2015, the Dublin Region Homeless Executive (DRHE) devised and introduced the National Quality Standards Framework. The standards were developed in collaboration with other stakeholders, such as non-government organisations (NGOs), Tusla (the Child and Family Agency), HIQA, the Health Service Executive (HSE) and service users themselves. All statutory, NGO and private providers that receive funding under Section 10 of the Housing (Miscellaneous Provisions) Act 2009 must abide by the standards set out.

To address the overwhelming number of families entering homelessness, emergency accommodation (Family Hubs) was introduced in 2016 (O'Sullivan 2020). The NQSF was updated in 2018 to include family homeless accommodation. There is an inspection team who conduct inspections in each homeless service funded by the DRHE to ensure that organisations are adhering to the standards. There are currently 26 standards under eight themes. These are outlined on the DRHE's website (www.homelessdublin.ie/content/files/NQSF-Standards.pdf). The terminology used in the NQSF is similar to that in the regulatory framework devised by HIQA. See HIQA's website (www.hiqa.ie/sites/default/files/2018-11/national-standards-for-childrens-residential-centres.pdf).

Health Information and Quality Authority

HIQA is the sovereign authority accountable for ensuring safety, quality and accountability in social care and health settings. It is responsible for ensuring that children's residential, child protection and fostering services are compliant with the standards and conducts frequent inspections (HIQA 2018). Although HIQA carries out inspections in residential homeless services for the under 18s, it is important to note that as of 2020 HIQA does not conduct inspections on family homeless emergency accommodation. The DRHE's own inspection team is tasked with conducting assessments of family homeless services.

Family homelessness is complex

Families enter homelessness for a variety of reasons, including parental substance misuse, mental health problems, loss of employment, domestic violence and breakdowns in family relationships (Walsh & Harvey 2015). The role of the social care worker is to support family members with identifying specific needs for which they may need support and ensuring that appropriate services are provided to meet such needs. When working with families in homeless accommodation, the priority of the service is to support them to find suitable accommodation, while also ensuring that their individual needs are met. Building relationships enables the social care worker to develop trust with the service users and support them to meet those needs. Lishman *et al.* (2018) assert that creating positive relationships through displaying empathy and unconditional positive regard towards service users is an integral part of social care work.

Children First 2017 Guidelines

Tusla (2015) emphasise that each organisation and practitioner involved in homeless emergency accommodation has a statutory obligation to comply with the 2017 Children First Guidelines (Children First Act 2015). The economic crash in 2008 resulted in high unemployment, and over-reliance on the private housing market has caused family homelessness to soar in recent years (Kenna *et al.* 2018). In September 2020 there were 1,128 families with 2,583 dependent children residing in emergency homeless accommodation throughout Ireland (DHLGH 2020). The high number of children experiencing homelessness creates additional challenges for social care workers.

Children are at risk of many forms of abuse or neglect, and they can also experience bullying in social environments from other individuals or groups. Ensuring the safety of children is paramount, although it is essential for practitioners to strike a balance between safeguarding children and respecting the needs and rights of the parents and the family (DCYA 2017). There are many children from different backgrounds, nationalities and cultures living in homeless accommodation together. The Ombudsman for Children's Office (2019) reported that living in communal areas in close proximity within family hubs caused tension among children, which led to numerous children

experiencing bullying. One approach used by social care workers to address bullying in a family hub was to deliver a bullying education programme.

If a child is experiencing abuse or neglect it is imperative for practitioners to be aware it may not be intentional. The parent/carer may be struggling to cope themselves (Harris & White 2018).

This can be evident in family hubs – parents are experiencing emotional distress, which can lead to them feeling frustrated and becoming temperamental towards their children (Brand & Ciccomascolo 2020). When residing in family hubs, social care workers must ensure that children are safeguarded from any abuse or neglect, while also providing emotional support for the parents/carers.

Having to adhere to both the National Quality Standards and the 2017 Children First Guidelines can create challenges for practitioners. Completing documentations such as incident reports, risk assessments, observation logs and handovers increases the administrative workload for social care workers. Means *et al.* (2008) note that bureaucracy inhibits social care workers from engaging in direct practice. The NQSF places a strong emphasis on applying a person-centred approach. Each organisation and practitioner must ensure the service user is supported with developing their own independence and afforded the choice to make their own decisions. The 2017 Children First Guidelines state that it is essential that children's safety is paramount and that all practitioners must report any concerns regarding the child's welfare to Tusla. The NQSF was established to assist organisations and practitioners to ensure high-quality standards in the provision of services (Ombudsman for Children's Office 2017); and Biesel *et al.* (2020) emphasise that the main objective of the Children First Guidelines is to protect the welfare of the child. Social care workers must ensure that the Children First Guidelines take precedence over any other framework. The following case study outlines a challenging situation typical of the kind that staff working in Family Hubs encounter.

Case Study 1

Jane is a single mother (34) who is living in a Family Hub. She has two children aged 10 and 16. Jane does shift work, which involves doing some night shifts, and she is not in a position to have someone mind her children while she's working. On occasions, the staff team have noticed, she leaves the 16-year-old to mind his sibling while she is in work. The policy of the

service states that children must be supervised at all times, and that if children are not supervised a report must be sent to Tusla.

Jane's key worker discussed their concerns with her and Jane said that she is struggling to find people who can support her with minding the children. Jane is aware of the policy and procedure and told her key worker that she needs the job to be able to provide for her children; and the job is helping her to retain some normality in her life with the current situation she's in.

Her key worker was unsure of the right course of action to take.

Task 2

What action would you take if you were faced with this situation? Refer to:

Tusla report forms (www.tusla.ie/children-first/publications-and-forms/)

Children First National Guidelines (2017) (www.tusla.ie/uploads/content/Children_First_National_Guidance_2017)

Jane's key worker brought the issue to management and was informed that a report had to be sent to Tusla in line with Children First Guidelines. Her key worker highlighted the National Quality Standards and said that the team needed to support Jane to maintain her own independence. A decision was made that the children could stay in the service with staff supervision until 10 p.m. Jane would have to be in the service at that time to ensure she is supervising her children.

The decision caused Jane to lose trust in the team as she felt her parenting ability was being undermined. It also limited the number of shifts Jane could do, which created a financial burden on the family. The positive relationship between Jane and her key worker allowed for them to discuss the situation and Jane acknowledged the gravity of the situation and appreciated the flexibility the team had provided to try support her. Jane complied with the agreement and no additional reports or further action needed to be taken. Jane was supported with securing suitable accommodation for her and the children and moved out within the next two months.

Local Documentation Standards: Holistic Needs Assessment

Organisations and practitioners working with individuals who live in emergency homeless services are provided with Housing Needs Assessment (HNA) books. The forms provide clear advice regarding the service user's rights to give consent in relation to their information being shared. If the service user does not give or wishes to withdraw their consent, practitioners would not have

the legal right to discuss any information regarding the service user. The HNA permits the service user and practitioner to develop a person-centred care plan and identify a plan to secure suitable independent accommodation. The HNA also enables the service user and practitioner to identify any additional needs for which the service user may need supports. The HNA assessment is a voluntary system and service users are given the choice of whether they wish to engage in the process. The system was introduced to ensure that service users and staff are not having to continuously engage in initial assessments. The focus is to encourage consistency within the service user's assessment and care plan and enhance the sharing of information between organisations (DRHE 2017).

Two social care workers – Eoin, working in a homeless residential service; and David, in a community addiction service – emphasise the importance of relationship-building and communication:

'The HNA and the Initial and Comprehensive Assessment systems are similar in design; both take a holistic approach. Both books are appropriate tools to assist the social care worker and service user with identifying specific needs and developing suitable care plans.' Care Plans may need to be adapted or a new one devised if additional needs arise. The establishment of a good relationship between the social care worker and the service user enables honest discussion on such issues. Building a good rapport with other services will place social care workers in a good position to develop good communication between other practitioners, which prevents duplication and repetition of the work and ensures the right actions are taken to support the service user's needs.'

A majority of people experiencing homelessness have many and complex needs. No one service has the capacity to support individuals to meet all their needs. Homeless residential services are limited in their facilities, which prevents them from being able to deliver appropriate supports to individuals who want to overcome addiction or mental health issues (O'Sullivan 2008). When engaged in the HNA system while residing in homeless accommodation the service user, with support from the practitioner, may identify specific needs in relation to addiction issues. To ensure the service user gets the appropriate support needed to overcome their addiction the practitioner would need to refer the service user to either a community or residential addiction service, whichever is deemed appropriate.

Initial and Comprehensive Assessment Book System

In 2014, an Initial and Comprehensive Assessment Book system was developed to support addiction services and practitioners to conduct initial and comprehensive assessments (Kirby 2014). The 2017- 2025 National Alcohol and Drug Strategy suggests community and residential addiction services use this system as an appropriate tool to assist with identifying suitable supports to assist and address complex needs (DoH 2017).

The book is designed with questions which are devised under specific themes including substance use, accommodation, medical, financial, treatment history, education/employment, legal and relationships. The concerns identified may change either positively or negatively and additional issues may arise. The role of the practitioner is to have an understanding and awareness of each need that was initially identified, and compare and contrast these with the service user's current status.

Establishing specific needs ensures an appropriate care plan is devised to assist the service users with accessing the right supports. Displaying empathy and transparency towards the service user assists with building a trusting relationship. This will help the service user to feel comfortable and encourage them to disclose the precise nature of their current circumstances. Establishing a positive relationship supports the development of an effective care plan.

An example of the Initial and Comprehensive Assessment Book can be found at: www.corkdrugandalcohol.ie/wp-content/uploads/2015/04/Case-management-manual-2014.pdf.

Engaging in both the HNA and Initial and Comprehensive Assessments Care Plan systems supports social care workers and service users with identifying specific needs, which assists with devising appropriate support plans. Good communication and collaboration between all parties involved in the service user's care plan can lead to productive outcomes for the individual.

Example

When engaging in an initial assessment the service user may not feel comfortable revealing the exact extent of their substance use. The service user may say they are engaged in a methadone programme and adhering to the prescribed dose and that their goal is to seek detox residential treatment. The care plan would be developed with the aim of making a referral to a residential detox unit and providing therapeutic supports while they are waiting to access the residential service. However, while engaged in a comprehensive assessment, which happens

over time, the service user may disclose that they are also using additional substances such as benzodiazepine and cocaine. This would mean that the care plan would need to be revised and the goal may change to suggesting the service user attend a residential or community stabilisation programme.

‘An individual who resided in our service was supported with accessing supports regarding his addiction and is now entirely abstinent from all substances and secured his own accommodation with our supports. His positive journey is inspiring.’ (Tracey, a social care worker in a residential homeless service)

Terminology Used

When discussing individuals, the terminology we have used throughout this chapter is ‘service user’. Martin (2010) asserts that the phrase ‘service user’ has for many years been the most common term in social care literature and practice settings. But it is not the preferred term in all services. Because different terms are used to describe service users in different social care settings, the language used in documents and reports is not always consistent. Homeless residential services refer to individuals as residents. Residential addiction services are primarily staffed by the medical and therapeutic professions, which means that the individuals are known as clients. Community addiction treatment (day programmes) may categorise individuals as clients or participants. As a social care worker, it is important to be fully aware of the terminology used both in the field in which you work and other fields which you engage with. Social care workers liaise with multiple agencies and professionals, which involves a diverse range of correspondence in relation to care plans, reports and referrals. Knowing and complying with the terminology used is part of being a competent professional.

Signature Requirements

In 2018, the Irish Data Protection Act was devised following the introduction

of the 2018 European General Data Protection Regulations. Under the Act, all organisations, agencies and practitioners must ensure that they receive written consent from each individual who engages with their service. The individual's right to confidentiality is at the forefront of both the HNA and Initial and Comprehensive Assessment systems. It is imperative when requesting consent that the service user is aware and fully informed of the reason why they are being asked to give their consent. As a social care worker it is important to note, as highlighted by Morley *et al.* (2014), that service users must be informed that their confidentiality cannot be assured if there is a disclosure of potential risk of harm to the service user or to others.

Ireland has become a multicultural society, which has led to many nationalities from different ethnicities experiencing homelessness (IHREC 2019). There can be language barriers, creating difficulties for non-Irish national service users and social care workers when seeking consent (O'Connor & Ciribuco 2017). Having a professional translator present would ensure adequate communication between both parties. Since this is not always possible, another tool used by social care workers is a translation device on their mobile phone. In addition, the HSE (2013) emphasises that service users may have limited literacy skills and difficulties with communicating, so it is important to give individuals time before they give their written consent. If the service user finds it problematic to provide written consent, having them place a mark (e.g. 'X') on the document to indicate consent would be sufficient.

Some useful information on this subject includes:

- *Migrant Integration Strategy 2017-2020* (DoJ 2019)
- *Guide to the General Data Protection Regulations* (ICO 2018)
- *National Consent Policy* (HSE 2013)
- *GDPR Consent* (Intersoft Consulting website)

Some individuals who experience homelessness and/or substance misuse would have experienced mistrust, which makes them more cautious about signing any type of document. The service user could refuse their consent for the social care worker to contact specific others, as it is their legal right to do so. This can create challenges, because if consent forms are not signed the social care worker would not be in a position to discuss the service user's case with other professionals. This in turn would prevent the social care worker from gathering or relaying relevant information needed to implement appropriate supports outlined in the care plan. This is another reason why it is so important for the social care worker to form a good positive relationship with the service user. Riggall (2012)

emphasises that this is the first requirement for a practitioner when working with a service user. A positive working relationship encourages trust to develop between the two parties. It is imperative to reassure the service user that any information relayed to others is to support them to achieve their goals. You can learn more about how to develop a positive working relationship in Chapters 35, 36, 38 and 39.



Tips for Practice Educators

The basis for this proficiency is for the student to acquire an awareness of the national and local documents that outline the standards that practitioners must adhere to in social care settings. The proficiency places an emphasis on the ability to understand the requirements needed in relation to obtaining the service user's signature, and the differences in the terminology used in specific social care settings (particularly documentation). Identifying, outlining and discussing the different national and local documents would assist the student to develop an understanding and awareness on what is required of them when on placement or working in the relevant fields.

Having the student's complete case studies would help them develop an awareness and knowledge of national and local standards documentation and an understanding of the documents used to conduct assessments. This would encourage confidence and prepare them to be in a position to be able to apply their learning in practice.

Throughout their studies students will encounter a multitude of literature and textbooks that use the phrase 'service user' when discussing individuals availing of social supports. This terminology may create challenges for students as this term is seldom if ever used in the work setting. As highlighted in this chapter, there are a variety of terminologies used in different social care sectors. Identifying and discussing the various terms used in specific sectors would enable the student to be self-confident when undertaking their placement practice.

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Chapter 32 – Maeve Dempsey and Collie Patton (D2SOP9)

Domain 2 Standard of Proficiency 9

Be able to express professional, informed and considered opinions to service users, health professionals and others, e.g. carers, relatives, in varied practice settings and contexts and within the boundaries of confidentiality.

KEY TERMS
Professional boundaries
Communicating informed opinion
Professional and ethical communication
Boundaries of confidentiality
Davidson's Professional Relationship Continuum

Social care is ... a relationship-based practice characterised by the dynamic and complex needs of vulnerable individuals within society. The role of the social care worker is to support and respond in a manner informed by knowledge and best practice, tailored to the individual's identified needs, while being aligned to ethics, standards and engaged in accountable and reflective practice that is both respectful and boundaried towards the individual. By its very nature, care and support permeates social care relationships, which have the capacity to become a pathway and catalyst towards positive change.

There are four other relevant proficiencies in the Standards of Proficiency for Social Care Workers (SCWRB 2017), outlined in the table below. This chapter focuses explicitly on the boundaries of confidentiality.

Domain	Chapter in this book	Focus on the Relationship
D1 SOP10 (2017: 4)	CH 10 by Anthony Corcoran	<i>Understand and respect the confidentiality of service users</i>
D1 SOP11 (2017: 4)	CH 11 by Noelle Reilly	<i>Understand confidentiality in the context of the team setting</i>
D1 SOP12 (2017: 4)	CH12 by Maria Ronan	<i>Understand and be able to apply the limits of the concept of confidentiality</i>
D1 SOP14 (2017: 4)	CH14 by Teresa Brown and Margaret Fingleton	<i>Recognise and manage the potential conflict that can arise between confidentiality and whistle-blowing</i>

TASK 1

Please read Chapters 10, 11, 12 and 14 and answer the following questions: What is confidentiality? From your experience, are there limitations or situational contexts associated with confidentiality?

Defining Boundaries

Boundaries are ‘*the limits that allow for a safe connection based on the client’s needs*’ (Peterson 1992: 74) and are also the limits we set in relationships that allow us to protect ourselves. Through self-awareness, we develop clarity and insight into what is acceptable and unacceptable to us as individuals in terms of our boundaries, both personally and professionally. The concern about appropriate boundaries is, at least in part, a concern about the effects of the power differential between client and professional, recognising that we are working at a deep level with vulnerable individuals and thus there is a risk of boundary violations (Dietz & Thompson 2004). It is our responsibility to ensure that the support and care we provide to vulnerable individuals does not further disenfranchise or disempower them.

From a self-care perspective, social care work can be challenging and

practitioners are frequently exposed to highly stressful and emotive situations. Consequently, maintaining strong and clear professional boundaries allows us to manage ourselves and regulate our emotions to ensure we are operating in a safe and ethical manner, cognisant of the limitations and boundaries of our role.

Professional Boundaries in Social Care

The relationship between social care practitioner and client is the central component in meaningful and effective social care work. How this relationship develops and functions is of significance when understanding the importance of boundaries and the limitations of confidentiality. In many ways, this relationship is born from an imposed and artificial situation and is characterised by a distinct imbalance of powers. This is inevitable because the worker's role, influence, authority and access to confidential and sensitive information pertaining to the client and the client's needs guide the relationship. The journey for both social care worker and client towards developing this relationship to a therapeutic one requires trust, effective communication, empathy and unconditional positive regard on the part of the social care worker. It also requires time and commitment. During this process, like any relationship, there is a 'getting to know you' stage which involves sharing information, often personal and significant to the client. It is at this stage that the foundations of clear and professional boundaries are laid, and the onus to both establish and maintain those boundaries must fall to the social care worker. This is not always an easy task and, in recognition of the dynamic and complex lives of clients, social care workers are often faced with ethical grey areas that challenge their professional boundaries and can result in lines being crossed. The context, the needs of the individual, the role of the social care worker, and the potential for misinterpretation are significant factors in understanding what constitutes balanced and bounded practice.

TASK 2

Think about: Where do we draw the boundary between personal and professional relationships? How should social care workers present themselves to service users?

Davidson's Professional Relationship Boundaries Continuum

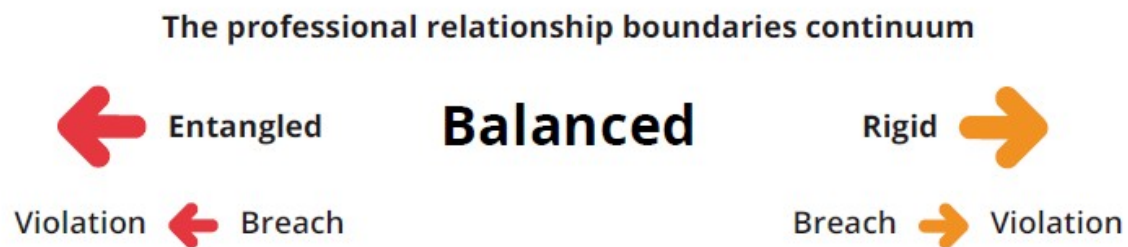


Diagram created by the author, adapted from Davidson's Professional Relationship Boundaries Continuum (2004), illustrating balanced professional boundaries between extremes of entangled and rigid behaviours.

A useful model for understanding and exploring appropriate professional boundaries is Davidson's (2004) professional relationship boundaries continuum, a conceptual framework that encourages social care workers to engage critically with the complex relationships that exist with clients, between professionals, and subsequently identify boundary violations, increase self-awareness and critical reflective practice and initiate prevention strategies. Davidson (2004) provides both a point of reference and a common language for discussing the actions, choices and processes related to the boundaries of human service providers' professional relationships.

According to Davidson (2009: np), *'an individual who has an authentic and caring manner while maintaining clear boundaries is demonstrating balanced boundaries ... They actively use professional judgment, consistently apply self-reflection skills, and are intentionally accountable to other professionals ... Professionals with entangled professional boundaries are consistently over-involved in the lives of the clients they serve. They invest more of their time, emotional energy or favour in these relationships than in others, and they meet their own emotional, social, or physical needs through the relationship at the client's expense.'*

The significance of this framework as a 'continuum' acknowledges movement, progression and stages that are not clearly delineated. Therefore we can conclude that our boundaries have the capacity to change, are not concrete and can both progress and regress. In order to prevent regression to entangled boundary violations or rigidity in approach, and to ensure social care workers

are practising with balanced boundaries, the topic of boundaries needs to be consistently on the agenda in team meetings and in supervision and should feature consistently within our own reflective practice. Research reflects that the more honest and open the communication between practitioners, the less likely it is that clients' boundaries will be crossed (Thompson *et al.* 1995).

TASK 3

Using the Davidson professional relationship boundaries continuum (2004), describe and reflect on a recent experience in which you felt your professional boundaries were challenged. What insights and awareness have you in relation to what influences or impacts your boundaries?

Ethical and Professional Communication

The concept of relationship-based practice (RBP) has, at its core, the centrality of relationships and reciprocity in professional helping relationships (Mulkeen 2020). Acknowledging that the therapeutic relationship is at the core of social care practice, it would make sense that communication, an ability to express oneself appropriately and succinctly as a professional, is key to developing relationships between practitioner and client, and their families, but also between practitioners and other professionals. Language is a medium for communication, whether through words, images or symbols, and should be used appropriately to facilitate understanding. Furthermore, having a shared and common language and terminology is imperative for relevant and accurate record-keeping and communication between teams and disciplines. In all contexts, ethical and professional communication must be underpinned by respect and integrity towards freedom of expression, alternative perspectives and views, and the ability to tolerate dissent. To respond professionally, social care workers should take the time to understand and respect the contributions of others and subsequently evaluate for context. This means utilising silence skilfully as a means for essential space for thinking and reflection; asking questions to obtain clarity and stimulate thinking; and observing to comprehend non-verbal forms of communication, formulate hypotheses about what is happening and test the reliability of our perceptions against those of other individuals and other information available (Trevithick 2005: 121-2). In doing this,

we are creating and promoting an environment conducive to effective and professional communication that allows for informed and effective decision-making by all parties. Practically speaking, this involves the social care worker understanding the communication needs of the individual they are engaging with, meeting them at their level, and ensuring that they suitably express informed opinions in a manner that is clear, succinct and appropriate. Avoiding jargon, using suitable and clear vocabulary, adopting a communication style that is inclusive and encompasses the entirety of expression, including verbal and non-verbal interaction, is key to a social care worker effectively communicating in a variety of settings and contexts.

Communication facilitates collaborative practice between professionals in social care practice. Deviation from this can result in the needs of service users and families not being met, and a failure to position the service user at the core of decision-making. Healthy communication takes place in ever-evolving social circumstances that are impacted by external influences and interpersonal factors. How social care practitioners and service users communicate with one another has a significant impact on the quality of care and on health outcomes such as service user satisfaction with care and overall improvement in health (Street 2003). Social care workers can often find themselves in a role where they are offering support to service users as part of a multi-disciplinary team. Indeed, these communications take place between social care workers and service users, family members, healthcare providers and others. Interpersonal health communication exchanges are part of a complex social system that influences health knowledge, behaviours and outcomes through information exchange (Nelson *et al.* 2004).

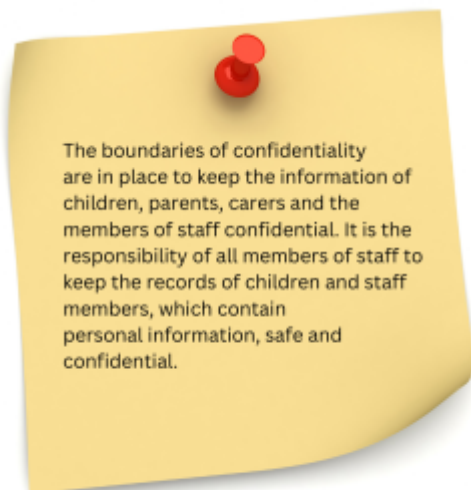
Case Study 1

Rosy is 35 years old and has a moderate intellectual disability and, as such, a reduced capacity to understand and process new situations and experiences. This is further complicated by literacy problems and communication problems. Rosy is a service user in a residential programme in which you work as a social care worker. Rosy's parents are both engaged in her care and visit with Rosy regularly. A member of the residential social care team has noticed that Rosy has a lump on her side that is discoloured, and after they gave that information to the team, Rosy has had it explained to her that she would be going to the GP for a check-up. At this check-up the GP was sufficiently concerned about the lump that she has recommended Rosy go for a biopsy. As a social care worker, you have attended the appointment with the GP and will attend for the

biopsy at the hospital. Rosy has noticed the lump and it has been causing her discomfort. The GP has explained to Rosy what is happening but is unsure how much of the situation Rosy has understood.

How can you support Rosy in understanding what is happening with her body and what the next steps are in her medical treatment?

Informed Opinions within Boundaries of Confidentiality



The boundaries of confidentiality are in place to keep the information of children, parents, carers and the members of staff confidential. It is the responsibility of all members of staff to keep the records of children and staff members, which contain personal information, safe and confidential.

As previously stated, the relationship between social care worker and client is dominated by a power differential due to the social care worker's access to sensitive information pertaining to the

client, remuneration for their work, the relationship being led by the client's needs and the influence the social care worker has in terms of decision-making. In most settings, the social care worker will be considered the expert. Clients will therefore believe you have the knowledge and experience to develop informed opinions and subsequently to give these opinions authority. How a social care worker develops this informed opinion is of relevance here. Information-gathering occurs not just through direct communication with service users and their families but through observation, and through attending both team and multidisciplinary meetings.

The social care worker can subsequently be found at an impasse whereby they are in receipt of knowledge or information relating to the client that has not directly been shared with them by the client. The human nature of the work does

not allow us to disregard or forget this information, regardless of professional boundaries. We are therefore faced with recognising the importance of sharing information relating to our clients on a 'need-to-know basis'. There is no scientific formula or direct theoretical guidance for making these decisions and so the social care worker takes the role of being discerning within the parameters of confidentiality, taking context, situation and time into consideration and ultimately their own professional intuition. Therefore, ethical decision-making is inevitably influenced by values, context and human fallibility.

It is in these situations that a scientific approach or formula may provide comfort and security to the worker, but in its absence the importance of the worker receiving support from their team and management when developing informed and considered opinions is imperative. Understandably, there is a culture of fear associated with making such informed decisions and the potential of negative professional repercussions due to a boomerang culture underpinned by accountability. What is meant by this is the acknowledgement that every decision made has the capacity to come back to the practitioner with significant professional implications. While accountability in practice is essential for quality and delivery of safe and effective care, it brings its own challenges and without adequate support can result in practitioners shying away from making informed and considered decisions.

An effective model of informed and shared decision-making that highlights the importance and benefits of inter-agency communication can be observed through Tusla's Meitheal partnership approach. Meitheal is a targeted, co-ordinated intervention for families who do not meet the threshold for social work intervention but would benefit from a multi-agency approach where agencies can communicate and work together effectively and respond to families with a range of expertise, perspectives, knowledge and skills. The service user is at the centre of deliberations and considerations and is privy to and involved in the decision-making process throughout.

Boundaries of Confidentiality in Relation to Information that must be Shared

According to HIQA (2012), confidentiality in the health and social care context refers to the duty a practitioner has to safeguard information that has been entrusted to him or her by their service user. A duty of confidence arises when one person discloses information to another in circumstances where it is

reasonable to expect that the information is held in confidence, such as between GP and patient (HIQA 2012). In general, it is essential that social care workers respect confidentiality and keep sensitive information pertaining to the service user confidential. Deviation from this can have a detrimental impact on the therapeutic relationship and result in a breakdown of trust. Generally, sharing confidential information, even between professionals or family members, should require informed consent from the client. If service users are confident that their information is being appropriately protected this increases trust between practitioner, service and client, which could result in the client feeling comfortable enough to share more information, ultimately improving safety and quality of care at an individual level (HIQA 2012).

However, there are exceptions and boundaries of confidentiality and the right to confidentiality is not absolute. Situations can arise relating to safeguarding of vulnerable individuals where confidentiality cannot be maintained. It is important to have transparent and detailed conversations informing clients about the limitations and boundaries of confidentiality from the beginning of the relationship. This clarity provides security to both worker and client and also ensures that the client is informed from the start in relation to conditions where limitations of confidentiality exist and that, even though social care workers are responsible for promoting and protecting confidentiality, situations exist where this cannot be maintained or guaranteed. The professional's opinion about what to do in cases where confidentiality cannot be maintained is contingent on the degree and severity of the risk to the service user or another vulnerable party.

TASK 4

As a social care worker at the beginning of your career, can you think of a list of people who might appropriately influence your informed opinion-making process? Consider professional supports you would have access to and personal support networks the client may have.

Case Study 2

John is a 15-year-old boy who has been in the care of his maternal grandmother, Mary, since his mother passed away ten years ago. John's father is incarcerated and John has never had any contact with him. John has had a turbulent couple of years and has struggled in terms of engagement with education and youth reach. Currently, John is

not engaged with any form of education and has come to the attention of the police several times in the last year for anti-social behaviour. John's placement with his grandmother has become unstable due to a combination of behavioural issues, anti-social behaviours and also the deterioration of his grandmother's health. The Tusla Social Work team have suggested the possibility of John moving to a residential placement. When this has been mentioned to John he has responded vehemently against the idea as he wants to stay with his family. Mary is upset by this idea of John being 'taken away' as she feels responsible as John's only family; however, Mary also accepts that she can no longer meet his needs in the home. As a social care worker in non-residential day services you have engaged with John over the past year and have developed a close relationship with the family. You are keen to support John during this difficult time. When you go to the house for your weekly session with John, Mary has asked you to explain what all of this means and what you think is the best option for John. Mary is upset that John is being 'taken away' but also acknowledges that she cannot meet his needs any more. The social work team have described to Mary the nature of residential care, but Mary's understanding is that it is a form of incarceration. John is scared that he is being taken out of the family home and that fear is being expressed as anger.

Now consider the following questions:

What is your role as a social care worker in this situation? Consider effective and professional communication in your answer.

How would you respond to Mary's questions about residential care in this context?

What is your understanding of this situation in terms of professional boundaries and boundaries of confidentiality?

Final Thoughts

From a practitioner's perspective, it is imperative that we do not make promises pertaining to confidentiality that we cannot keep. If we do this we are in breach of and violating professional social care boundaries and subsequently putting our clients or other vulnerable individuals at risk. As previously stated, we frequently find ourselves in situations that call for careful ethical and professional decision-making and consideration of the SCWRB Codes of Professional Conduct and Ethics. Ensuring a commitment to our own professional boundaries will facilitate our ability to express professional, informed and considered opinions to service users, health professionals and others within the boundaries of confidentiality and will prevent us practising in an automatic, unthinking way. The juxtaposition that exists within practice that is concerned with maintaining boundaries, upholding rights of clients and the conduct and duties of social care workers compared to the narrative associated with choice,

collaboration and care highlights the intricacies and human nature of social care work and the importance of understanding context, the complexity and sensitivity of the social care relationship and the need for a continued commitment to informed and knowledge-based practice.



Tips for Practice Educators

Understanding the context of the environment that students in the allied health professions will work in is key to effective practice education support (Mulholland *et al.* 2005). This context includes the interpersonal professional relationships that students develop within the placement environment. Students develop direct relationships with service users over time and through ongoing contact. However, students will also engage on an ad hoc basis with professionals from multi-disciplinary teams and personal support networks of these service users. Additionally, the interpersonal relationship and communication between the student and the practice educator plays an important role in the success of the placement learning experience (Mulholland *et al.* 2005). An understanding of social context is also important in navigating these tricky and complex interpersonal relationships (Ackerson & Viswanath 2009). Social context requires an understanding of the impact of macro-level environmental factors such as socioeconomic disparity, ethnicity and race, access to social networks, social support and social capital. Additionally, communication inequality should be considered when expressing professional, informed and considered opinions to service users, health professionals and carers or relatives. Communication inequality is defined as differences among social groups in the generations, distribution, manipulation of information at the population level and access to and ability to take advantage of information at the individual level (Viswanath & Ackerson 2011).

How can you prepare a student for these different roles and interpersonal relationships?

- Keep the topic of boundaries on the agenda for both individual supervision and team meetings. Our boundaries have the capacity to change throughout our career and should not just be a focus during student placement. Encourage discussion relating to professional boundaries and ethical scenarios.
- Ensure that students understand the boundaries and limitations of their role. Interpersonal relationships can get complicated in any setting and this can be even more apparent when working with vulnerable populations (Cooper 2012).
- When possible, allow students to engage with and/or observe the functionality of a multidisciplinary team and the sensitivities associated with boundaries of confidentiality in practice.
- Ensure that those with practical and recent experience of their professions take on the role of practice educators. Kilminster and Jolly (2000) recommend that practice educators have at least one year full-time post-registration experience prior to taking on the practice educator role.
- Placement educators should support students in their various forms of interpersonal

communication such as information seeking, observation, uncertainty management, and stress buffering (Nelson *et al.* 2004).

- An effective practice educator needs good communication and interpersonal skills as well as practice proficiency and the ability to facilitate learning opportunities (Mullholland *et al.* 2005).

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Chapter 33 – Bernie Breen (D2SOP10)

Domain 2 Standard of Proficiency 10

Understand and be able to recognise the impact of effective leadership and management on practice.

KEY TERMS

Management
Leadership
Power
Culture
Practice implications

Social care is ... ensuring that particularly vulnerable people receive quality service provision where respect, dignity and unconditional positive regard are shown and always upheld.

Fundamental to social care practice, leadership and management is that the person receiving the care and support feels genuinely cared for and the environment reflects this. You may not remember what people say to you, but you will never forget how someone makes you feel. Where outcomes are concerned, that is the biggest outcome you can have for someone in your service – that they feel genuinely cared for. People in our services do not have a choice in why they are there, but we do have a choice as to the career we go into. We can leave or choose different options, but the people we care for do not have that option. There is no doubt that it is a stressful and challenging sector, but we made the choice to pursue it and must ensure we are in it for the right reasons and that we understand trauma-informed practice.

Task 1

Take a pen and paper and complete the four leadership styles worksheet to identify your own style.

https://cdn.we.org/wp-content/uploads/2016/05/Part-2-Activity_Four_Leadership_Styles_May271.pdf

Leadership and management are crucial factors in any organisation, but particularly in social care, where vulnerable people rely on quality service provision. Having worked as a manager for a number of years, I am aware that quality service provision comes from the top down. When people think of leaders, they often think of people in well-paid positions of authority and official roles such as managers, people in charge and social care leaders. Although they may share similar characteristics and are often linked together in generic literature, there is a growing focus on leadership as being an essential component in social care management. It is important to realise that simply holding a managerial role does not necessarily make one a leader. It's commonly asked, Do good managers make good leaders? Do good leaders make good managers? A definitive answer can be difficult to come up with. We can, however, say with certainty that, although leadership and management are not contextually the same, in my view they are both essential for best practice in social care.

If managers are to be successful in their role, it is vital for them to absorb certain leadership skills. Likewise, if leaders want to be effective, they must understand how to manage their employees so that they feel inspired, empowered and connected, ultimately leading to quality care provision and a successful organisation. Managers and leaders need an understanding of human behaviour and personality traits to create a more engaged workforce and a more dynamic workplace. This in turns creates an environment conjunctive to best practice.

Management in Social Care

The term 'manager' refers to the person who is responsible for the effective running of a centre, or operations within an organisation, and co-ordinating and managing resources such as staffing and budgets. The manager is expected to have strong organisational skills and to hold a position of seniority. In residential

social care the manager/person in charge (PIC), deputy manager, social care leaders, and people with various other titles, make up the centre's management team and set the culture within the organisation. Within these roles they provide supervision to staff and oversee the administrative requirements and work practices in the centre to ensure they run effectively. This governance should ensure that operations are running in line with national standards and legislative requirements, particularly, in residential centres, in relation to safeguarding. Job titles may vary, but the effective running and management tasks remain the same. In contemporary practice, social care workers are increasingly occupying leadership and management positions, in line with requirements from their Tusla service level agreements (SLAs). In contemporary practice, social care workers are increasingly occupying leadership and management positions, in line with requirements from HIQA requirements and Tusla service level agreements (SLAs).

However, a leader does not necessarily need to be in a position of authority to influence others.

Leadership in Social Care

Managers may effectively run the day-to-day operations but may not lead the team or inspire others to share the vision of the organisation or motivate people within their roles. Leadership can be defined as any behaviour that influences the actions and attitudes of others to achieve certain results. The ability to manage should be coupled with the ability to be a leader to achieve maximum efficiency. Leaders need to believe in themselves and their ability if they expect others to believe and trust in them. Knowing your own limitations is also essential as a leader and that can then be served and balanced by surrounding yourself with a team of varied skillsets that complement each other and work together in collaboration.

One aptitude that distinguishes leadership from many other competencies is the capacity to teach and mentor others. Effectively teaching staff, role modelling and directing creates professional growth. Often, this skill necessitates leaders thinking less about themselves and more about the team as a whole and how to create successful outcomes, and this requires drive, ambition and motivation to achieve planned outcomes and to cultivate more leaders within the team.

A key attribute in cultivating other leaders within the team is mastering the art

of effective communication. As a leader, you need to be able to explain clearly and concisely to staff everything from the purpose and function and ethos of the organisation to specific tasks. Leaders must grasp all forms of communication, from one-to-one meetings such as formal supervision to group forums such as team meetings. They must also be able to communicate effectively by phone, email and webinar, considering what approach works best with each individual as well as the team as a whole. Professional development plans for staff are paramount in providing a sense of purpose and growth, and balanced feedback on performance should be provided through supplemental and formal supervision. This creates a growth mindset. A leader cannot promote the leadership capacity of an employee through performance management alone. Evaluating performance leadership entails exploring the qualitative ways an employee has exhibited positive behaviour. When recognition and acknowledgement are given to the leadership attributes of staff members, they not only receive the support and encouragement they need to continue their journey as leaders, but they become better engaged with and content in their work overall.

TASK 2

Think of some leaders you admire. What makes them stand out to you?

Why do you admire them? How do they influence others?

Power

Management and leadership positions denote a sense of power which, within the context, is legitimate. It can, however, be detrimental to organisations if the individuals in these roles see themselves as superior to others as human beings, not just by virtue of their positions. Attitudes are a pivotal part of what makes effective leaders. While accountability must be a part of managing performance of staff, if this is not balanced with support, it can seem authoritarian. This in turn may lead to people operating out of fear, which impacts on transparent practice and in turn promotes a blame culture. Respect is earned – it does not automatically come with an official job title. If staff feel they can openly admit to mistakes/errors of judgement and this is used as a learning and reflective tool, it will in turn lead to improved practice and reduce the incidence of such errors.

Having said that, with all support and learning opportunities being provided, if there are safeguarding concerns or if individuals do not respond to this constructively, if they have a laissez faire attitude and do not adopt a professional approach to their work, then disciplinary procedures may need to be implemented.

TASK 3

Download a copy of the Workplace Bullying Power Control Wheel by Scott (2018) available from <https://socialscienceandhumanities.ontariotechu.ca/workplacebullying/power-control-wheel.php> Discuss how the categories of power and control can exist in social care settings.

Culture

Ultimately poor leadership and poor culture impacts negatively on the staff team and the lived experience of the service users and there may be a controlling culture in place. This can also lead to greater instances of challenging behaviour, particularly if there is a culture of 'them versus us'. The staff team may feel disempowered or coerced into practices they may not necessarily agree with, especially in how they are instructed to relate to a service user group, for example a punitive as opposed to therapeutic approach. This can impact on the social care worker's confidence and motivation in their role.

Without being in a formal leadership/management role, we are, as practitioners, very powerful. We are the people who ultimately have control over the environment and daily running of the centres. Hanlon (2009) states that staff have the power to influence, ignore, coerce and manipulate but also have the power to intervene, identify the person's feelings, needs and wants and to make each day a positive experience and a learning opportunity. With increased governance through the inspection processes, there is more emphasis on providing evidence for our work through report writing and record keeping. It must be said that this too gives power as practitioners generate the data and the data is only as good as the author and the culture in which we operate. Reports can be phrased in a way that frames the service user's behaviour as the issue. For example, the author might omit the actions practitioners took that may have become a trigger for the service user. A good leader should encourage transparent practice that reflects actual events, not how we want the event to be

perceived. At times reports can neglect to identify all the positive aspects of the day and focus on the negatives. Significant event notification forms are generally negative and focus on an incident of behaviour that challenged or a behaviour of concern. There are positive significant events too, such as a young person engaging in school for the first time, or a positive overnight family access visit. It is important to report and record the positives – you can imagine how it would feel to access reports on your life in years to come and find that everything reads as negative. Recording these details also reflects not only the achievements in someone's life but also the progress and soft outcomes as well as tangible ones.

To ensure accuracy and transparency a manager or leader needs to provide supervision on the go, observing practice, not just seeing supervision as a formal process. A good leader will oversee paperwork and ask questions for clarification on daily logs and incident reports, for example, and use them as a source of learning. Exploration of the approaches and responses to service users should be discussed with the staff, ensuring that they are therapeutic. Outcomes should focus on natural consequences for behaviours as opposed to punitive sanctions. Exploration through debriefing of incidents is paramount to support staff and ensure accountability and learning for everyone. Positive organisational culture is engrained in any organisation by the leaders and managers.

Formal supervision should occur frequently or as per organisational policy. It is a dual process between the supervisor and the supervisee. The supervisor is usually the manager or deputy for full-time staff and social care leaders may be involved in the supervision of relief staff or students. A dual process means that both parties should be active participants and it should not be seen as a box-ticking exercise. Best practice would involve both parties having an input into the agenda, and the supervisee should be proactive in seeking supervision if for some reason it has not been scheduled or has been missed. The supervision process ensures that the supervisee receives focused time to reflect on work practice, professional development and feedback on their practice. There should be a balance between accountability and support. Leaders can ensure that the vision and purpose and function of the organisation are upheld and that expectations are clear. Staff should feel valued and motivated following the session. It is not a disciplinary meeting; neither is it a counselling session. In my experience supervision provides opportunities for workers to reflect on their practice in the following seven ways.

Supervision in Social Care Work

Workers can reflect on the content and process of practice

Monitor and ensure the quality of work

Review and plan work

Consider any responsibilities and input of the supervisee

Develop understanding and skills

Seek and receive information, support and feedback

Voice and examine concerns.

Central to the process is that both parties (supervisor and supervisee) should be trained in their role. Very often supervisors have said that they were given the task and role of supervisor, but were not adequately trained and they did not feel that they were equipped to provide it effectively.

Practice Implications

‘Leadership is a process whereby an individual influences a group of individuals to achieve a common goal’ (Northouse 2010: 5). Research by Hicks *et al.* (2009: 59) stresses the importance of getting the ‘right personnel in place’. The leader should aim to improve the collective performance and should be able to take feedback from other members of staff without feeling threatened. It is important that managers and leaders recognise themselves as human beings who do not know everything, although they strive to be as informed as possible to inform others. It is okay to admit to not knowing something, as long as you commit to find out or to research more.

Social care environments often experience crisis-driven and difficult times. This leads to increased pressure on managers and leaders to oversee and manage complex care needs of service users, implement systems, support and debrief staff teams and participate in the multidisciplinary team with social workers, inspectors and other relevant parties. It is crucial, according to Mackian and Simons (2013), in order to ensure efficiency and to implement programmes supportive of the service users’ needs, to endeavour to have the most effective

managers and leaders in place. This extends to senior management to support social care managers and their management teams, particularly in challenging times, when they may feel isolated in supporting their teams, trying to stabilise the centre and ensure that service users' needs are being met. It is vital that support is provided and even a physical presence of senior management, who may usually be working quite a distance away, can provide reassurance to the leaders on site. During critical times, managers may be caught up in the crisis and therefore unable, emotionally, physically or because of time constraints, to provide the necessary supervision and debriefing. It is crucial that managers recognise this, seek support and are transparent about their capacity during these times in particular, and also that they engage in their own regular supervision and are themselves debriefed. Everyone is accountable to someone, and senior management will also need support from their peers and the board of management. They may require external supervision as their source of support as they carry the weight of their organisation.

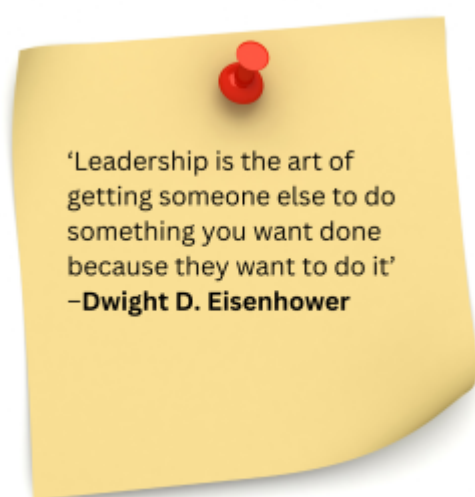
The critical skills leaders require are to be able to manage diverse situations, comprehend relationships and their development, understand how people work and how the organisation shapes staff members' ability to function. An effective manager should also possess leadership skills to ensure that the organisation's vision is shared across all staff and to create a positive organisational culture. Therefore, it is important for leaders and managers to understand contemporary leadership theories and how they can influence their own development and approach.



Diagram created by the author illustrating different leadership theories: Trait Theory or Great Man Theory, Behavioural Theories, Contingency Theories, Charismatic and Authentic Leadership, Transactional and Transformative Leadership, and Servant Leadership.

It is important to understand the theories of leadership and how they relate to your own style to identify areas for professional and personal development to be versatile and adaptive. Much like the nature/nurture debate, leadership theories also debate whether you are born a leader or whether it is something that is influenced and developed. The great man theory and trait theory for instance suggest that leadership is innate, and people are born with the traits that lead them to attain powerful positions of authority. In contrast, the leadership skills approach sees leadership skills as being cultivated in individuals so they can develop into leaders. Contingency styles of management allow for the ebbs and flows within the complexities of social care and ensure flexibility and variations in approaches to respond effectively and appropriately to each situation.

The style approach then considers what people can do as opposed to how they are in the above theories. It looks at behaviour and attitudes, and incorporates interpersonal skills and relationships that the leader builds with the staff team.



Mackian and Simons (2013) critique the issue that research often focuses on management and leadership styles exploring the individual traits while ignoring the organisational influence and failing to critically analyse its impact on even the most effective leaders and managers. Northouse (2019) claims that it is advantageous to use the trait approach as a viewpoint for leadership and argues that research validates the basis of the trait's perspective. He states that a specific focus on the leader

themselves leads to a greater understanding of this element of the process of leadership. To lead effectively, it is essential that managers themselves are managing their stress and receiving support (Mackian & Simons 2013).

In a caring management style, managers and leaders build on their own self-awareness and emotional intelligence to support staff, recognising them as emotive human beings. Professional development in leadership occurs in this process. Managers and leaders who developing emotional intelligence, Mackian and Simons (2013) argue, are more likely to retain staff, increase morale and increase productivity in times of stress. Ward (2014: 213) highlights the discourse for leaders in holding the responsibility for the wellbeing of children and staff while trying to self-care and states, 'it's not a position or state that one can take on, or put aside too casually', continuing, 'you need to be and feel on

top of everything since you hold ultimate responsibility' (2014: 216). The position as a leader means you hold so much responsibility that trying to self-care at the same time is difficult or sometimes impossible – you cannot just put your responsibilities to one side.

When leaders are self-aware, they can become group-aware, which enables them to modify their own behaviour or responses to staff and situations. Increased self-awareness ultimately leads to constructive relationships in the working environment as staff feel listened to and understood, which generally leads to greater productivity. Self-awareness is something that is continually developed and involves constant reflection, not a one-off event such as a training course that becomes focused on achieving a certificate rather than putting what has been learned into practice.

An effective manager and leader should also recognise leadership traits in the staff team and recognise the influence they can have on the team. This can be both positive and negative as individuals can lead the team in actions that are not always positive for the manager or organisation. For example, if a staff member become demotivated or begins to speak negatively, this can influence others to think the same; suddenly there is a toxic atmosphere, which impacts on retention and staff turnover. If the same staff member receives praise and recognition for their efforts and perhaps is delegated areas of responsibility, they can influence progression and morale in a positive way. It is crucial to ensure that managers or leaders do not feel threatened but recognise the positive aspects. They should cultivate this by giving individuals tasks to utilise their strengths. Generally, this dissolves negative feelings and makes leaders in the team feel appreciated and recognised, but it needs to be managed if it is an issue or threatens the organisational culture or demotivates the team.

In my experience, I have identified six key elements in effective leadership that impacts positively on social care practice.

SIX KEY ELEMENTS OF EFFECTIVE LEADERSHIP

1. **Positive Communication:** This is considered one of the largest influencers in the workplace. If you choose praise and recognition over orders and criticism, the tone of your leadership will be set.
2. **Gratitude:** Acknowledging the hard work of the staff will increase morale, build trust, and create a strong and robust team.
3. **Team Building:** Create an environment where gossip or negativity is not tolerated and ensure value and respect are promoted within the team. Recognise strengths and areas for development and show that you are human.
4. **Empower and Develop the Team:** Create opportunities for learning. Provide and participate in training, share knowledge, and empower others to become leaders.
5. **Take Responsibility:** Admit mistakes and do not let others take the blame. This encourages others to do the same and creates transparency and trust.
6. **Show Empathy:** Emotional intelligence is a requirement in effective leadership. You need to understand where people are coming from even if you do not agree with them (i.e. group awareness). Showing empathy makes people feel understood and therefore leads to greater job satisfaction.

TASK 4

Read 'Lessons from Geese: A Better Way to Lead' by Lolly Daskal, available at <https://www.lollydaskal.com/leadership/lessons-from-geese-a-better-way-to-lead/>



Tips for Practice Educators

An important element for students' understanding of this proficiency is to experience and observe different leadership and management styles while out on practice placement. It will be useful to the student to make notes and reflect on the approaches and their impact on team dynamics, morale and productivity. In turn, they should reflect on their experiences and the impact of management on the service users' daily life events. How these correlate with the leadership and management in the organisation will form part of pivotal learning.

Students should be provided with a placement supervisor. This supervisor should be experienced and a member of the management team who can provide a platform for the student to reflect on their experiences and ask questions. This should be

considered constructive feedback for the organisation as it is highly beneficial to see the perspective of the student from their placement experience and as a future practitioner and potential colleague.

It would be a positive experience for the student if they could attend training that is provided to the staff team as it will enhance their understanding of the core elements of care provision and allow them to form an association between the training and how it translates into practice. An activity could be introduced whereby the student creates a reflective piece to bring to a team meeting based on the training and the team can reflect and give feedback on how the core concepts are integrated into day-to-day practice. This would be a useful tool for everyone to see the concepts from a range of perspectives, to enhance the correlation of training and provide a great learning and professional development opportunity for the student.

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Chapter 34 – Gillian Larkin and Marian Connell (D2SOP11)

Domain 2 Standard of Proficiency 11

Understand and be able to discuss the principles of effective conflict management.

KEY TERMS

The brain and emotions
Emotional intelligence
Self-awareness
Conflict styles
Principles of conflict management

Social Care work is about being in relationships with and listening to service users and their narrative to help and support them to flourish in their lives.

This chapter will outline key principles of conflict management (Weinstein 2018), drawing on case vignettes from social care practice to help explore ways to manage conflict in social care settings. It will also explore emotions and concepts for developing your emotional intelligence and explore different conflict styles.

At its core, social care work is a relational-based practice (RBP) (Mulkeen 2020). Social care workers engage in relationships not only with service users but also with colleagues, and central to the development and maintenance of such relationships are the concepts of trust and respect, underpinned by the key theoretical framework from Rogers (1957) that includes empathy, congruence and unconditional positive regard, and working from a human rights-based approach. However, RBP understands that people are rational and emotional beings. According to McGarr and Fingleton (2020), the primary tool at the social care worker's disposal is the 'self', and the 'self' brings into these relationships all their experiences, values, beliefs, ideas, attitudes, feelings and behaviours. This view can be applied to the service user too, and when there are differences

between people, conflict can occur. Higazee (2105: 1) posits conflict as a dynamic process that can be positive or negative, healthy or dysfunctional within a work environment. A common misunderstanding is that conflict is in some way a breakdown of normality, and is viewed as detrimental to those involved; however, conflict can lead to new ways of thinking, new practices and the growth and development of the people and the organisation (Everard *et al.* 2004).

In addition, social care workers play different roles, including care provider, advocator, educator, mentor and manager. These roles lead to various types of connection between social care workers and their service users, work colleagues and the wider multi-disciplinary team, including family members of clients, which increases the possibility of conflict within a social care environment. Keogh and Byrne (2016: 78) argue the need for 'social care workers to engage in ongoing continued professional development and professional supervision' to develop 'skills in managing resistance and/or defensive responses' that can contribute to conflict management.

Reflection

Why do social care students need to understand the principles of conflict management in a social care setting?

Before we explore what conflict is, take a moment to think about your experience of conflict in your home life. Are discussions viewed as an argument or an exchange of views? When there are disagreements, are they viewed as one person winning and one person losing? Do disagreements lead to silences? Fear? Anger? Rejection? Are disagreements avoided at all costs? Or do they lead to hearing another viewpoint, learning, and developing an ability to agree to differ?

How we view conflict and our experiences of conflict impact on how we engage in conflict; whether we see it as a battle or a learning experience, whether we view it as a winner and loser scenario, whether we embrace it or hide from it, or whether we see it as an opportunity for growth and development.

What is Conflict?

Conflict, defined by Doel and Kelly (2014: 21) 'is a group dynamic that occurs

when there is a difference of opinion, or a disagreement regarding the work or functioning of the group'. Conflict is unavoidable and can occur between professionals, between staff and service users and/or their family members; thus, having the skills to manage conflict is essential in social care work.

Conflict between Professionals

Conflict may emerge within the team that we are working in or in a multidisciplinary team that we may work alongside. Unlike other professions, social care work is unique in several ways which can contribute to conflict arising, including workers spending much of their working hours sharing a daily living space with staff teams (Share & Lalor 2009), and working a shift with staff members who have different values and beliefs. Thus, the social care worker may have to use their conflict resolution skills to de-escalate conflict arising between themselves and colleagues, or, if they are in a management role, between staff members.

Conflict with Service Users

Service users engage with social care services to have their needs met. Sometimes it is their choice; at other times, such as when service users are placed in residential or foster care, they may have had no choice in who they live with or where they live. Additionally, social care workers may engage with service users who have experienced abuse or neglect, present with behavioural, psychological and mental health problems, disability or addiction that contribute to poor emotional regulation (Keogh & Byrne 2016), which may contribute to incidences of conflict. Conflict resolution skills are essential in this context.

Types of conflict (Hizagee 2015)



Diagram created by the author based on Hizagee's (2015) Types of Conflict, illustrating six categories: Intrapersonal Conflict, Interpersonal Conflict, Intragroup Conflict, Intergroup Conflict, Competitive Conflict, and Disruptive Conflict.

While conflict can be healthy, Prendiville states that conflict is 'an indication of competition between people which has surpassed a healthy level' (2008: 65), and the figure above identifies different type of conflict that can be experienced (Higazee 2015). Scannell (2010) cites how unaddressed conflict can cause groups to collapse, while Jones *et al.* (2019) state that unresolved conflict in the workplace can cause low morale, poor performance, frequent absenteeism, and an increase in stress, combined with feelings of hostility, anxiety and anger.

Reflection

Reflect on the different types of conflict you have experienced working in a team. What was your emotional response to experiencing conflict? What strategies have you used to deal with conflict? Can you link your response to your previous experiences of conflict?

To support social care workers in engaging in conflict resolution, learning commences in their undergraduate training where students have multiple opportunities to engage in exploring their core values and beliefs through practice-based professional practice, workshops and practice placement. This learning advises social care students to seek resolutions to issues that emerge with their peers through identifying emerging triggers and developing clear

communication patterns and active listening skills. Excellent critical reflection and self-awareness skills are a prerequisite in assisting with this process and students are encouraged to adopt a more open-minded view of conflict while utilising a compassionate approach to themselves and others. These topics are explored in more detail later in the chapter.

Why does Conflict Occur?

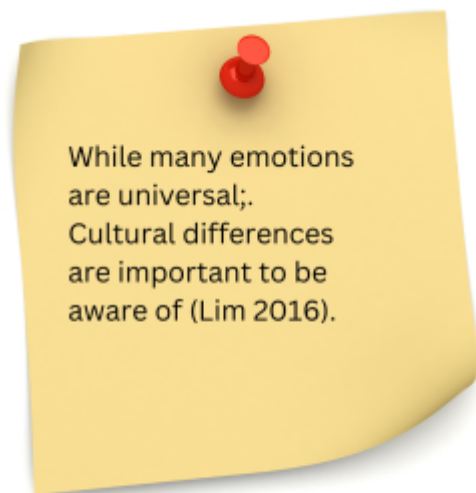
Research carried out by the nursing profession (Jones *et al.* 2019; Marquis & Huston 2012; Kleinman 2004; Tomy 2000) highlight many reasons for conflict – limited resources; competition between professionals; variations in economic and professional values; reform; poorly defined roles and expectations; the ability to work as a team; interpersonal communication skills – and these can be equally applied to the social care profession.

Case Study 1

Monieka, aged 12, is living in a residential care home. Due to an acquired brain injury Monieka is unable to understand when she is full, resulting in overeating. A plan devised with a dietitian that involved structured meal plans, portion control and treats was implemented. When Monieka's key worker was not working, staff in the unit brought Monieka out for treats to the tea shop and failed to adhere to her plan. At the team meeting, Anne, her key worker, was very cross and became red in the face and her heart raced when she talked about the plan not being adhered to. She became even more irritated when staff member Queen, raising her eyebrows, said it had only happened a couple of times and she was over-reacting. Paul, another staff member, said in a raised voice that he did not like his work to be analysed by staff not on duty.

- What is the cause of the conflict?
- Why did Anne respond as she did?
- What are the emotions emerging for the team?
- What are the reasons for the emotions?

What are Emotions?



According to Hockenbury and Hockenbury (2007), an emotion is a complex psychological state that involves three distinct components: a subjective experience; a physiological response; and a behavioural or expressive response. The first component, the subjective experience, relates to how we understand the emotion. To illustrate, the emotion of anger may translate into mild annoyance for one person to blinding rage for another. Emotions can also be mixed; for

example, you might be excited and nervous about starting a new job, and these emotions can occur either together or separately. The physiological response relates to a physical reaction we experience when we have an emotion, e.g. sweaty palms, heart racing, shallow breathing, stomach unsettled, redness, trembling and so on. The behaviour response is the display of emotion, so the smile indicates happiness, the distorted face anger and so on.

We as social care workers spend a large part of our time interpreting the emotions of the service users we work with, but also of our colleagues. Equally, they are interpreting our emotions through our behaviour. Looking back to Case Study 1, we can ask: Why was Anne cross? Why was Queen dismissive of Anne's feelings? Why did Paul raise his voice? By being able to correctly interpret the emotional displays of other people, we can respond appropriately. This is very important in conflict as to not understand yourself or others can lead to a negative emotional response due to amygdala activity.

The Brain and Emotions

Have you ever completely overreacted to a stressful situation/person/event? This is known as an emotional overload or, as coined by Goleman (1995), an amygdala hijack. You usually know you have had an emotional hijack if afterwards you or someone else asks, 'What were you thinking?' The usual response is 'I wasn't thinking' and this would be correct.

Goleman (1995) argues that we usually process information through our cortex or 'thinking brain'; this is where logic (thought, judgement) occurs. However, there may be occasions where the 'thinking brain' is bypassed and signals are sent straight to the 'emotional brain' (limbic system). When this happens, there is an immediate, overwhelming emotional response disproportionate to the original event. The information is later relayed to higher brain regions that perform logic and decision-making processes, causing you to realise the inappropriateness of your original emotional response. In social care, there may be times when service users experience this kind of emotional overload, due to previous trauma and an inability to regulate their emotions. While social care students and workers tend not to experience this emotional overload, they can and do still experience an emotional response due to the activity of the amygdala. This can often be brought on by stress, fear, anxiety or anger and can result in conflict.

A stressful situation such as an approaching work deadline, service user/colleague difficulties, difficult tasks, role conflicts or emotional exhaustion can trigger a surge of stress hormones such as adrenaline, norepinephrine and cortisol that produce physiological changes such as the heart pounding, breathing quickening, muscles tensing, the appearance of beads of sweat and the 'fight- or-flight' response. This immediate emotional response was essential to early humans who were exposed to the constant threat of being killed or injured, so to increase survival, the fight-or-flight response evolved – an automatic response to physical danger that allows a person to react quickly without thinking.

In today's world, you are unlikely to experience the same threats as our forefathers; however, you are likely to experience other kinds of threat, such as behaviours that challenge from service users or colleagues, people in in your daily life, and stress. When you sense danger is present, your amygdala automatically activates the fight-or-flight response. However, at the same time, the frontal lobes in your neo-cortex are processing the information to determine if danger really is present and, if so, the most logical response to it. When the threat is mild or moderate, the frontal lobes override the amygdala, and you respond in the most rational, appropriate way. However, when the threat is strong, the amygdala acts quickly. It may overpower the frontal lobes, automatically triggering the fight-or-flight response, which while not leading to a hijack of emotions, may lead to you reacting, resulting in negative behaviours such as raised voices, silence, avoidance, withdrawing or forcefulness, which impact the individual, the work environment and often the service users (Howard 2004).

Case Study 2

Sarah regularly cleans out the bedroom where staff stay when on a sleep-over. One day, she unknowingly throws out Martin's toiletries, which he always leaves in the wardrobe. The next day, Martin discovers his toiletries are missing and erupts at Sarah. She responds by saying he should have clearly marked them as his belongings. They both leave this exchange feeling angry: Sarah feels under-appreciated for the work she does to clean the staff bedroom while Martin feels that no one respects his personal belongings.

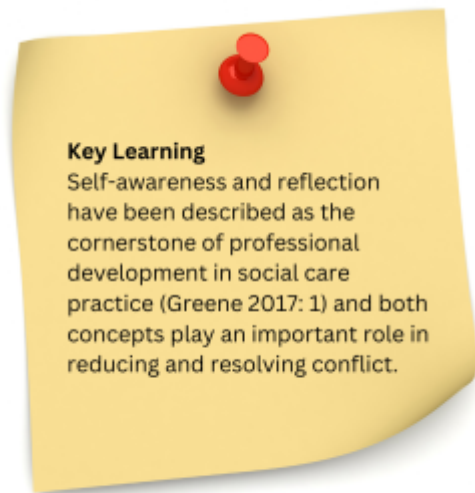
- What is the cause of the conflict?
- What are the emotions emerging for Sarah and Martin?
- What has been left unsaid?
- How might this be resolved?

The Amygdala Response and Conflict

To gain a better understanding of what happens when we experience a threat or stress which can result in a fight-or-flight response, let's look at Mary's experience:

*I was in a disagreement with a colleague who would not let me speak and constantly talked over me. I started to experience some **physiological responses** – **my heart rate increased, my breathing became rapid, my body started to shake, and my voice was quivering. The active amygdala also immediately shuts down the neural pathway to my prefrontal cortex,** so I become disoriented in the heated conversation. I was unable to make any kind of decision and could not see my colleague's perspective, only mine. As my attention narrowed, I found I was only concerned with my safety, which in this instance was 'I'm right and you're wrong.' Even though I knew my colleague well I could not remember a positive thing about her. **[When our memory is compromised like this, we cannot recall something from the past that might help us calm down and instead we feel the amygdala indicating 'Danger, react. Danger, protect. Danger, attack.'** When the amygdala is active, we cannot choose how we want to react because the old protective mechanism in the nervous system does it for us.] I shouted at my colleague to be quiet, which resulted in my colleague snapping back at me.*

How to Manage Conflict

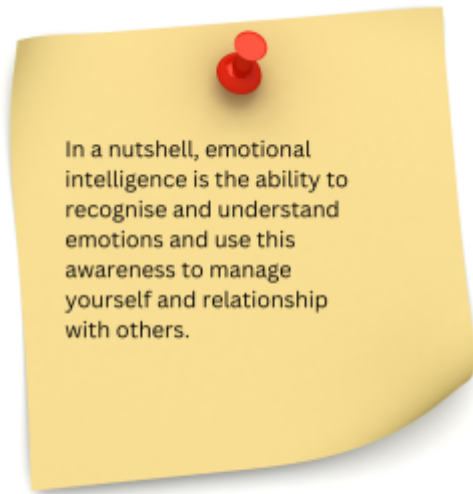


Key to managing conflict is not allowing our emotions drive us and making sure to **respond and not react**. In the example above, Mary allowed her emotions to take over and she reacted to her colleague, rather than responding. To manage conflict constructively, we need to be able to take charge of our emotions; in essence, we need to be able to override our automatic response to a threat or stress, as this will enable us to respond more appropriately.

Self-Awareness

Self-awareness is the exploration of our feelings, behaviours and thoughts. It is about recognising our skills and limitations and what impact they may have on others. It is also about recognising how external and internal events affect us and how we respond to them (Sharples 2013, cited in Stonehouse 2015: 1). Hayes (2004: 37) states that 'the more we are aware of our values, beliefs and attitudes (and how these affect the assumptions we make about ourselves, others and the situations we encounter), the better equipped we will be to read the actual or potential behaviour of others and to construct effective courses of action in accordance with our reading.'

The Role of Emotional Intelligence (EI)



Emotional intelligence (EI) has been identified as an important component of self-awareness. EI has been noted as playing a significant role in positive workplace outcomes, and that includes managing conflict constructively (Schlaerth *et al.* 2013). EI has been defined as the individual's 'ability to motivate oneself and persist in the face of frustrations; to control impulses and delay gratification; to regulate one's moods and keep distress from swamping the ability to think; to

empathise and to hope' (Goleman 1995: 34). Employees who have high levels of EI can accurately perceive, understand and appraise others' emotions and build supportive networks.

They are also considered more interpersonally sensitive and understanding, warm, protective of others, less critical and deceitful, and more likely to turn to the better perceivers for advice and reassurance (Abas *et al.* 2012). Howe (2008: 12) notes that the emotionally intelligent worker understands that emotions affect behaviour, beliefs, perceptions, interpretations, thoughts and actions. If you have EI competence you will understand when a friend is feeling sad, when a colleague is angry, and you will understand when you are angry, sad, happy, scared. This knowledge will enable you to manage your emotions in a more positive way, which can reduce or eradicate conflict. Daniel Goleman's (1996) model of EI comprises five realms: know your emotions, manage your emotions, motivate yourself, recognise and understand other people's emotions, and manage relationships (others' emotions), and these are broken into four quadrants as detailed in the diagram below.

Figure 1: Emotional intelligence model (Goleman 1998)

	Recognition	Regulation
Personal Competence	Self-Awareness • Self-confidence • Awareness of your emotional state • Recognising how your behaviour impacts others • Paying attention to how others influence your emotional state	Self-Management • Keeping emotions in check • Acting appropriately • Handling stress • Pursuing goals
Social Competence	Social Awareness • Picking up on the mood in the room • Caring what others are going through • Hearing what the other person is 'really' saying.	Relationship Management • Getting along with others • Handling conflict • Clearly communicating • Using social skills to achieve success

Becoming more self-aware through increased awareness of how we are perceived by others is important for our emotional development. For example, it allows us to reflect on the emotional impact of our behaviours on others and can enable us to change our behaviours and regulate our emotions more efficiently. In essence, EI competence can reduce conflict. Although conflict is a main function of work culture, it leads to desirable outcomes only if resolved constructively and managed effectively (Schlaerth *et al.* 2013). To think rationally and respond rather than react emotionally, we need to allow the information to reach the logical part of the brain and we can do this by becoming aware of our emotional triggers and learning to take a moment before reacting. This is achievable through having EI competence, and according to Salovey and Mayer (1990) EI competences can be learned and developed¹, so students and workers can cultivate skills that support conflict resolution.

1. Resources to discover more about EI, questionnaires and exercises to increase EI:
<https://positivepsychology.com/importance-of-emotional-intelligence/>
<https://positivepsychology.com/emotional-intelligence-skills/>
<https://positivepsychology.com/emotional-intelligence-frameworks/>

Awareness about your Conflict Style

In addition to developing EI competence as a means of managing conflict constructively, an individual can learn what conflict style they have. The Thomas-Kilmann conflict mode instrument (TKI)² has been used successfully to help individuals in a variety of settings understand how different conflict styles affect personal and group dynamics. The TKI measures five 'conflict-handling modes', or ways of dealing with conflict: competing, collaborating, compromising, avoiding and accommodating. These five modes can be described along two dimensions, assertiveness and co-operativeness. Assertiveness refers to the extent to which one tries to satisfy one's own concerns, and co-operativeness refers to the extent to which one tries to satisfy the concerns of another person (Thomas & Kilmann 1974 2007).

2. This Kilmann diagnostic website provides a range of resources, research and instrument to determine conflict styles: <https://kilmanndiagnostics.com/overview-thomas-kilmann-conflict-mode-instrument-tki/> This document provides the instrument and interpretative report: <http://www.lig360.com/assessments/tki/smp248248.pdf>

Figure 2: Models of conflict management (Thomas & Kilmann 1976, cited in Darjan & Tomiță 2015)



Diagram created by the author based on Models of Conflict Management (Thomas & Kilmann, 1976, cited in Darjan & Tomiță, 2015), illustrating five conflict resolution strategies: Competing, Collaborating, Compromising, Avoiding, and Accommodating, mapped along axes of Assertiveness and Cooperativeness.

In essence, the Thomas-Kilmann instrument (TKI) evaluates the behaviours of individuals in a conflict situation, how they react to certain situations and what is the most appropriate way to intervene (Ciorță 2020). Those using the competing style demonstrate a high concern for self, which is evidenced by the need to maximise individual gain, even at the expense of others. At the other end is the collaborating style, which seeks to find solutions to meet the needs of all involved. The avoiding style disengages from conflict completely, demonstrating a low concern for self, while the accommodating style puts others' needs before one's own, thereby sacrificing self-interest. Those with a compromising style tend to stand between co-operativeness and assertiveness and make concessions so that a resolution can be found (Thomas & Kilmann 1974).

This model does not assume that individuals have only one style in managing conflict, but it does suggest that they may have a preferred style that they defer to in conflictual situations. Similarly, the model does not purport to state that only a collaborating style is always the most suitable, but rather different style may be relevant to different situations (Darjan & Tomiță 2015). For example, if an issue is not important and confronting may be time-consuming, the avoiding

style may be best. However, if the issue is considered important, a competing style may be used. If we refer to Case Study 1, it could be assumed that Anne, the key worker, sees the issue as important and will use a competing style.

In helping to manage conflict effectively, it might help to ask the following questions, as the response may be influential when selecting a conflict style:

- How much do you value the person or the issue?
- Do you understand the consequences?
- Do you have the necessary time and energy to contribute?

Reflection

When conflict occurs, a social care student or worker has a choice – they can either react in a way that creates more conflict or respond in a way that create growth and harmony. According to Hocking (2006), when in conflict, professionals tend to use three styles to handle the situation – avoiding, forcing behaviours, and negotiating. This demonstrates that people usually deal with conflict in unhealthy ways, by either suppressing it or escalating the conflict. Suppression can include avoiding conflict, yielding during conflict, and withdrawing during conflict. Escalation can include forcing others, manipulation, being argumentative, threats. The use of reflection can help a student or worker to manage conflict in a healthy way.

Reflection is the purposeful rethinking of an action, the beliefs driving it and the resultant outcomes, to gain insight and understanding. Reflection enables the individual to step back and become critically aware of the assumptions, beliefs, values, hunches, biases and justifications that are pulling them into the conflict, and thereby provide insight through self-evaluation (Hocking 2006: 255). This reflection can occur prior to entering a conflict as well as throughout and after it, and it can help us avoid destructive scenarios, and create new communication patterns. While it can be a challenge to consider reflection when it feels like you are under threat or stress, the ability to pause and reflect does provide significant help. By taking the time to reflect, we are more likely to make some space within ourselves for understanding the actions, behaviours and viewpoints of ourselves and the other person.

Using the iceberg analogy, what we see in others is what is above the surface: tension, silence, withdrawal, stress, exhaustion, anger and disappointment. What we do not see is what is under the surface: fears, sadness, vulnerability,

powerlessness, self-doubt and other beliefs that drive others to protect themselves³ (University of Florida 2017). They equally only see what is above the surface in us too, and without self-awareness, EI and reflection, there is a propensity to view just the behaviours, which can result in conflict occurring.

Examples of Conflict in Social Care Practice

Case Study 3

Cathy is sitting in the office fuming. This is the third shift she has worked with Robert where she has had to make the dinner and he has done nothing to help. Cathy spoke to Mary and Princess about Robert not helping and they laughed and said, 'Ah, Robert just comes to the table hungry, like the kids.'

What is the cause of the conflict? How might the conflict be resolved?

Case Study 4

Paul is Tommy's key worker and is part of the care in review team. As Tommy is leaving the unit soon, discussions are ongoing as to where Tommy might live. Paul has been advocating for Tommy to go and live with his aunt as he has a good relationship with her and her family, and he will be near his mum, so building relationships will be possible. Tommy's social worker, Kay, considers another residential unit the best option for Tommy, due to ongoing behavioural issues. Paul is aghast at this suggestion and engages in a very hostile manner with Kay. Voices are raised and Paul is asked to leave the meeting to calm down.

What do you think has caused this conflict?

Review it from Paul's point of view. Review it from Kay's point of view.

How might a resolution be found?

3. This resource offers different questions you can ask to increase your knowledge of self and healthy conflict resolution: http://training.hr.ufl.edu/resources/LeadershipToolkit/job_aids/Mastering_Conflict_Through_Self_Awareness.pdf

Whether you are a student, a social care worker or a manager it is important to understand how conflict arises, the causes of conflict, and the best ways to defuse conflict situations or to prevent them escalating. Conflict cannot always be avoided and while the above aspects of EI and knowing and understanding our conflict styles can help us to manage ourselves through self-development and awareness, we need to know how to manage conflict when it arises. Weinstein (2018) has articulated seven principles to effective conflict resolution, which will enable both an individual and an organisation to understand, discuss and resolve difficult situations.

Seven Principles of Conflict Management

The first principle is *acknowledging the conflict*. Often when conflict arises, an individual may worry about it, avoid the person they are having the conflict with, talk about the person behind their back and so on; however, this often leads to an increase in stress and anxiety about the issue and it can grow ‘bigger’, so it is best to accept that there is a conflict. Weinstein (2018) states that at this stage you may be acknowledging the conflict just to yourself, but it is important to do this as it allows you to reflect on what happened, what caused the conflict, how you feel; and this reflection can help to bring some clarity to the situation. Wachs (2008) describes this as assessing the situation, and it is preparation for the next principle, which is to *take control of your response*. Here our EI competencies can help. If we have good awareness of ourselves and our triggers, and understand the impact we have on others, we are likely to be able to respond in an appropriate way. Similarly, if we are sensitive to the other person, we are likely to understand what they are feeling and thinking, and their emotions. If action is required, it is best to think clearly about the conflict – the issue, your feelings, the choices available to you – before you respond. Often, it is safest to take a break as this allows you to step away and think logically rather than emotionally about the issue, and thereby avoid an emotional reaction, which can lead to consequences for you.

The next principle suggests that you *construct a resolution* using a conflict resolution framework (Weinstein 2018)⁴. In Weinstein’s framework there are two

4. Weinstein’s The 7 Principles of Conflict Resolution (2018) offers an in-depth

steps: the first is to prepare the conversation: this includes areas such as managing your physical and emotional response, writing down your initial fears, wants and needs, accepting responsibility for how you act and respond in the dialogue, ensuring that you have all the correct information, and identifying potential outcomes. In the second part of the framework, where you are talking to the other person, use active listening, paraphrase and summarise to ensure clarity, and be aware of the importance of body language. When responding, Wachs (2008) highlights the importance of using words appropriately so they do not hurt and emphasises speaking factually, using 'I' statements, using words such as 'and' and 'instead', rather than 'but', as the former can lead to constructive discussions, while the latter can lead to a defensive response. The Thomas-Kilmann framework is useful at this stage as our style is very important in the negotiation element of conflict.

The first three principles can lead to an effective resolution between parties: however, if resolution cannot be reached, principle four discusses *managing the resolution via a third party*. This person will generally have a vested interest in the matter being resolved and could be the unit manager, or a colleague of the two parties. Their role is nonetheless one of neutrality and of ensuring a satisfactory outcome.

Whether conflict is resolved by the parties or via a third party, Weinstein (2018) discusses the importance of *creating a culture of early conflict resolution* and this is principle five. This means creating a context in which all people in the organisation can accept their role in conflict and use such situations to increase learning. This does require a cultural shift within organisations: the use of policies and procedures, conflict training, identified 'resolution agents', coaches, mediators and a positive attitude towards conflict modelled from senior management supports the development of a new culture. When addressing conflict and ways to resolve it, the role of the manager or team leader in a social care setting cannot be undervalued. Part of their role is to contain and hold feelings that arise out of conflict and facilitate appropriate ways of expressing these emotions to bring about resolution for their team (Winnicott 1964; Bion 1959). This may be achieved through formal or informal supervision, peer support and mentoring, debriefing following a critical incident and open and honest discussion at team meetings.

appraisal of conflict and ways to resolution with a variety of activities and case studies to support understanding and development in this area.

Principle six is *walking the walk*. This is a particularly important part of conflict resolution. Weinstein (2018) posits that if we belong to a culture that accepts and engages with conflict, we need to take responsibility for our behaviour and conflicts at work and with the relationships we have with the people we engage with every day. How do we respond to conflict? Do we contribute to conflict? Are we willing to look at how we respond and react? To help us, Weinstein provides the CAN inventory, a quick personal check that we can run through daily to raise our **C**onsciousness about the conflicts in our lives, **A**cknowledge them as potential triggers for change and growth and **N**ow take action⁵.

The final principle discussed by Weinstein (2018) is the *necessity to engage the safety net*. In some instances, informal resolution will not work, so it is important for the individual to know what policies are in place within the work environment should a resolution not be possible.

Summary

7 Principles of Conflict Management

- Principle 1: Acknowledge the conflict
- Principle 2: Control your response
- Principle 3: Construct a resolution
- Principle 4: Discuss managing the resolution via a third party
- Principle 5: Create a culture of early conflict resolution
- Principle 6: Walk the walk
- Principle 7: Engage in the safety net (Weinstein 2018)

TASK 1

5. For more detail on the CAN inventory go to: <https://learning.oreilly.com/library/view/the-7-principles/9781292220949/html/chapter-010.html>.

Revisit Case Studies 3 and 4 and consider how you would apply Weinstein's (2018) seven key principles to resolve the conflict emerging.

1. Identify a situation where you recently experienced conflict.
2. What was your emotional response?
3. What differing viewpoints, values or beliefs created the conflict?
4. How did you resolve the conflict?
5. What could you have done differently?
6. Identify skills and competencies that you drew on to resolve the conflict.
7. What policies, legislation and support are in place to support you?



Tips for Practice Educators

Tips for Conflict Resolution for Students/Practice Educators/Managers

- Accept that conflict can be positive and can lead to growth and development.
- Take responsibility for your responses.
- Acknowledge conflict and 'take a breath' before responding.
- Use supervision as a means of reflecting on practice and learning and developing new skills in managing responses to difficult situations (Keogh & Byrne 2016).
- Engage in continuous professional development to understand self and emotional responses (Keogh & Byrne 2016).
- Create a culture of openness and commit to improving staff communication mechanisms and make discussions part of team meetings.

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Chapter 35 – Natasha Davis-Dolan (D2SOP12)

Domain 2 Standard of Proficiency 12

Understand the need to work in partnership with service users, their relatives/carers (if appropriate) and other professionals in planning and evaluating goals and interventions, as part of care planning and be aware of the concepts of power and authority in relationships with service users.

KEY TERMS

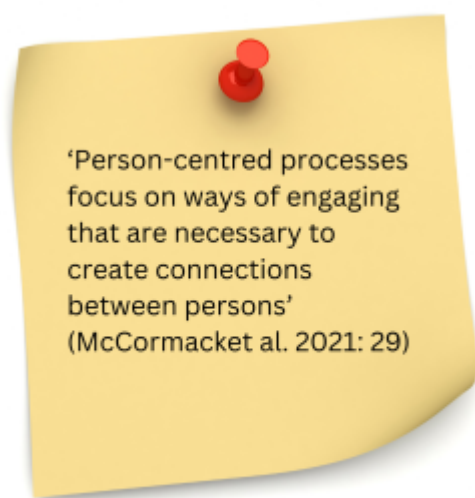
A partnership approach
Key skills and qualities
Social care in practice – case studies
Power and authority

Social care is ... the provision of professional care, protection and advocacy for and on behalf of vulnerable people and groups across the life span. Social care workers identify areas of need where support is required and implement solutions and interventions to address these needs. A partnership in social care involves two or more individuals or organisations working together towards a common goal or shared interest.

Introduction

Social care workers are employed in a wide range of settings supporting children and adults who experience disadvantage, discrimination, social exclusion, prejudice, marginalisation and oppression. Working with children and young people in care and aftercare, I have experienced first-hand the importance of adopting a partnership approach with service users, with parents/carers and with other services. This proficiency highlights the importance of adopting this approach in order to meet the needs of service users. McArthur and Thompson (2011) advise that the effectiveness of family support work is dependent, in part, on working in partnership and applying a child and family-centred approach

when addressing the needs of children and families. Fahlberg (2012: 239) stresses the need to establish a partnership with parents when it comes to decision-making as *'no matter how scanty their knowledge, at the outset of case interventions and planning, the parents know more about their child than anyone else'*, therefore, *'for the sake of the child and the parents both, an alliance must be built with the family'*. Research conducted by Gilligan (2019: 226) on the Irish foster care system reiterated the importance of working with service users, relatives and carers, confirming that a *'stronger emphasis on person-centred work with children in care and their family members'* is required.



This chapter will focus on children and young people in care and aftercare and it will highlight the importance of and the relationships required to work in partnership and ultimately support the achievement of better outcomes for children and young people in care and aftercare. These relationships include the social care worker and the child or young person; the social care worker and the parents/ carers; and the social care worker and other professionals and services. The ability to build relationships

and work in partnership in social care requires certain skills and qualities which are the building blocks to a mutually respectful and trusting relationship.

Building a partnership and the achievement of better outcomes is not without its challenges (Lalor & Share 2013: 252). However, equipped with the necessary skills and attitudes, the social care worker can successfully build a partnership. This chapter aims to promote awareness regarding the need for a partnership approach in social care and demonstrate, through the use of fictional case studies, how building partnerships is essential when working with these client groups. Three practical case studies are provided, upon which the student can examine, discuss, reflect upon and find solutions to best work through the underlying problem which acts as a barrier to the development of an effective partnership. Each case study, while not based on true events, are situations which can arise when working with children and young people in care.

The Partnership Approach in Social Care

The rights of children in Ireland are protected by:

- Child Care Act 1991
- Children First Act 2015
- Children First: National Guidance for the Protection and Welfare of Children
- United Nations Convention on the Rights of the Child.

Section 45 of the Child Care Act 1991 places a statutory obligation on Tusla, the Child and Family Agency, to make determination as to the support required for young people making the transition from care into aftercare. The Child Care Amendment Act 2015 requires that Tusla prepare an assessment of need and an accompanying plan for young people progressing to aftercare which identifies the needs of the young person and the supports required to achieve those needs (Tusla 2017). Child-centred planning, such as an aftercare plan, ensures that children and young people are heard and that the welfare and best interests of the child and young person are of the utmost importance. Access to parents is also the right of a child, reinforced by Article 9(3) of the United Nations Convention on the Rights of the Child. In situations where a child is separated from a parent, such as when placed in the care of the state, the Convention provides for the child to have access to one or both parents. The Convention places obligations on state parties to *'respect the right of the child who is separated from one or both parents to maintain personal relations and direct contact with both parents on a regular basis, except if it is contrary to the child's best interests'*.

In order to realise the rights of the child or young person, the social care worker and other professionals work in partnership with the child as part of a care planning process. This provides for the child's voice to be heard in the decision-making. The Children First Act 2015 and *Better Outcomes, Brighter Futures: The National Policy Framework for Children and Young People 2014-2020* (DCYA 2014), place certain obligations on those working with children to promote the achievement of the five national outcomes, which include safety. In order to achieve this outcome, Tusla (2015: 11) advises that:

'Children and families are most likely to do well if they are provided with appropriate support in a timely fashion that is well coordinated, with good communication and partnership working between all professionals. From both a policy and practice perspective, partnership with families and between key

agencies is essential. There is a need for on-going dialogue between parents, children and service providers to ensure that all those involved contribute to common solutions.'

TASK 1

Read Chapter 38 by Des Mooney for information on how professional partnerships are achieved through inter-agency collaboration.

A need also exists to increase the child's participation in care and care planning (Gilligan 2019: 224). There is anecdotal evidence that suggests that children in care and aftercare display characteristics such as anger and suspicion towards adults. This is indeed my own experience with children in care and highlights the necessity of a partnership between the social care worker and the child or young person. Lalor and Share (2013) suggest that building relationships with children and young people in care may prove challenging as the child or young person may have no previous experience of a trusting relationship. Therefore, the social care worker must work in partnership to support the child or young person through direct work, building trust to establish a safe place where the child or young person can feel comfortable and secure in expressing personal needs and goals. Parents whose children have been placed in care may experience displaced anger towards the social care worker and other professionals (Fahlberg 2012: 192). This anger, coupled with raw emotion and mistrust, can result initially in a volatile partnership that may take time to build, where the social care worker has to work harder to support the parent in building the confidence and capacity to parent well. Chapter 38 provides a detailed insight into professional partnerships through inter-agency collaboration resulting in better outcomes and will therefore not be discussed in detail here. The following table outlines the benefits of creating partnerships.

The Benefits of Working in Partnership when Evaluating Goals and Interventions

A partnership builds trust where the voice of the child or young person is heard and both child and parental autonomy is respected.

A partnership provides for a child-centred and family-focused approach.

Working in partnership and encouraging participation in care planning and decision-making is shown to reduce anxiety and stress in both children entering care and their parents (Moran *et al.* 2016: 12).

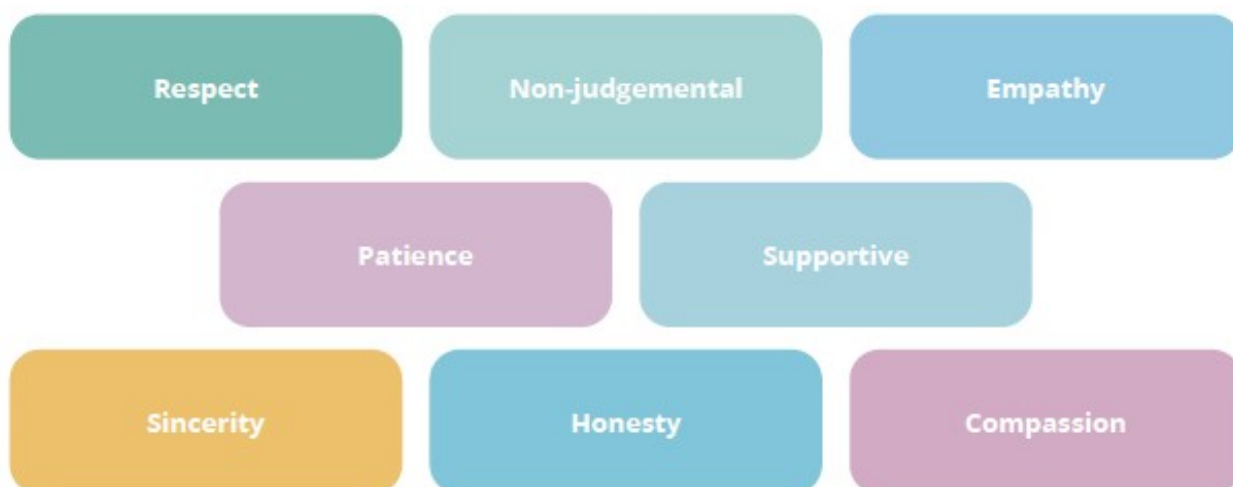
Building a partnership with service users, parents/family and other services can act as a protective factor which Moran *et al.* (2016) advise is '*a person, process or system that helps to protect a young person from circumstances or risk factors that could adversely affect their quality of life or life chances*' and includes '*both formal policy measures and programmes aimed at improving young people's lives*'. Biological family members such as grandparents and siblings, according to Moran *et al.* (2016), can provide a protective factor for children and young people in care and aftercare and help to support a smooth transition from aftercare to living independently.

Partnership with other services and professionals promotes shared learning through interagency collaboration promoting increased efficiency in the delivery of support and service (McArthur & Thompson 2011).

A partnership approach can empower parents to become better parents, supporting them to work through problems and find solutions.

The inclusion of foster parents in care planning and a partnership approach regarding the child promotes positive fostering outcomes (Lietz *et al.* 2016), while Moran *et al.* (2016) advise that a collaborative approach which increases the participation of the child and all relevant adults in the care planning process can promote positive care experiences and better outcomes for the child.

Key Skills and Attitudes Required for Quality Partnerships



Author-created diagram illustrating Essential Skills and Attitudes for Building Meaningful Partnerships.

The key qualities and skills illustrated above are the building blocks required to develop and effectively build a partnership or relationship with a child or young person in care, a parent who may have children in care, a carer such as a foster parent, or another service which impacts on the child's life, for example school, disability and mental health services, aftercare services and psychologists. Key qualities include compassion, patience, supportiveness, empathy, a non-judgemental attitude and respect. Corless *et al.* (2017) also identify patience, empathy, a non-judgemental attitude, respect, and honesty as some of the key skills and qualities which contribute to rewarding relationship and partnerships in family support. Sincerity, patience and genuineness were also noted as key skills. Communication skills, self-awareness and self-reflection are also essential, including reflection on any bias which may act as a barrier and slow down or prevent the establishment of a mutually respectful partnership. The building blocks to quality partnerships remain unchanged regardless of who they are with. The skills utilised are not going to change when communicating and working in partnership with a service user or when supporting a parent or another service provider. Where a caseworker displays a positive, caring and nurturing attitude towards birth parents, the probability of the parents experiencing positive change and growth increases (Fahlberg 2012: 237). Person-centred care and person-centred care planning provides the service user with a forum to communicate and be heard. However, the service user must trust that the social care worker will support the attainment of personal goals. This trust results from a partnership which was built step by step, block by block.

TASK 2

Review the reflection guide below and write down the answers to the questions posed on the potential gaps in your knowledge, skills and personal development needed to build partnerships.



Author-created diagram illustrating a reflective cycle for assessing and developing essential skills and attitudes for building meaningful partnerships.

Social Care in Practice

These three case studies provide examples of a partnership approach to social care work.

Case Study 1

Maria

Week 1

Maria is a young mother who has two children, aged 3 and 5 years. The children were placed in foster care two months ago, due to neglect. Maria's capacity to parent was seriously impacted by an addiction. Maria voluntarily entered into a rehabilitation programme for this addiction.

Supervised access for Maria and her children has been organised by the social work team.

You are assigned to meet the foster parents with the children on the morning of access and then meet Maria at a local Tusla building for a 1.5 hour fully supervised access visit. The foster parents are quite anxious leaving the children. Mum arrives and is very excited to see the children, and they embrace. On entering the room in which the access is to take place, you observe many toys, blocks and colouring materials. Maria sits down and begins to talk to the children. The children appear to enjoy this time with Maria but are young and soon become bored. John, who is 3 years old, starts to cry and Billy (5 years) runs round and round the room in circles. Maria appears deflated and hands Billy her phone to look at cartoons. The children then sit watching the cartoons and do not engage any further with Maria despite her many attempts.

What can you as a social care worker do to enhance this valuable time for Maria, John and Billy?

How can you work in partnership with Maria to encourage her to become more involved and interactive with her children?

Is there a need to also work in partnership with the foster parents and the children?

What are the benefits of working in partnership for Maria, John and Billy and also for you, the access worker?

Week 2

The following week you ring Maria to discuss the upcoming access. You ask Maria if she would like to prepare an activity for the children to engage in. Maria does not respond. You

suggest some age-appropriate games and activities. However, Maria appears annoyed by each suggestion, stating they would not work with her children and that her children would not enjoy them.

What do you feel has caused Maria's annoyance?

How can you support Maria's autonomy as a parent?

Reflect on why parents whose children are in care may be reluctant to take on board suggestions and support offered by the social care worker and other professionals.

Suggest how you as a social care worker can build a partnership with Maria to ensure Maria and her children enjoy quality time together at each access.

Case Study 2

Kate

Kate has four children who are in foster care. You are briefed by the social worker on the case and advised that Kate can be inconsistent in her contact with the children. Therefore, the social worker feels it would be best if you made contact with Kate a number of times in the days preceding the access to ensure Kate has transport to and from the access and is aware of the time, duration and location. Access is arranged; however, Kate cancels on the morning of the access. Access is

rearranged but Kate once again cancels due to illness. You speak with Kate and are assured by her that she has everything organised for a newly rescheduled access. You ring the foster parents and communicate the new arrangements. Kate is getting public transport,

so you ring on the morning of access to confirm she is on the train. Kate confirms she is on her way and will arrive 20 minutes before access. You confirm the arrangements with the foster parents, assuring them that Kate is on her way. The foster parents and Kate's four children will have an hour-long journey to access and advise you that they will be leaving earlier to ensure the children have lunch before they meet with Kate. You are en route to the access when your phone rings and Kate advises that she boarded the wrong train and is now stranded with no connecting train to bring her to access on time. Kate states that she has forgotten her purse and that the next connecting train is later in the day. Kate is very upset at the possibility that she will not see the children and requests that the time of access is changed to later in the day. You are conscious that the foster parents and children are already en route but also that the social worker really needs this access to go ahead so that the children can spend time with Kate. You will be driving past the train station where Kate waits at the train station.

- Do you cancel access?
- What are the implications of doing so?
- Is there an alternative option?
- What are the implications of the alternative option?
- Can you see the need to work in partnership with Kate in order to ensure the children have regular and rewarding contact with her?
- Is there a need to work in partnership with the social worker also?

Kate's case is a reminder of the very thin line between empowerment and enablement!

The social care worker has to make a quick decision: either cancel the access, resulting in more disappointment for the children, another wasted journey for the foster parents and a parent who you know would benefit from seeing her children; *or* discuss with the social worker and arrange to pick Kate up and bring her to access.

TASK 3

Discuss the following questions:

What choice would you make?

Is this choice enabling or empowering Kate?

What factors do you take into consideration?

How can you support and work in partnership with Kate to ensure this does not happen again?

Case Study 3: Michael

Michael is 16 years old. He has recently been placed in an adolescent residential unit. Michael was initially placed in relative foster care; however, after a short time this placement broke down due to Michael's challenging behaviour which included self-harm, substance misuse and overtly sexualised behaviour. You are asked to undertake direct work with Michael in order to support the achievement of Michael's personal goals, which include a desire to gain part-time employment. You know that in order to do so, Michael will require support to express his emotions in a positive way. You have studied Michael's case file and feel that all interventions to date have focused on the challenging behaviour and have not explored the underlying reasons for the behaviours that challenge.

- Is there a need to work in partnership with Michael as part of his care planning?
- How can a partnership between Michael and the social care worker support Michael to find alternative positive ways to express emotions?
- In developing interventions to best meet Michael's needs and help him achieve his goals, is a partnership with other professionals important? Why?
- Is there a need for the case worker to work in partnership with other professionals and services in order to best support Michael?

Power and Authority

Social care work involves supporting service users, parents and families during times of need when emotions run high. The family, according to Clarke Orohoe (2014: 76) may feel powerless and unheard in interactions with support services. Research conducted by Gilligan (2019: 224-5) on foster care in Ireland reports that *'for some parents there seems to be a general sense of losing influence or status'* plus a sense of exclusion from the child's life heightened by *'the lack of information they receive about what is happening in their children's lives'*. Social care work with children and young people in care and aftercare as described in Case Studies 1 and 2, highlights the power imbalance that some service users and parents/carers may find challenging. This negative perception of who holds the power or authority can also result in challenges for the social care worker who hopes to develop a partnership with the service user or parent. The involvement of service users, parents and carers in decision-making and care planning can provide for the sharing of power, thus promoting better outcomes. Person-centred planning respects the rights, feelings, thoughts and

wishes of service users. This partnership approach to care planning empowers the service user, parents and family to participate meaningfully in decision-making and planning.

This proficiency raises the student's awareness of power and authority dynamics in social care practice and encourages the development of a self-awareness regarding power in relationships with service users. The student is also encouraged to use the case studies to reflect on the ways in which a perception of power can negatively influence partnerships and how a partnership approach can alleviate negative perceptions of who holds the power or authority in the relationship.



Tips for Practice Educators

This proficiency enables students to understand the need for and importance of working in partnership with service users, carers and other professionals.

1. **Help students to apply theory to practice.** Lalor and Share (2013) advise us that social care workers require a 'thorough knowledge of procedures, policies and legislation' and that it is this 'theory base that gives them an understanding of people, systems and practices'. This theory base is achieved through study and examinations. However, this proficiency requires more than theory, aiming to support a practical understanding as to why a partnership benefits service users, parents/carers and professionals.
2. **Focus on skills of partnership work.** Explore in supervision what skills and qualities the social care worker must possess in order to develop partnerships and why a partnership approach to care planning is essential.
3. **Design service-specific case studies.** Interactive case studies can be utilised to encourage the student to explore and reflect on different areas of social care practice, and examine the need for and types of partnership in each area. The student can then relate theory to practice. Case studies can be supported by gaining the insight of other professionals or services on their partnership with the social care worker in a range of social care settings. This insight can demonstrate to the student just how important the partnership between the social care worker and the relevant other professional is and how the partnership can support the development of person-centred care planning and interventions to meet the needs of service users. Guest speakers can also increase the student's awareness of the ways in which different services work in partnership with social care workers.

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Chapter 36 – Des Mooney (D2SOP13)

Domain 2 Standard of Proficiency 13

Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team.

KEY TERMS

Professional relationship as a process
Impact of professional on personal
Supporting roles of relationships

Social Care Workers are professional practitioners engaged in the practice of social care work. Social care work is a relationship based approach to the purposeful planning and provision of care, protection, psychosocial support and advocacy in partnership with vulnerable individuals and groups who experience marginalisation, disadvantage or special needs. Principles of social justice and human rights are central to the practice of Social Care Workers' (SCWRB 2017).

Introduction

This chapter sets out to explore the theme of professional relationships in social care practice. As professionals we do need to be mindful that at times there can be a blurring or misunderstanding of relationships in the workplace. Using the themes relationships as process, integration of theory to practice, communication, power, supports and teams, this chapter will explore some of the complexities involved in our work. While we work with the most vulnerable in society, we need to be mindful of the impact of this work on our professional relationships. Using a case study, the chapter will explore how difficulties in one area did impact on other areas. We will also look at how, through good communication and supports, relationships were strengthened with better outcomes for all involved.

Professional Relationship as a Process

Given that much of our work is driven by relationship-based practices it is incumbent on us to understand that how we act and react, our use of language and manner, and our actual practice, both with our colleagues and our clients, is very important. The bonds of trust between service users and social care workers are tenuous at the best of times and one false word or deed can significantly impair a previously positive working relationship.

We need to be mindful throughout our work that we understand the world and our experiences in a different way from many of our service users. The idea of trust has been shattered for many of them, so that any action or word can be interpreted differently from what was intended. As we form a professional relationship with a service user, we explore the ways in which the service user communicates and responds to messages. We work within the parameters of their understanding, not ours. We need to be kind and careful. It is important that when we impart information the service users completely understand what we are communicating. This could be important information relating to their care or placement; or it could be a joke. How we relate to our service users, our tone and body language are equally important.

Case Study 1

Blossom

A social care practitioner and student, Blossom (not her real name), approached me last year and wanted to talk. She explained she had been suspended from her full-time job for two weeks because a service user, Judy (not her real name), had made a complaint about her to the management of the agency she was working in. The agency has residential and day care settings for individuals with a range of intellectual disabilities. Blossom was upset and tearful and could not make any sense of what had happened. Blossom spoke about having a good 'relationship' with Judy, of 'getting on great', of being 'friendly' with her, of 'having a laugh', and of some of the work she engaged in with Judy. This work involved supporting Judy with daily tasks such as going to the shops, understanding and filling out forms, some personal tasks, and, playing games and talking. One of their routines was to go for a cup of tea each time Blossom was on shift. Judy was said to have looked forward to this.

I noticed immediately that Blossom regarded Judy as something of a friend and was proud of the work she had done with Judy. When I asked what led to the suspension, she explained that in the course of a conversation with Judy she had referred to her as a 'wagon'. She stressed that she was only joking and that within the relationship Judy should have understood what she had meant. Judy had become very upset by this comment and had subsequently made a complaint. The result

of this complaint was that Blossom was suspended for two weeks and had to make reparation with Judy. She had returned to work but realised that 'it wasn't the same'.

I spoke to Blossom about how I felt she had made an error, that she had thought she was in a 'friend' relationship with Judy, where loose language could be tolerated, that her boundaries were skewed, that the mantra 'friendly not friend' was absent, that, while being friendly, the social care practitioner had to maintain a professional relationship with the service user at all times – not sometimes. I asked Blossom did she think she was going to be sitting at home, PJs on, glass of wine in hand, watching *Ant and Dec's Saturday Night Takeaway* with Judy? Blossom replied with horror, 'Of course not.' I replied, 'Why, then, did you speak to her like she was one of your mates?' We spoke for a time about whose needs were getting met by the dynamic within the social care practitioner/service user relationship. We also talked for a while about how Blossom imagined Judy saw the relationship. Blossom thought about this for some time and then spoke of Judy really looking forward to 'me coming in'; of Judy smiling and waving when she entered the building and of Judy getting very upset when Blossom greeted someone else before she greeted Judy. I asked Blossom what they talked about. Blossom responded 'everything', but could not be specific about anything they had talked about.

Integration of Theory with Practice

Laura Steckley writes of students and practitioners of social care struggling to meaningfully integrate theory and practice 'with concerning gaps between what is being espoused in the literature and what happens in the field' (2020: 2). Phelan in Steckley (2020) notes 'the immobilising sensory overload experienced by students on placement and newly qualified practitioners', describing how they instead turn to "common sense" explanations and approaches' (2000: 2); of a sense among some students that theory is a university requirement rather than an aid to practice. 'This lack of integration or even rejection of a theoretically informed basis for understanding and decision making has concerning consequences – not only for the development of the workforce, but for the care experiences and outcomes of children and young people' (2000: 2). While Blossom understood the importance of maintaining a relating approach in her

relationship with Judy she had not adequately reflected on what was in fact taking place. The ‘immobilising sensory overload’ Phelan notes is a very common place for students and people new to social care. At times they are fooled into thinking that what we do is simple, when in fact they are not quite grasping what is taking place. At other times it can be overwhelming.

Cameron notes the difficulty in breaking down communication into a skill set and of producing meaningful criteria for assessing its quality, while also noting how safe and appropriate practice to service users has a moral and ideological dimension. ‘Therefore, it is important to give trainees the opportunity to discuss – and reflect critically upon – the beliefs and values that underpin judgements on communication in care settings. If they are presented as simply common sense, there is no way to resolve the problems and contradictions which may arise in real world situations’ (2004: 71). The ability to reflect upon practice through positive working relationships, supervision and other supports gives us practitioners the opportunity to unravel the complicated messages we are experiencing all the time. Over time it became clear that Blossom was not reflecting on her relationship with Judy, rather was taking a ill-considered common sense approach and not thinking in a deeper way about how one dynamic might support another and how these in turn might reflect in better outcomes for Judy. The cup of tea remained ‘just’ a cup of tea and not an opportunity.

Power within the Professional Setting

Grainger notes power differences: carers, though themselves not a powerful group, presenting ‘their own definition of reality as more valid than that of a confused elderly patient’ (1998: 54); carers entering into patients’ ‘confused fantasies’ ‘because this made it easier to secure co-operation with routines’ (1998: 55). Seden notes the importance of communication; of a process involving thoughts, feelings, ideas and hopes being exchanged between people. Seden also notes how important it is to respect the values and beliefs of others and for carers to be consistent in their professional authority and function. ‘Meanings must be checked carefully, and in each exchange, care needs to be taken to be aware of, and reduce, the blocks to communication that can come from the many differences between individuals, such as authority and power, language, ability and disability, personality, background, gender, health, age, race, class’ (2004: 214).

Clearly Blossom needed to be more aware of what she was saying and how it might be understood by the service user, and, of the power dynamic on display. On the face of it there were two people sharing a cup of tea. Judy clearly enjoyed her afternoon tea with Blossom. It appeared to me that Judy was in control of the relationship and understood that Blossom, a staff member, took her out for a treat every time she came in; while Blossom appeared to think something else, that she was engaging in important work with a client (she was, actually) and that this in some way involved befriending her. Sometimes you don't have to chase the work; it is right in front of you and you don't have to tamper with it. If Blossom had done nothing at all maybe Judy would have enjoyed their time together more. By being overfriendly with Judy, Blossom made Judy feel uncomfortable; so uncomfortable that she made a complaint. The relationship already existed between social care practitioner and service user.

It was evident that Blossom had been engaged in some good work with Judy, and she definitely thought she was doing good work. Perhaps when Blossom made the remark Judy sensed a change in the power dynamic; from one where she was comfortable to one where Blossom was 'in charge'. This prevented the relationship from progressing to one where practical social care issues could be addressed. It is often said by social care workers, 'I get lots of work done in my car.' I take this to mean a situation where a social care worker and their key person (for example) share a journey where gentle conversation, space, time and lack of intrusion from others allows firmer foundations to be created for stronger relationships, trust to be built and further work to take place.

Case Study (continued)

Blossom was Initially irritated by my comments, but we began to talk about relationships in work in general. Blossom was not getting regular supervision, she had 'good, not great' relationships within the wider staff team and had felt marginalised by the team at times. In addition, Blossom felt she was learning nothing while working in this agency. I spoke to Blossom about the links between college learning and workplace practice and noted that her application to boundaries and actual simple things was troubling. The most troubling aspect was when Blossom explained to me that she fully understood what I was saying but this had not been explained to her in her workplace. While Blossom was punished for referring to a service user as a 'wagon' the incident was explored at surface level only and little learning had taken place. It was interesting to note that Blossom seemed to think that the service user/client was her friend, while at the same time stating that she had no real friends or people to talk to on the staff team. Perhaps Blossom's relationship with Judy was in some way compensating for her lack of relationships within the wider staff group. This matter was further conflicted by Blossom having no avenue to discuss such inconsistencies

through informal talk or regular supervision. Blossom continued to shield herself through the belief that she was engaging in powerful work and was demonstrating good relationships while in fact doing the complete opposite.

The Dance (Part 1)

Some might argue that Blossom was lucky to keep her job, that she had made a big mistake. However, on reflection and in conversation it became clear that the agency had some responsibility in this matter also. The concept of a team doing a 'dance', perfectly in step, where said and unsaid are understood, where higher thinking practices are normal, and empathy, listening, understanding others, the ability to wait and kindness are the norm is one I hear about in social care circles. Krueger writes, 'like modern dancers, competent workers study, practice, and develop the knowledge and skills that allow them to be in their experiences with youth in the most effective and responsive way. These workers sense, as well as know, when to intervene or not intervene, move close or farther apart, raise or lower their voices, and increase or slow the pace' (2005: 22). Krueger also stresses the importance of relationships when promoting development. In his 2005 study of youth work as a contextual, interpersonal process of human interaction, Krueger identified four main themes – presence, rhythmic interaction, meaning making and atmosphere – as contributing not just to positive relationships but also to the development of appropriate interventions.

Myer (2017) writes of social carers having varying levels of knowledge and experience within the social care system. It is a combination of experience, knowledge, maturity of personal and academic qualities and an ability to critically reflect, and self-reflect, that supports this social care 'dance' that we do. But significantly it is about relationships, understanding the difference between personal and professional relationships, and being willing to explore and reflect and change attitudes where necessary. Lalor (2013) writes of the quality of the practice environment, training, professional supervision, the philosophy of one's peers, the ability to self-reflect, the ability to turn criticism into best practice, research and advocacy as ways in which a social care practitioner develops. All of these are done in the context of relationships.

One of the biggest learning curves a social care practitioner makes is when the concept of professional working relationship is ingrained into their practice.

This, however, is a process. If I am asked how I would explain social care practice, my response is that it is all about relationships. Without positive working relationships, the work we do is stymied by miscommunication, suspicion, stress and weariness, by functions and form, by judgement and fault finding. It is not that the job doesn't get done, it is just that it is exhausting, and no joy is gained from it. And it is where bad practice occurs. There is quite a blend of personal and professional relationships in social care, especially given the amount of time we work together and the sometimes stressful nature of the work. With positive working relationships the atmosphere is better, more creative, there is more sharing of information and ideas, people support each other and are honest with each other. Criticism is turned into better practice rather than personal offence and natural learning opportunities are rife. And people are kinder to each other.

Supporting Relationships in Practice

As a social care practitioner, I have my 'go to' people when I need advice. These are people who will tell me when I mess up and offer honesty and care. They will also support me at times of stress and worry. And they will celebrate with me when appropriate. This is important.

Three significant things happened when I started as a social care practitioner. One was that I had regular supervision from the time I started. This immediately meant I had a relationship in work even if I did not understand much about it. My supervisor did, thankfully, and over time I came to understand the value of reflecting on practice and acknowledging areas of learning. This includes making relationships with other staff members, making relationships with the young people in my care, the links between the staff team and the collective multi-disciplinary network and the macro/micro system of relationships that occur within this. I listened to the way people spoke to each other and to the people in our care. I watched as people created structured and boundaried environments for our young people to act out their own relationships with their world. I took risks and it worked, or it didn't, and I brought this back to supervision and discussed the hows and whys. I watched how people work. I saw how different approaches work with different people. I watched as people displayed great bravery and no little honesty and yet at the same time they did not dominate situations, leaving room for the young person in our care to express themselves, and not be overloaded. And I talked about this in supervision. I watched as a group of 15 people, different personalities, with different

approaches to the work, some loud, some quiet, some sporty, others artistic, some unassuming, others a 'force', action men, admin angels, kitchen devils, specialists, comedians, therapists, provocateurs, slackers and completists, all seemed to gather together under an umbrella of care and single-minded ambition; to try to make the tomorrow better than the yesterday for the people in our care. And I talked about where I might fit into this brilliant human machine.

I began to make relationships within the wider staff team. With some people you would be up until the wee hours talking about everything, not just work; with others it was function, get the job done, it's late, time for bed. Some people came in with a 'bag of tricks' in the form of ideas, or activities, and sometimes I wondered if I would ever get a look in; other times I was glad because the 'bag of tricks' was so full of good stuff. Some were real talkers and I found out a lot about people's families or relationships; others were full of questions and, depending on the friendship or mood I was in, I would tell all about myself. Some were funny, others were brilliant at getting you to say what was true, about yourself and others.]

Some challenged my practice. This was uncomfortable but it was honest. Over time I understood that this was part of 'the process'. That we weren't going to get the job done by being nice all the time. This created fractures and at times there were tears and upset, and sometimes I took this terribly personally. Over time I realised that to challenge someone's practice appropriately is a good way to help them to learn, reflect and shape their practice when necessary, to meet the demands of the task. Through experience and watching and listening and getting braver I learned more about controlled emotional involvement, theories of practice, listening, responding, sharing and recording information and workloads, and the importance of the team. I learned not to be afraid to look at myself. We ask so much of our service users. In some ways we have to 'go to the well' ourselves at times. When these difficult times occurred I still had other relationships within the team where I could discuss my dilemma. And when the learning was done we regrouped and moved forward. And I am more than willing to have my practice questioned and more than willing to question others'. The goal is the best care for the people in our charge.

I also began to make relationships with the people I worked with, in my case a group of teenagers in residential care. One was leaving soon, wanted nothing to do with the 'new' person. Her time was up. Making a new relationship just might have been too painful, or maybe she just wasn't interested. Our relationship was one of respect, but I can't say I got to know her well at all. Another 'toyed' with me; they were there a while also and knew how to play new staff; nowadays I look at how the young people look at new staff when they first meet them, what do

they have in store for them? And will they survive? Two other young people were curious, and I began to get to know them. Between play, shared experiences, events, accidents, incidents, talking and listening, and time, relationships formed.

The next step was key-working a young person, being their advocate at meetings with the multi- disciplinary team, at reviews, listening to their ideas about how they wanted to be, making sense of challenging behaviours, empathising and being part of their holding environment. A very significant professional relationship but one with huge personal investment. The very fact that you know every detail about a young person you are key-working is in itself a personal investment. Trying to support them as they come to terms with their past, present and future can have quite an impact on the person. This is the place where wider team relationships become crucial, where the support network, both silent and obvious, becomes essential. Some moments become easier to understand, others become more bearable, when shared. Since then there have been many kids who have come and gone. We remember every one of the young people who pass through our door and we celebrate them and thank them for the collective learning they have bestowed on us.

Learning from Experience

The first thing that irked me when I spoke to Blossom was that she reported that supervision was not happening regularly. Proper and regular supervision with an experienced supervisor will support better practice and also identify many of the issues Blossom was presenting with: lack of boundaries; thinking that she needed to be a friend to the service user; the fact that she felt on some level that she was working alone; and the fact that her relationships within the team in general were not great. In addition, proper supervision would have enabled Blossom to form a professional relationship with her supervisor where good practice would be discussed and encouraged. That Blossom spoke of 'not great' relationships with the wider staff team also concerned me. Social care practitioners speak about 'a lonely place' where work is difficult and suspicion abounds, where mistakes are pounced on and good work overlooked, and where relationships within the team are at a low. These are among the toughest times in our working life.

In my role as Blossom's college supervisor I made contact with Blossom's employer and arranged a meeting. At this meeting a number of issues were

discussed. The issue of supervision was resolved and Blossom now has supervision once every two weeks. It was explained to me that because the unit was so busy it was not possible to provide regular supervision up to this point. Blossom was also appointed a mentor and an arrangement was made where Blossom would fulfill a number of learning tasks each week and these would be monitored. Blossom would also attend team meetings regularly and would be invited to/included in any training or events the unit would be having. I would also check on how Blossom was doing more often with both Blossom and her employer/supervisor. Much more structure and detail supported Blossom's understanding of the experience, even though it increased the workload considerably. I also spoke with Blossom about how she could improve relationships within the wider staff team. Very often it just takes time for a team to get used to a new member; at other times a new staff member must look at what they are bringing to the collective and see where that fits in.

Blossom is happier at work, is still making mistakes, but nowadays she is learning from them rather than being punished and not knowing why. She is also engaging in good social care practice and this is being acknowledged, and the learning is being recorded and noted. Blossom has also made strides in her relationships with the wider team and has developed a good working relationship with her mentor. In addition, Blossom has attended meetings and training days with the team and noted how beneficial they have been to her development as a team member. She jokes about the shared 'horror' of role plays at these events and the fun and engagement, as well as the learning. I have encouraged Blossom to contribute to the meetings she is attending and to listen to the way others manage themselves at these meetings. Blossom asks more questions and reads more. She is engaged in a supportive role in many projects the unit is involved in. These include links between the local community and the unit, social skills, COVID-19 awareness, art, and 'dance' classes. Blossom also has developed much better relationships with the service users and when she talks it is now with a much deeper understanding of boundaries and the nature of care. Blossom also has a much better understanding of her relationship with Judy, although for the time being they are not working together on their own.

The need for us to build and nurture relationships within a team is very important and is in my opinion a key component in working independently with service users. Blossom has now got a place to go where she can discuss the dynamic between herself and the service users in her care and an opportunity to regularly explore the finer points of practical work with vulnerable people. Blossom also has the opportunity to talk about the way work is impacting on her life.

Conclusion

This chapter invites us to look at professional relationships under the gaze of the Standards of Proficiency – Domain 2 Proficiency 13; ‘Understand the need to build and sustain professional relationships as both an independent practitioner and collaboratively as a member of a team’. It sets out a scenario where Blossom’s inexperience, allied to an absence of good enough relationships within the staff team, leads to a situation where bad practice was evidenced. This proficiency acknowledges the significance of building and sustaining relationships in social care. This chapter outlines how we can do this in practice; through positive workplace relationships, effective supervision, mentoring of new staff, of an atmosphere where practice is discussed, ideas are floated and decisions are not made without consultation, where we watch for good practice from people, where we watch different styles of communication, and where we only do the work we are ready to do. Now that Blossom is more integrated into the wider team she can accompany others and work collaboratively and effectively. Soon Blossom will begin to work independently of others, while maintaining her team ethos and supports. This way Blossom’s potential is checked, and celebrated, her current learning is acknowledged, and further learning identified. Blossom now has a much better understanding of the role of the team and consequently has made significant progress in learning their particular ‘dance’. It is going to take time. But it does take time to learn new moves.

The Dance (Part 2)

Some day, very soon in fact, Blossom will walk into a room and in an instant understand the ‘temperature’, and she will know how to respond to it. She will move at a pace that interrupts no one, she will feel no less and no more important than anyone in the room, she will listen and watch for cues, she will ‘hold’ herself, and she will wait, and then she will go to work.

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Chapter 37 – Gráinne Powell (D2SOP14)

Domain 2 Standard of Proficiency 14

Understand the role and impact of effective interdisciplinary team working in meeting service user needs and be able to effectively contribute to decision-making within the team setting.

KEY TERMS

Interdisciplinary teams
An interdisciplinary response
Ingredients for success

Social care is ... a worthwhile and fulfilling profession, filled with possibilities. The social care profession thrives on innovation and creativity. It is ever evolving. The cornerstones of social care are empathy and commitment. It's a profession that is built on relationships and a therapeutic environment.



An interdisciplinary team in social care is a collection of people from different disciplines who come together with a shared goal and vision to benefit the service user.

Intradisciplinary: Single discipline working as a team

Multidisciplinary: Staff from different disciplines working together, each member representing their own discipline and bringing their professional knowledge and expertise to the team. Generally creating discipline specific care plans.

Interdisciplinary: An integrated approach to

working, sharing, resources and learning from the expertise within and across the team. Sharing responsibility and making joint decisions.

Interdisciplinary Teams

Interdisciplinary teamwork is a common practice across the social care settings. It involves different types of staff working together to share their skills, expertise and knowledge. Working in interdisciplinary teams gives service providers the ability to pool their resources and provide a holistic package of supports to service users. Terms such as intradisciplinary, interdisciplinary and multidisciplinary are used interchangeably to describe collaborative team working. However, there are some distinct differences. Inter/multidisciplinary teams are generally broader than intradisciplinary teams and involve staff from different professional backgrounds working together. Other teams in the social care area are made up of staff from single disciplines working in an integrated way using open communication to share ideas and make decisions.

An Interdisciplinary Response

The issues that impact on the lives of families and communities are often complex and varied. The uniqueness of individuals and the impact of their circumstances must be accounted for when responding to them. This often requires a myriad of approaches and resources to meet specific needs. No one agency or discipline has all the expertise and resources to meet the needs of the individuals we work with. While upholding the ethics and integrity of our agency, we strive to blend a response for the greater good of the service user. However, success does not 'just happen' because services pull together. It is usually the result of a substantive investment of skills, resources and time to ensure that all members of the team work well together. By pooling our resources and providing a holistic and integrated response, we can do so much more than we can on our own.

Lalor and Share (2013) describe how the social care profession is ultimately concerned with the delivery of high-quality professional care to adults and/or children with health and social care needs. The underpinning principles that guide us in our work in social care, such as building respectful client interactions, help us to listen more deeply and understand more compassionately when advocating for and on behalf of others. A core aim in social care is to empower individuals to develop the resources required to overcome adversity in their lives. This special emphasis on the capacities of individuals in meeting their own social care needs frames how the social care worker highlights and addresses needs within the interdisciplinary team. Focusing on strengths and resources and empowering service users to access their internal supports builds self-belief and strengthens coping mechanisms. The worker and the service user work in unison to address concerns and seek out solutions that will meet real needs.

All members of interdisciplinary teams are selected on the basis of their relationship with the service user. Social care practitioners play a very valuable role on interdisciplinary teams due to the 'hands on' nature of the work. Social care practitioners work alongside service users in a non-judgemental way that gently supports growth and development. Our role with service users is to offer care and support in a safe, trusting environment. The empathy and understanding that is fostered in social care relationships means that the social care worker gains an insightful knowledge of service users that many other professionals at the interdisciplinary table may not have. This knowledge, based on respectful everyday interactions, strengthens solutions by placing a practical, person-centred lens on them. So never underestimate the value of the social care practitioner's contribution to the interdisciplinary team. It is rich in insight and offers a fresh relational approach to meeting the real needs of families and communities.

Ingredients for Success

The functionality of any group depends on a having a few important things in place. Because the interdisciplinary group embraces a collection of people from different backgrounds, there may be conflicting organisational cultures, agendas and values. Working towards a shared goal requires compromise and setting aside organisational differences. Having terms of reference and guidelines in place can prevent conflict and ensure that goals are met. Every group needs a well-defined purpose. This gives clarity and focus so that everyone involved

knows what is expected of them as a team member, and what success would look like. Good leadership, along with clear roles and responsibilities, will also make the team more efficient and focused. Having committed members who want the best outcome for all involved is a crucial marker for success, as it propels the group to think outside the box, to be creative, insightful and flexible in seeking the best solutions.

Purpose

Any interdisciplinary team must have a clear purpose. All too often, groups and teams are formed without a clear purpose, which can lead to feelings of frustration at their lack of direction and progress. It can also make members of the team feel insecure and unsure about their role on the team and doubt the value of the group. The purpose of the team should be clearly outlined and some measures for success should be noted from the onset so that progress and achievements can be monitored and evaluated on an ongoing basis.

Reflection

Think of a group, team or committee you have been involved with. It could be a sports team, a school committee, maybe even an event or party planning group. Think about these questions:

- What was the purpose of the group?
- What helped get things done?
- What strategies were used to keep everyone focused?
- What didn't work well?
- What would you do differently?

Leadership

Leadership in interdisciplinary teams keeps the momentum and integrity of the group in place. It adds structure to the team by ensuring that timeframes are met and decisions are made. Strong leadership will strengthen interdisciplinary team work by encouraging equal participation in the process. It should drive the team forward to overcome barriers, to build connections and to seek out success.

Roles: Respect and Understanding

It's not always easy to work together, especially when the values and expectations of organisations are so varied. However, if respect is expected from the outset and if there is an understanding of how other agencies operate, a way forward can be achieved in the best interest of service users. This appreciation for other styles and approaches to supporting individuals will make the information-sharing and decision-making processes more fluid and genuine. A successful interdisciplinary group is one where the individuals are valued equally for their insights and contributions. Less experienced members should be given opportunities to ask questions in the team. This often brings fresh perspectives and learning for all team members. Working together to achieve a shared agenda requires actively listening to colleagues so that opinions and thoughts are heard and mutually respected. Successful teams build on the strengths of each individual member.

Flexibility

Interdisciplinary teams need to have an element of flexibility to get things done. When working with people and for people we must be mindful that people react differently to the same situations, change is difficult, need is complex and one size does not fit all. With all this in mind, meeting the needs of service users requires a flexible approach and a collective response.

Commitment

Working together can be challenging, but a committed team who are working towards a shared goal will make the process more focused and productive. Committed team members will take their responsibility more seriously; they will follow up on issues and will work to find solutions to overcome barriers and obstacles. It's important to reflect on the motivation behind interdisciplinary teams and to think about the most desirable outcomes and practical steps needed to achieve them.

Language

Language is very important in social care and we need to be mindful of how our language is received by others. All agencies and services use terminology familiar to their own disciplines. The language we use every day with our peers becomes familiar and comfortable to us; however, it may not be widely understood outside our own circles. When we work collaboratively it's important to explore and discuss the different terminologies and interpretation attached to them across services. It is then useful to agree and outline the terms to be used for the purpose of the team.

Personal Reflection

Having spent most of my career in the health service, I am extremely conscious of how easy it is to fall into the 'language trap'. The use of abbreviations and terminology that are not widely familiar outside your organisation can alienate interdisciplinary partners. I have found from my experience in delivering training, facilitating groups and participating in interdisciplinary teams that the more relational and plain I keep my language, the more tuned-in people are. We don't need to embellish our points or use jargon. Be present, be clear and ask for clarity if you don't understand something. Someone else will probably be relieved that you asked! Setting a tone of inclusivity and clarity is essential for good communication in interdisciplinary teams.

Collaboration

It will not always be possible for a single agency or individual to bring about change. Time is spent during the initiating phase of an interdisciplinary team in agreeing who needs to be involved. This decision is based on previous connections to the service user and possible new sources of support that may be beneficial. Then, the process of deciding what needs to be done, how it needs to be done and when it needs to be done can take place in a collaborative and inclusive way to maximise impact and outcomes. Interdisciplinary teams rely on service providers and service users working together as a collaborative team to set goals. Sharing responsibility across the team while also respecting the individual team members' autonomy and expertise will generate a collaborate approach to supporting service users.



Author-created diagram illustrating key elements of effective teamwork, highlighting Purpose, Leadership, Collaboration, Respect, Commitment, and Flexibility in a continuous cycle.

Interdisciplinary Teams

Benefits of an Interdisciplinary Approach

The benefits of interdisciplinary teamwork are substantial for service providers and service users. They have the ability to improve the overall effectiveness of services provided to children and families in the community. They can enhance the services offered by improving work practices and creating a one-stop shop for sharing expertise, exchanging ideas and pooling resources. The generation of creative ideas and alternative perspectives can inspire new methodologies for managing complex issues. Interdisciplinary teamwork prevents the duplication of services and assessments by bringing together the key people involved in the lives of service users to give their input to plans and make decisions.

Regular meetings can also improve the relationships and communication between different disciplines. This leads to higher levels of innovation and a joined-up approach to care. Many times in the past, service users sadly fell

through the net and were not protected due to a lack of co-ordination and communication between the people involved in their lives. If services talk to each other, share resources and think how they can jointly support service users, time can be saved and more robust, sustainable outcomes can be achieved.

TOP TIPS FOR ENGAGING IN INTERDISCIPLINARY TEAMS

Ask for clarification on the purpose of the meeting.

Learn about the terms of reference, decision-making processes and the general running of the group.

Be prepared. Arrive on time, read over notes and minutes and have your paperwork organised.

Know what your service can contribute and what the limitations are.

Be comfortable and content in your appearance.

Express your views and be assertive in making your points.

Keep an open mind and listen to the opinions and suggestions of others.

Be clear and concise in your communication.

Make connections, try to get to know other members of the team. Peer support is an invaluable asset in social care.

Be confident in your ability to bring solutions and offer insight.

Ensure an agreed framework for evaluating and reviewing the team purpose and productivity.

Use supervision sessions to reflect on your personal progress and seek out new ways to be more effective.

Questions to consider.....

What does the social care practitioner bring to the interdisciplinary team?

What, do you think, are the barriers to interdisciplinary team working?

How can these barriers be overcome?



Tips for Practice Educators

This proficiency will require students to have an understanding of how to engage and participate in interdisciplinary teams. It is important that the student is afforded the space to reflect on what makes teams successful and the value of the social care contribution. Time spent unpacking interdisciplinary team success and the drivers of success as it relates to the service will develop the students' understanding of interdisciplinary teamworking in a very real and tangible way. The practical aspects of participation and engagement, such as preparation and presentation, should be discussed as they are modelled through the placement. It's important that the student is exposed to the level of preparation, the attention to relationships and the follow-up required in interdisciplinary teamwork. The finely tuned professional will often make the work look effortless and seamless, so getting students involved in preparation and collaboration before and after will be extremely useful. Encouraging the student to link actions to policy and theory will also help them to place the actions in context. Sharing agency reports and guiding national/international documents with the student will strengthen their learning for future practice.

Taking part in meetings generally will provide the student with the opportunity to view different perspectives from services and families. It will also give the student the invaluable opportunity to practise with the support of a supervisor in a safe environment, to articulate responses and to receive critical feedback. It may not always be appropriate for the student to actively participate in interdisciplinary team meetings; however, time spent reflecting and documenting what went well, how decisions were made and what outcomes were achieved will help the student to focus on the skills and techniques involved. Assigning practical tasks pertaining to the set-up of meetings and follow-up with services and families will increase the student's participation in the dynamic of collaborative teamwork. A practical and solid piece of work for the student could involve the collation of a community needs assessment to gain insight into the workings of the different disciplines involved in the lives of families and communities. In exploring and examining the needs of communities, the allocation and co-ordination of resources will be better understood.

Students often have fresh and enlightened perspectives on the complexities of social care circumstances. Giving the student the opportunity to share their thoughts and creativity while encouraging them to shape these ideas in light of the community circumstances, resources, services and guiding documents will focus their application of theory to practice. Feedback and the use of reflective practice will help the student to sharpen their preparedness and their expertise through active participation and reflection. Asking the student to consider their strengths and the challenges they encounter, in relation to working as part of a team in their everyday life, combined with their practice experience, will help them to identify progression pathways.

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Chapter 38 – Des Mooney (D2SOP15)

Domain 2 Standard of Proficiency 15

Understand the role of relationships with professional colleagues and other workers in service delivery and the need to create professional relationships based on mutual respect and trust.

KEY TERMS
Professional
relationship
Respect
Empathy
Labour of love

Social care is ... when I am asked what social care is I te

Professional Relationship – Lexi's Story

This chapter uses a case study (Lexi's story) to discuss the role of relationships with professional colleagues and other workers in service delivery, noting the various relationships Lexi has in her life now, and how the dynamics between these impact on Lexi's life. The chapter makes the argument that the relationships we have with service users are also a measure of the type of relationships we are looking for us as professionals and how respect, empathy, love, accountability, teamwork, integrity, organisation, nurture, self-regulation, harmony, initiative, and partnerships are enacted in our professional lives.

Interdisciplinary and *multi-disciplinary* are terms used to describe the links between the various professionals involved in people's lives and the roles they play. Interdisciplinary teamwork involves a number of people across a staff team sharing their skills, knowledge and expertise, with a common purpose; to set

goals and boundaries, make decisions, share resources and responsibilities. The multi-disciplinary *inter-agency* team approach to care refers to the significance of how agencies and individuals communicate with each other; and how mutual trust, respect and professional responsibility can lead not only to a creative working environment but much better outcomes for service users. One definition offered by Linden (2002: 7) states, 'interagency collaboration occurs when people from different organizations produce something through joint effort, resources, and decision making, and share ownership of the final product or service.' This collaboration refers to family caseworkers, social workers and social care workers, mental health providers, teachers, support workers, policy-makers, managers and legal experts. The team members focus on specific areas of care and these in turn are brought together in the form of an overall care package or plan. Linden further notes that better understanding by each member of the multi-disciplinary team of the others' roles in the case, of their actions and perspectives, will only lead to better outcomes for the service users.

Respect

This chapter uses a case study to look at professional relationships, and how actions in one area impact on others. Throughout this chapter we will be reminded of Lexi and how people like her are affected directly by our actions and decisions. When you look at Lexi's story, think of the many and complicated relationships she has through many disciplines, and how sensitivity, communication, kindness and honesty are essential to helping her realise her true potential.

Case Study 1

Lexi

Lexi is amazing. She is funny, kind, thoughtful, full of surprises, is helpful and has a keen memory. She is a great singer and loves praise. She will ask you how you are. She is interested in your life. She doesn't like questions about her life though, and always says things are

'good' or 'I don't know' when asked even the simplest question. She is also angry, depressive, inconsistent with the truth, has body issues, toileting issues, overeats, has poor hygiene, takes no responsibility, argues, and makes veiled threats to those who try to help. When you first meet Lexi you see a thoughtful and engaging child. Over time the cracks become more apparent

and at times it is difficult to establish what is real and what is part of some story she is involving herself in. But you never forget the first meeting or forget what is beyond the chaos that her life has become. She is so deserving of love, especially when you consider her journey to now.

Lexi was born to a substance-abusing father, Peter, and a mother, Sandra, who was not capable of showing her daughter the love she deserved. Sandra was plagued by mental health issues, poverty, occasional homelessness and an unreliable partner and it was not long before Lexi came to the attention of the social services. Indeed, Sandra has had three other children who have gone through the care system, two to adoption and one in a long-term foster placement.

Lexi was alone and all but abandoned in the early weeks of her life. Through the intervention of a social worker a foster placement was sourced, and Lexi moved when she was just a few months old. Thus began a series of moves from short-term emergency placements to more

long-term ones. At one point Lexi returned to her parents' home from a foster placement where she was said to be thriving. Her parents had completed a parenting course and her father had been clean for some time. A little over a year later Lexi was on the move again. At the age of

six Lexi had moved seven times. The next foster placement lasted four years and was to be catastrophic for Lexi.

When you consider the number of people working on Lexi's behalf it is quite daunting. Directly or indirectly, I can count 28 people who are working for or with Lexi. These include the staff team at the centre where Lexi lives, the social work team, support workers, doctors, therapists, teachers and her recently appointed guardian ad litem. It is important that we all have a good sense of what the others are doing, but more important is that we respect what it is we are all doing. From the social care worker who wakes Lexi up for school, gives her breakfast and sits with her as they discuss the day ahead – or anything, really – to the teachers, therapists, social workers and decision-makers, a level of understanding and respect for the roles they play, and for the tasks within these roles, for each other and, most important, for Lexi, is essential, not only for clear communication but for producing the best outcomes for her. It is difficult to have a clear understanding of the term *respect* in a professional setting. Do you respect someone you don't like? Do you respect someone who can have a huge influence (positive or negative) over the life and welfare of a service user? Do we respect those who have unacceptable goals, such as lapsing addicts? Do you respect a colleague who appears to have a limited focus on events and appears to you and others to have formed an opinion of a service user and is then acting according to this view, to the neglect of others'? How do we address these dilemmas?

Definitions of respect include links with dignity, moral obligation, human rights, respect for cultural differences, reflection on professional relationships, ethics and the culture of respect (Hicks 2011; Beach *et al.* 2007; UN 1948; Gostin

1995; Hargraves & Page 2013; Paasche-Orlow 2004; James 2018). Dictionary definitions include: 'a feeling of deep admiration for someone or something elicited by their abilities, qualities, or achievements'; 'due regard for the feelings, wishes, or rights of others' (Oxford Dictionaries); and, 'Respect is a way of treating or thinking about something or someone ... People respect others who are impressive for any reason, such as being in authority – like a teacher or cop – or being older – like a grandparent. You show respect by being polite and kind' (vocabulary. com). To my mind these definitions fail to recognise what respect is; neither do they note differences between people and ideas. Perhaps one of the better definitions might be: 'Respect means that you accept somebody for who they are, even when they're different from you or you don't agree with them. Respect in your relationships builds feelings of trust, safety, and wellbeing. Respect doesn't have to come naturally – it is something you learn' (Kids Helpline); this definition identifies difference and notes that respect is a learning event.

Beach *et al.* (2007) explore the concept of respect as having a twofold meaning; the exercise of 'personhood' and a moral obligation. They note the autonomy of service users but add that respect is independent of a person's characteristics, and therefore ought to be accorded equally to all. They argue that there is a cognitive aspect – respect acknowledges 'value' in others; and a behavioural one – which impels us to act in accordance with this belief. This moral duty is not to be reduced to politeness, honesty or deference to a service user's wishes. *Personhood*, meanwhile, is described as 'an essential characteristic of the human species' that 'gives to the human individual a universal worth and an exceptional standing' (White 2013). Warren (1973) listed six criteria for personhood: consciousness, reasoning, self-motivating activity, capacity to communicate, presence of self-concept and self-awareness.

The role of relationships with our professional colleagues could perhaps be a mirror of sorts of the relationships we have with our service users; our attention to detail, for example, or how we respond to situations. The value we hold for the service user or colleague might impact on how we respond, and we need to be mindful of this. In my professional practice I can see how sometimes judgement of others, if not checked in supervision or with ourselves, can impact on professional relationships. How we communicate is very important. While social care workers by nature can be very expressive, our greatest tool is our ability to listen and to identify important information. Within this listening space we can identify not only what needs to be done for the service user, but also something of the person delivering the information, and how much they are involved with the case. We may disagree with something, but healthy

professional relationships are not mutual agreement committees, rather platforms where debate can happen and progress can be made. Respect is central to this. Acknowledging another's difference is another way to see their individuation, self-identity and personal identity. Mutual respect and trust are also nurtured through consistency of approach, by reliability and by how we are seen to behave towards others. The value we attach to others, and its reciprocation, creates a space where respect can be shared. Self-awareness allows us to respond in a timely and mannerly way. Self-awareness also allows room for difference, in personality, approach, work style and delivery. Constant reflection and learning will only increase our ability to acknowledge and show respect and to create spaces where our shared goals can be achieved, and for great work to be done.

Case Study (continued)

When a neighbour raised her concerns regarding how the foster children were being cared for in the foster home it began a process that is still unravelling today. What started out as a complaint about Lexi being threatened with a hairbrush while on a family holiday became a full investigation into how she had been treated throughout the placement. Stories of emotional and physical abuse followed, and later allegations of sexual abuse came to light. It appeared that Lexi had become the scapegoat. She took the blame for others' misdemeanours within the home (she was one of two foster children, and the couple had three other children of their own), faced the wrath of an angry man, was neglected and has spoken of being left with strangers while her carers went partying. Lexi later moved to another foster placement, but sadly her new carers were not equipped with the skills to care for her increasingly erratic behaviours. Lexi moved again two years later, this time to a residential placement where she now lives.

Empathy

Among the most important skills a social care worker can possess is the ability to communicate effectively, and it is important that healthcare professionals understand people's feelings, experiences and perspectives in order to assess and identify the needs of that person. 'Empathy among health care users and professionals significantly contributes to how both groups behave as well as to their therapy and overall well-being. The development of empathetic skills constitutes an important priority in the education of health and social care students' (Moudatsou *et al.* 2020: 6). Sympathy and empathy are both acts of

feeling, but with sympathy you feel *for* the person; you are sorry for them or pity them, but you don't specifically understand what they're feeling. 'Empathy is understood as a more complex interpersonal construct that involves awareness and intuition' (Moudatsou *et al.* 2020: 2), and can best be described as feeling *with* the person.

In the day-to-day shared experience with service users the use of empathy can yield positive results, among them improved relationships, creativity, trust and more harmonious living and working experiences, as challenging behaviour is better understood and responded to. In addition, a consequence of empathy can be a greater willingness by the service user to take risks in education, the community or life in general, as well as a greater chance of making the necessary changes that might lead to recovery from past hurt. In my practice with Lexi I am informed not only by the person in front of me but by information garnered from all available sources. I cannot help but be moved by her plight and how through her behaviour she re-enacts old wounds. My understanding of her case, and also my understanding of my relationship with Lexi, is significant; but more important, it is my ability to empathise in those moments where Lexi takes risks and lets us see her pain, or her dreams for her future, that are the building blocks for future progression and development. To catch these moments, and to bring them to our colleagues and advocate for Lexi, is a kernel of our mission as social care workers.

There is much written about the professional-service user relationship and the use of empathy. However, the use of empathy among professionals in their relationships with each other is not written about so much. It seems that if empathy is a tool for understanding the perspective of the service users it is not one that we choose to recognise often enough when working with each other. Within interdisciplinary teams I witness empathy between people and I see the types of skills people use with the service users in evidence between us professionals. People who understand the professional/personal situation someone might be in are less likely to judge but not afraid to engage around areas of care. These skills would include communication skills, but what is also notable is that one professional has a good knowledge of the other, as a person and as a professional.

The situation between social care workers and the multi-disciplinary teams is less empathetic. Social care workers can be mistrustful of social workers and other professionals who, as they see it, only see the service users a fraction of the time social care workers do, while apparently wielding far more power. As a result, social care workers can feel not listened to, while complaining that they are in the perfect position to effect change. Social care workers have also

been criticised in studies: for their inability to deal with children's problems (Clough *et al.* 2006; Hayden 2003); for being more reactive than proactive (Colton 2002; Berridge & Brodie 1998); and for at times assigning too much blame to the system for their problems (Smith 2009, cited in Brown 2016: 65). Brown further notes that, given these criticisms, it is inevitable that residential workers experience a long-standing inferiority complex (Gharabaghi 2008) and lack of confidence in their work (Howard 2012, cited in Brown 2016: 65). Brown notes that 'the realignment of the role of residential social care workers and cognisant disciplines needs to be re-configured in a way that acknowledges the pivotal role of residential care workers in the child welfare system' (2016: 70).

Social workers meanwhile have increasing demands placed on them as caseloads become larger, more rules are implemented, and they face greater expectations around performance (Wacek 2017: 5). Studies also note the level of stress and burnout among social workers (Acker 1999; Egan 1993; Lloyd *et al.* 2002; Wacek 2017). Hohman (2012) notes that despite being noted as central to the role, social work practice was not characterised by empathy. Antonopoulou *et al.* (2017) ask, 'is the social worker vulnerability to and experience of high level of stress likely to act as an inhibitor to the cognitive and emotional processing of empathy in conversations?' (cited in Lynch *et al.* 2019). Perhaps more work needs to be done to address the different roles each professional is playing in service delivery. A better awareness could lead to a more empathic understanding of the perspective of each professional. This in turn could lead to more trust and better working relationships, and consequently better outcomes for our service users. To support this idea, joint think tanks could be created where open discussion could take place and differences and difficulties could be aired. More professionals' meetings and better explanations of decisions will bring about better understanding of each other's roles and how it is a combination of all our struggles that produce quality care and better outcomes. This is discussed in more detail later in the chapter.

Labour of Love

Case Study (continued)

Lexi has a social worker, Pauline. She is Lexi's fourth social worker in six years. Lexi has begun to have a good relationship with Pauline. In conversations Lexi seems unsure of her social worker's role and cannot remember all her previous social workers' names. Lexi struggles at school and has a support teacher, Una, who has a really good relationship with Lexi, who visits her office a few times a week for a chat and some tea and biscuits. Lexi did have a play therapist but is now doing work with a psychotherapist and is preparing the groundwork for further work in St Louise's Unit, where her sexual abuse will be investigated more closely, and where, it is hoped, the correct supports and actions will be identified. She has been very reluctant to talk about this to date.

At the residential care home Lexi has a key worker, Polly, with whom she is developing a good relationship. Lexi speaks highly of Polly and most of the staff at the unit. She has also identified two or three other staff at the unit as being significant others and says she likes being minded by them. In conversations with Pauline, Lexi says it is her favourite placement so far and she has no desire to go to another foster placement. Staff at the unit are experienced in dealing with young people who present as Lexi does and are mindful of the hurts she has endured and of the repercussions of these. However, there are problems in their day-to-day dealings with Lexi. Arguments about favouritism persist and Lexi gets into a lot of arguments and rows with the other young people at the unit. Lexi is prone to rages and while she does not lash out physically at staff she does quite often scream and threaten to make complaints; and she runs from room to room banging and clattering into people and furniture. Nervous, excited, out-of-control laughter often turns to tears and upset. It is said she craves one-to-one contact, and this is provided. Polly and others set aside time for regular sessions in the house and outside in the garden, where they play, talk or watch Lexi's favourite programmes on TV. Lexi particularly likes the garden and, weather permitting, plays outside quite a bit. She sits on the swing on her own from time to time, just gently moving on the swing and not looking anywhere in particular. Staff are mindful to leave her to her thoughts as this seems to be serving some purpose we have not yet figured out. However, she seems more collected after her time there.

Lexi attends her doctor for ongoing issues. She has some toileting difficulties and in addition to this has some small mobility issues that have been identified for occupational therapy. She attends her dentist every six months and has had some fillings and some other work to correct dental problems. She needs much encouragement to attend to body matters – hygiene is an ongoing issue. And Lexi loses everything! Clothes, shoes, schoolbooks, mementos, gifts ... While schoolwork is problematic it is not the most pressing problem.

Lexi is fourteen.

Note: All names have been changed.

In her article 'Care Work, Capitalism and the Labour of Love', Erica Lagalisie argues that 'because "care" is implicitly presumed to be *not* work – but rather an act of love – [...] one [needs to] put the word "work" after it to suggest its productive and strenuous aspect' (2019: 1). She further argues that that relative assumptions in society about what is productive, of economic value, and what are 'natural' socially enforced activities, has led some to see 'care' and 'work' as separate activities. 'In short, it is only because "care" is imagined as the natural activity of women that it is not automatically conceptualized as work ... The woman who expects (better) financial pay for the activity of caring for others in

hospitals, elderly care facilities and pre-schools is also suspect: She should be drawn to this form of employment out of her natural feelings of care for others – which do not therefore constitute a “skill”. The man who expects (better) pay for the activity of caring for others in the commercial sector is also misguided – he is only doing (unskilled) “women’s work” after all’ (2019: 2).

Anecdotally, social care workers will tell you of being asked, ‘Just what is it you do?’ and of people having no real understanding of what social care work is actually about, other than ‘caring’. ‘Misconceptions abound, and in many cases practitioners are not afforded the recognition or status they deserve’ (Lalor & Share 2009: 3). Byrne-Lancaster (2014) writes, ‘Lack of recognition is perceived as one of the blocks to professional identity ... and ... this is particularly evident in Irish Social Care’ (2014: 2). Lalor and Share note a ‘dearth of authoritative written material or academic research related to the area. Social care syllabi have tended to draw on elements of knowledge from social work, sociology, social policy, psychology and a broad range of other disciplines’ (2009: 5). This situation is slowly changing as the last few years have seen several books and articles devoted to the practice of social care with much of the material written by practitioners themselves.

Byrne-Lancaster writes of a lack of recognition among health and other professionals: ‘One of the major barriers to Social Care recognition by other professionals lies not so much in Social Care’s diverse areas of employment, but in lack of clarity associated with Social Care’s “outcome”: what is the outcome of a Social Care Worker being involved in a service user’s life’ (2014: 2). She notes that CORU’s definition of social care – ‘a profession where people work in partnership with those who experience marginalisation or disadvantage or who have special needs’ (2012) – suggests a social justice element and a political dimension. To this she adds her own definition of social care. which recognises both the day-to-day shared experience with ‘more productive coping mechanisms and prosocial behaviours and a political element being introduced to the Social Care Worker role’ (p. 7). She writes: ‘Social care is a profession with the purpose of supporting the holistic growth, societal and political engagement of vulnerable people which is underpinned by partnership, advocacy and professional accountability’ (p. 7).

Byrne writes of love in the context of practice and notes that in ‘Irish “professional” social care, to feel love for a client is considered inappropriate. It is a blurring of the professional boundary’ (2016: 155). ‘The bizarre irony is that as Fr. Mc Verry explained, if you want to get a job in Irish social care, the one thing that you have to show is a sense of compassion for vulnerable people. The question then is; what is the difference between love and compassion?’ (2016:

155). Byrne notes passion and compassion as being ‘essential qualities for a social care worker’ (2016, p155) and reminds readers that one of our tasks as social care workers is to provide love and security to troubled people, within a safe ‘professional’ relationship.

The fact is that social care work is a very skilled job. It involves complete commitment and skills many do not have; patience, communication skills, research skills, the ability to interpret and reflect on large amounts of often conflicting information, to set boundaries, to challenge, to write, to attend meetings, to advocate, to make dinner and help with rooms, to sit and hold broken people and to tell them that you will not ignore them. It involves a mixture of domestic, sensory, practical and creative skills, and yes, it’s very hard to describe. I sometimes wonder if our fellow professionals have a clear understanding of what it is that we do. It is not ‘women’s work’; it is not unskilled labour; and no, not everybody can do it; and yes, we bring a lot of ourselves to the role, which is why most of us can say we love the people we work with. In our work with Lexi we seek at all times to hear and interpret the child’s voice. We talk with Lexi about her care plan and placement plan, careful to put this into language she can understand. We discuss the environment she lives in and changes she may want; from the decor in her room to where she wants to go on holidays, the clothes she wants to wear, to what clubs are available to her within her community, to education and access arrangements, and we discuss the reasons why we might make decisions she may not like. We also encourage Lexi to talk of what is hurting her at any given moment and try to help her make sense of some of the wrongs associated with her life up to now. We do not seek to fix everything, but we do seek to give Lexi opportunities she has not had in the past.

We are acutely aware of the impact on Lexi of marginalisation and disadvantage, and we address this through advocacy and representation at meetings with our fellow professionals. We also acknowledge the political dimension noted by Byrne-Lancaster (2014) and indeed in the *National Standards for Children’s Residential Centres* (HIQA 2018), which state: ‘Each child experiences care and support which respects their diversity and protects their rights in line with the United Nations (UN) Convention on the Rights of the Child’ (Theme 1, Standard 1:1). I am hopeful that over time and through statutory registration, increased accountability and improved educational opportunities social care will have a much clearer professional identity, and that our role in relationships with our professional colleagues will be better understood. Improved understanding and respect for the roles each of us play in the life of our service users can only be of benefit to all.

Discussion

In this chapter I am using the Lexi case study to discuss our understanding of the role of relationships between professionals. My work with Lexi is very varied. I play chasing and football and go for cycles with her. I also watch a lot of children's TV and discuss the merits of various rap and pop music she listens to. I help her clean her room sometimes, but she prefers the 'girls' to help her with this. I cook with her and I also sing stupid songs that make her laugh out loud. I sometimes tell her off for some misdemeanour and she sometimes tells me to 'fuck off' because she doesn't like what I said.

I also write daily reports of her life at the centre. I write weekly reports to her therapist (at the therapist's request), regular keywork reports and fill in all the logs associated with her care. I monitor and maintain the care plan and the placement plan in conjunction with the social worker, the staff team and the management. I also have regular phone calls with all the professionals in Lexi's case and attend weekly staff meetings where I report and advocate for Lexi. In addition, I attend regular supervision where I reflect, gain support and garner ideas that will further support the work we, Lexi and I, are doing; and indeed, all the work I am doing with the other young people at the unit. In addition to this I also attend two group consultations per month, facilitated by the centre and involving the staff team, where the work we do with all the young people and the impact on us as people and professionals is discussed. I do maintain and enjoy good relationships with the other three young people at the unit and spend time and do activities with them as well.

I came into work one day and Lexi was running around the centre screaming and crying. The only sensible thing I got out of her was that she didn't know why this was happening. I took her in my arms and held her for some time. This was not a restraint. This was a hug. She cried and held on for a while. When she was a little calmer, I suggested she have a bath, lots of bubbles, and relax for a while. I asked that a female colleague of mine sit outside the bathroom and not move for the duration of the bath Lexi was going to have, and she did this. I also told Lexi what I was going to do so there were going to be no surprises. Lexi sat in the bath and talked non-stop for about forty-five minutes. Most of the talk was about nothing at all, certainly not about the reasons why she had got so upset and frightened earlier. After her bath, Lexi spent time in her room with my colleague talking and listening to music. She never told me why she got so upset that day.

The role I have with Lexi is hard to describe, especially to someone who does not work where I work. It must be difficult for other professionals to understand

this too. I also do not fully understand what the social worker does, or the therapist, or any of the other professionals in Lexi's case. However, I trust they are good at their jobs and I have good relationships with them overall.

One of the things that bonds us as a 'workforce' and strengthens professional relationships is the nature of the work we do and the adversity we sometimes encounter. We social care workers need to get support from our colleagues so that we may in turn have the fortitude to give this support back to our service users. The building of relationships within the group we work with, the expressions of support, love and empathy, have helped create a very resilient team; and one where trust and respect are very evident throughout our practice. Many of us come to social care from very different places. Some of us have natural people skills but lack the academic skills this industry is asking of us. It is important that opportunities are provided for social care workers to increase their knowledge base in a way that does not overload them. Brown writes, 'Development of training on therapeutic models in the United Kingdom has proven to significantly improve residential care practice' (2016: 46). Access to supervision, outside supports and continued access to academic resources will also support our ability to practise at the highest level.

With the imminent statutory registration of our profession and its emphasis on mandatory continuous professional development (something most of us do anyway through reading, attending training, supervision and reflecting on practice), audits of practice and a professional code of practice and conduct I would hope our profession will be seen in the same light as others whose professions are regulated (such as nurses, midwives, medical doctors and pharmacists) and that the sceptics will have a better understanding of social care work.

There is a need for all those involved in social care practice to understand the roles of the multidisciplinary teams better. One idea to support this increased understanding is for the establishment of groups, or 'think tanks', set up to study social care. Think tanks are invariably not-for-profit organisations and engage in research and advocacy in a range of areas such as social policy, politics, economics, security, the environment, science and technology, "Think tanks share a common vision to improve their respective spectrums, as well as being sources of new ideas and research" (University of Oxford 2021). There are already good frameworks available through colleges, Social Care Ireland and some social media groups dedicated to social care. Perhaps more harnessing of common ideas throughout these would be a great way to start.

The use of study and focus groups could further help support our understanding of the many relationships and working practices that exist

throughout social care. Regular analysis of changes in attitudes, thinking and practice would be easier to notice and respond to where necessary. Additionally, more sharing of reports and increased use of professionals' meetings will give each member of the multi-disciplinary team the opportunity to discuss their role with each service user. They could also be forums for understanding different perspectives involved in the decision-making process, of the risks involved, and, for the questioning some of these decisions.

Training events can be seen as opportunities for formal and informal contact with our colleagues. Perhaps more sharing of training events and within these more sharing of viewpoints would contribute to more trust and mutual respect among professionals. This happens already in many areas such as Children First training, challenging behaviour and more recently understanding trauma training days. Furthermore, the invitation of professionals from one discipline to address another team directly would greatly support better understanding of their work with our service users. At the centre I work in we have invited therapists and others to address the team and discuss the nature of their work. This type of training and shared experience has greatly helped our understanding of their role and consequently increased our respect for what it is they are doing and, indeed, has guided us as to how we can approach different situations in a new way.

Conclusion

This chapter discusses how each of the professional relationships contributes to Lexi's overall care plan. It lists the number of professionals in her case. The importance of respect and empathy and how understanding others' perspectives is key to better outcomes for Lexi is also discussed. The chapter also maintains that the kind of relationship I have with Lexi, where respect, the ability to listen and communicate appropriately, attention to detail and effort can be a mirror to the type of relationships I need to have with my fellow professionals. This chapter also looks at the different ideas and misconceptions people have about social care work. The elements of social justice and political dimensions that are now becoming more significant are also discussed. The concept of love in the context of practice is also discussed and I have noted the irony that some people feel it is inappropriate to show love to a service user and yet the job spec asks us to be passionate about the task and compassionate about the service user. In an effort to further understand relationships within the

multidisciplinary team, I outline suggestions for how they could be improved or nurtured in the Tips for Practice Educators section. These include strengthening of relationships using think tanks, focus groups and training days; the use of professionals' meetings and the invitation of different professionals to address the staff team and discuss their work with young people. And we would be happy to do the same if we were invited.

This week was interesting for Lexi. She saw her father at a bus stop. This was the first time in six years that she had seen him. He 'didn't look too good' was what she said. I will inform the social worker and anyone else who needs to know. We will mind Lexi and encourage her to talk – she might, or she might not – about how she feels about it all. When she is ready, she will.



Tips for Practice Educators

There is a need for all those involved in social care practice to understand the roles of the multidisciplinary teams better. Ideas to support this increased understanding include:

- The establishment of think tanks to discuss each other's roles with a view to increasing our understanding.
- Study groups and increased use of focus groups to further support this understanding.
- More use of professionals' meetings will increase the standing of each member of the multidisciplinary teams as they are afforded the opportunity to speak of their actual role with the service user in a clearer manner.
- Regular reports shared between us professionals will enhance the understanding of how and why decisions are made, and recognise the various risks attached to these decisions.
- Attendance at different training events and the provision of formal and informal access to communication will increase the overall relationship base between professionals. Social care workers' attendance at training aimed at social workers, and vice versa, would also contribute to increased trust and mutual respect among professionals.
- Another idea could be that professionals, social workers and others could address social care staff teams directly and discuss their roles and their thought processes.

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Chapter 39 – Marian Connell (D2SOP16)

Domain 2 Standard of Proficiency 16

Understand the principles and dynamics of group work in a range of settings and be aware of the role of different facilitation techniques to improve outcomes and enhance the participation of service users in care.

KEY TERMS

Group work in social care practice
Key principles and dynamics
Facilitation on
Co-facilitation

Social care is ... about being in relationships with another, compassionately understanding their narrative to help and support them to flourish in all aspects of their lives.

Social care work is about being mindfully present in relationships with the service users who we are striving to help, empower and support. Professionalism is at the core of social care work, ensuring that we are deeply connected to our service users. The core principles of social care work include respect, dignity, compassion, being congruent while advocating for and holding the person in high regard, and doing your best for your service user at all times, while looking through a social justice lens.

Working in groups has become an integral part of social care work in a variety of settings and helping students to understand the nuances of this while also providing them with an opportunity to develop facilitation skills is a fundamental part of the students' social care training.

CORU (2020) defines social care work as 'a relationship-based approach to the purposeful planning and provision of care, protection, psychological support and advocacy in partnership with vulnerable individuals and groups who experience

marginalisation, disadvantage or special needs. Principles of social justice and human rights are central to the practice of social care workers.’ Lalor and Share (2013) also allude in their definition of social care to working in groups in a wide variety of settings.

This chapter will define group work and explore the principles of working with groups, based on my own experiences in social care practice and education. The principles of group work include understanding group dynamics and how enhancing your facilitation skills can increase service user participation and improve outcomes.

What is Group Work?

McGovern (2016: 65) states that ‘Groupwork is meaningful face to face contact by those who come together in a common space for singular or multiple sessions. It is a relational, purposeful, informed and collective activity which is designed to be helpful and responsive. Groupwork looks to the needs of the individual or group with regards to change or improvement in conditions or behaviours and in some cases for task accomplishment.’ Lindsay and Orton (2014) explore this further offering a working definition of social group work as engaging in meaningful group experiences to help participants to meet group wants and desires to inspire personal growth, and group development to bring about positive change. Doel and Kelly (2014:97) define a group as ‘three or more people who are connected and interdependent, usually to accomplish a shared purpose’.

Relational work is at the core of social care practice. Looking at the needs of the individual combined with the needs of the group can bring its own challenges for a social care worker. Mac Giolla Ri states that ‘Social care workers are well placed to identify creative interests, plan, organise, facilitate, support and provide safe creative activities ...’ while being cognisant of limits of their practice. Getting the balance of meeting both the individual’s goals and the group’s goals can take a lot of expertise and skill on the part of the social care worker. Group work training is recognised as an integral part of social care undergraduate training. In our university, we have a module called Creative Group Work and Facilitation Skills, which is designed to explore the complexities of group work in social care settings. We also ensure that students have exposure to group work activities throughout their four years in their undergraduate training, ensuring that they achieve this proficiency.

Social care workers may engage in group work in a variety of social care settings, for example: an advocacy group in a day centre or residential centre for disability service; reminiscence groups for older people; a children's social skills group in the community; residents in a hostel/residential home having a house meeting; a domestic violence group; a parenting group in a family centre; or a group of young offenders attending day service. When we consider group work we generally have the idea that people are willing participants in these groups. From my experience of social care practice, I know that some group participants do not want to be present and have a lot of resistance to being there. Examples could be a parent who is court-directed to attend a parenting course to prove their capacity to parent, or a young person who is involved in crime mandated to attend a youth diversion programme. Indeed, this is often reflected in the classroom setting. Some students struggle with group work, can present with resistance and are often unwilling participants. Providing learning opportunities for students to process these issues within a safe learning environment is crucially important.

As a lecturer I begin our module by delivering creative sessions in our weekly tutorials, drawing on my postgraduate training in creative arts integrating mindfulness, creative arts, drama and Lego. Students have the opportunity to participate and to experience creative arts in different formats. Creative arts can be a fast track to the unconscious (Case & Dalley 1992; Jung 1953; Vasarhelyi 1990). Students get to experience this for themselves in a safe and contained holding environment (Bion 1962, Lyons 2010, Fawcett 2014). Students are afforded the opportunity to reflect on the creative process and their own personal response to it. If students have a traumatic response, student supports services are offered, as well as providing a space to discuss issues arising, if appropriate, for the group setting. These issues are expanded upon by McGovern (2016): 'for the lecturer or group leader teaching groupwork can be a creative and cognitive challenge. Being available to each class member and the class group, while checking one's own practice skills and knowledge, requires a delicate work balance. Groupwork teachers therefore need to self-check their capacities regularly thus avoiding burn-out or lacklustre practice.' As a lecturer, it is important to ensure that self-care skills and techniques are modelled at all times in order for the student to learn from practice. Johnson, & Long (2020) also allude to the importance of social care educators having to ensure that their students meet the standards of proficiency on self-care and professional development. Time management, boundaries and turn-taking are also adhered to during these opening facilitation sessions. I would also select creative interventions where the room is set up in

different styles so the students can experience seeing the room set up to match the creative intervention and meet the needs of the service user.

TASK 1

What self-care skills have you developed as a social care student?

How do you incorporate them into your daily life?

Key Principles and Dynamics in Group Work

Group Dynamics

In exploring theories of group work, Tuckman's (1965) linear model can be examined:

It has five distinct stages:

- Forming
- Storming
- Norming
- Performing
- Mourning



Author-created diagram based on Lindsay & Orton (2014), illustrating the stages of team development—Forming, Storming, Norming, Performing, and Mourning—with a person-centred focus.

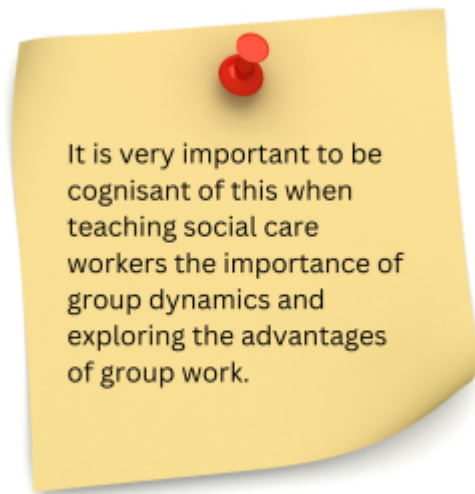
Conflict often occurs in groups at the storming stage. Benson (2019: 80) posits, 'The group worker who accepts that conflict is a central feature to group life and is attuned to aggressive and destructive forces is much more likely to be able to manage and channel these processes than a worker who is frightened by conflict and seeks to avoid or deny their presence.'

Principles underpinning group work

Douglas (1976), Friedlander (1958) and Konopa (1963) identify the following key principles of social group work:

- Genuine acceptance and recognition of individual strengths and weaknesses through the conscious use of self-reflection and critical reflection.
- Building purposeful relationships between the social care worker and group members.

Verma (2010) lists twenty-three key principles of group work, including all of the above, and notes the importance of incorporating key principles of equality and understanding, and of utilising relationship as a key tool for problem-solving and promoting self-development. Understanding group process, conflict, the importance of values and new opportunities are also cited as key principles to consider when forming groups.



Trevithick (2005) cites the importance of having a sound knowledge base of group work that draws on:

- theoretical knowledge
- factual knowledge
- practice knowledge.

Geldard and Geldard (2001: 4) outline five advantages of group work.

Five Advantages of Group Work

1. Groups can promote change: For example, through the power of the group the service user may be challenged to achieve their needs.
2. A group can parallel the wider social environment: In a group setting a member may learn to turn-take, to listen and build sustainable friendships.
3. A group provides a sense of belonging: As a group participant the service user may build their social support circle.
4. Common needs can be addressed in a group: Groups are often designed to meet common goals and help service users meet people who are in similar situations to them
5. Groups are cost effective: For example, eight service users may be seen by two facilitators in a two-hour slot, making the group cost-effective for the organisation.

Facilitation and Co-facilitation

Fundamental Principles in Teaching Group Work and Facilitation in Social Care Practice

According to Schwarz (2017: 14), a group facilitator is a person who:

1. Is not a member of the group
2. Is content neutral
3. Has no content decision-making authority or input
4. Is acceptable to all members
5. Diagnoses and intervenes in a group
6. Helps to improve the process by which the group identifies and solves problems and makes decisions in order to increase the group's effectiveness.

Benson (2019) cites Lieberman *et al.* (1973) and Coyne and Diederich (2013): 'four basic functions of a group facilitator [are] caring, affection, acceptance and support', drawing on Rogerian (1957) core principles which have been integrated into social care practice.

McGovern (2016) postulates that teaching group work at a university level must expose students to key principles, theoretical frameworks and models, roles and skills. She highlights the importance of exposing students to critical reflection, leadership and co-facilitation through participation and experiential learning, while also teaching the skills to manage and deal with conflict. Trevithick (2005) cites the importance of including theoretical and practice themes when teaching group work:

- Knowledge base group work
- Advantages and limitations of group work
- Leadership styles and approaches
- Group roles and the importance of being aware of defences
- Understanding family/team as a group
- Developing a toolbox of ice-breakers, creative group games and activities.

The importance of a social care worker developing specific skills such as empathy, communication, active listening, exploring silence and being able to

clearly explain the purpose and benefits of the group participation are cited by Verma (2010).

In our Creative Group Work and Facilitation module, we provide opportunities for students to be exposed to different theoretical frameworks and models and to become aware of skills that they may need. Students will have the opportunity to engage in personal reflection in a group setting, to co-facilitate a group work session, and to be able to recognise group dynamics and develop strategies to deal with conflict as it arises in their experiential learning classes. Each student gets the opportunity to participate in classroom learning through experiencing their lecturer facilitate creative classes. They also have the opportunity of witnessing their peers co-facilitating a variety of creative interventions, in which they can participate and gain worthwhile experience while also having the opportunity to peer review their peer's facilitation skills.

Some of the following issues may be important to consider when students are planning their group.

Group Contract

It may be worth considering having a group contract, which might include:

- Aims and objectives of the group – must be clear
- Group profile – matching your group takes considerable thought.
- Group rules need to be established with the group members
- Exploration of the limits of confidentiality
- Structure of the group – times, dates
- Expectations around participation and attendance
- Taking responsibility for self within the group – self-disclosure.

Establishing Clear Ground Rules and Building Relationships

Clear ground rules need to be established in the first session. Take the example of a parent being mandated to attend a parenting programme to assess their capacity to parent. Very clear limits of confidentiality need to be established from the opening session to ensure that group members are very clear what needs to be shared with external agencies. It is worthwhile considering what is expected

regarding attendance: are group members expected to attend all sessions? If there is poor attendance, how will this affect the group dynamics? Starting times and finishing times must also be considered. Clear boundaries need to be held by the facilitators to ensure good practice. Facilitators must arrive early to set up the room, be present to welcome group participants and ensure (if appropriate) that refreshments are available for the group. It is not advisable for groups to start late and extend the time boundary at the end. Boundaries help group participants to feel safe and secure, and extending time boundaries will not help with this.

Room Space and Safety

Think about the room space that you use and give due consideration to risk assessment. It is crucially important that you use the same room each week with the room laid out in the same way. This adds to the group participants' sense of security.

TASK 2

Take a few moments to reflect on where you sit.

Do you have everyone sitting in a circle?

Are you standing up when everyone else is sitting?

How might this be perceived by the group?

What considerations have you given to the layout of the room?

Challenges and Limitations

It is also important that you consider how you allocate time to each group member. From my experience of facilitating groups it can sometimes be a challenge for a group member to find their voice and you may need to reflect on how each member's voice can be heard. Having a 'round' at the beginning and end may assist with this as each group member can then have the opportunity to say what they wish. Having the right to pass without saying anything may also be worth considering. Group work can be very emotional at times and group

members may be triggered by the subject matter and may not feel able to speak openly. Having what I call a 'loose neck' is really important; in other words, as a facilitator you must be able to see what is going on with the group members at all times. Be attuned to their changing facial expressions and body language. If you think a group member has been triggered emotionally it is important to leave space and time to explore this. Perhaps it may be appropriate to reflect on this in the group session or afterwards on a one-to-one basis.

Another challenge I have experienced is a member who over-talks or over-shares in the session. Setting clear group rules in the opening session may help with this. However, it is sometimes important to know when to shut a conversation down. Perhaps it may be necessary to say 'Can we hear from someone else in the group who we have not heard from already this morning?' or 'I wonder what other group members' views are on this.' It is important to plan group activities well and ensure that you can draw on your creative toolkit. Occasionally a facilitator may need to change the group's direction if it is not facilitating the expression of feelings and emotions. It is important when devising a creative group that you have a back-up plan in place that you can draw on as required. However, some group programmes have set weekly sessions, for example the Incredible Years programme, Cooperative Parenting and Parents Plus. A challenge in this situation is to ensure that you know your material extremely well and that your and your co-facilitator's roles are clearly identified. Endings must also be considered. Many service users may have experienced traumatic endings in the past and this is an opportunity for facilitators to allow the participants to have a positive ending with a planned ritual attached.

TASK 3

Reflect on your own experience of facilitating a group work session or participating in a group.

How do you manage conflict?

What challenges you in relation to co-facilitating with your fellow students? What style of facilitation would you like to adapt?

What do you hope to learn about facilitating/co-facilitating a group?

Planning, observation and evaluation are key components in group work. (Timoney 2010; MacGiollari, Doel & Kelly 2014). Time needs to be allocated to this process with your co-facilitator. Social care workers must be open to critical reflection in group facilitation. O' Brien (2020:12) cites WHO (2018) which states

‘Critical reflection is a core component of many evidence-based norms interventions. It is a facilitated process that encourages people to think about their ideas or assumptions, influence their actions, and explores and challenges that dynamic through probing questions’. Key reflections can include: what worked well in the group; what needs to be improved on; was every participant’s voice heard?

To conclude, proficiency SoP 2.16, as outlined by CORU (SCWRB 2017) is crucially important for students to understand and experience. However, learning how to facilitate or co-facilitate and understanding the nuances involved in the delivery of group work is a challenge. This process of learning can commence in the lecture room, but it is one that is continuously developed as you grow and develop as a social care worker in practice and work as part of a multi-disciplinary team.



Tips for Practice Educators

Creative Art Exercise for Educators to Explore Boundaries

Requirements: A large sheet of paper approx., 3.5 metres by 1.5 metres, paint brushes, paints, paper plates.

The room is set up with a large sheet of paper on tables with room for students to move comfortably around. Paints, brushes, and paper plates are laid out in a separate table.

Aim: To explore boundaries through creative arts.

Participants: Max. 10

Ask the students to choose two paint colours, put them on a paper plate and take a space at the table. Ask them to close their eyes (if they feel comfortable to do so) and, in silence, mark out their boundary on the paper with the colours that they have chosen. Encourage them to paint and after five minutes ask them to move two places to the right.

After five minutes, ask them to move two spaces to the right again and continue to paint in silence. Then ask them to stop painting and comment in a round what the experience was like for them.

Issues around boundaries are discussed and what it is like to enter uninvited to someone else’s space. When everyone has had the opportunity to share what this experience was like for them, they are invited to work together to finish off their creative image.

As a facilitator, notice how the mood of the group changes as the group works together to create their group image.

Having had previous experience in group work activities some students may hold on to negative experiences and avoid conflict. Through our experiential group work activities, our creative art exercise on boundaries facilitates the students to explore issues around boundaries.

Issues that have arisen in conducting this exercise include the fear of invading others' space and how to manage the conflict that may arise. Open discussion in the creative space can explore this.

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Chapter 40 – Tanya Turley and Diane Devine (D2SOP17)

Domain 2 Standard of Proficiency 17

Be able to recognise all behaviour, including challenging behaviour, as a form of communication and demonstrate an understanding of the underlying causes in order to apply appropriate strategies.

KEY TERMS

Behaviour as communication
Challenging behaviour
Underlying causes of challenging behaviour
Behavioural management planning
Behaviour management
Strategies for everyday activities

Social Care is ... a human centred sector. Social Care is the recognition of the inherent value of human beings and the strength of the human spirit. It is working with and advocating for the most vulnerable in our society – with children, with adults, families, and communities. Social care is journeying on the life path of those who have entrusted us to listen to their stories. It is offering a holding environment when they are at their most exposed, helpless, defenceless and at risk.

Social Care is also a place where we advocate and give a voice to the voiceless, it is a place where we encourage a sense of belonging, of non-judgement and of acceptance of the individual. It is a place where respect is integrated into everyday life and relationships are cherished. Social Care is the place where personal, life skills and inclusion are promoted – it is the place where personal growth happens. It is a place where compassion and empathy are integral for all to be reassured, they are of value, their lives have purpose and have and give meaning on a personal level and equally to their family and community. Social Care is a privileged position where we recognise vulnerability as central to our everyday work and are faced with the complexity of human life – it is the place

on a moment-by- moment basis where we are cognizant, connected, genuine in our understanding that each vulnerable person's life is important and matters.

TASK 1

Describe a recent experience where you felt you were not being heard or could not communicate your point. How did it make you feel and how did you react to or internalise this experience?

Behaviour as Communication

Everybody communicates through behaviour. Communication allows us to express our emotions and it empowers us to interact with each other. We are communicating something through our behaviour during every moment in every day, even if we are not aware of it. Behaviour is shaped by social norms and cultural expectations that are passed from person to person in our daily encounters as members of a family, a community and society (Eysenck 2002). Behaviour is our fundamental method of making our voices heard as human beings, through our verbal and non-verbal communication. Understanding how our service user may communicate emotions, thoughts or feelings, either verbally or non-verbally, through sounds and gestures, is central to our role as social care workers.

TASK 2

Essential Reading

Before you begin, please read the following:

1. Eleanor Fitzmaurice, 'Managing Challenging Behaviour' (Chapter 13) in K. Lalor and P. Share (eds) (2013) *Applied Social Care: An Introduction for Students in Ireland*, Dublin: Gill Education.
2. P. Keogh and C. Byrne (2016) *Crisis, Concern and Complacency: A Study of the Extent, Impact and Management of Workplace Violence Experienced by Social Care Workers*. Dublin: Social Care Ireland.

What is Challenging Behaviour in Social Care?

All behaviour is communication, and behaviour that was viewed as an act of disobedience or non-compliance with formal authority was described as 'challenging behaviour' (Fitzmaurice 2013). The '*challenge*' was for the service to overcome in order to appropriately respond to the person's complex needs. However, the term '*challenge*' was interpreted as 'problem behaviour', a disruption, a form of hostility and potential violence (Fitzmaurice 2013). More and more professional groups are adopting alternative terms to describe challenging behaviour, such as 'behaviour that challenges' and 'behaviour of concern' (Chan *et al.* 2012). This in itself is constructive and its causes as it removes the negative and sometimes harmful label from the individual and places it on the behaviour. This can be very helpful as it supports professionals, family, peers and community in the person's life to understand and appreciate the whole person and objectively work with them in using tools and strategies to manage and regulate the behaviour, thus recognising that the behaviour doesn't define them as a person.

The main forms of challenging behaviour have been identified as aggressive behaviour, destructive behaviour, self-injurious behaviour, destructiveness, hyperactivity and socially unacceptable behaviours (Emerson and Einfeld 2011: 6). The ways in which these behaviours are generally communicated are through conduct and actions that can be aggressive, assertive, passive and/or passive aggressive. Kissane and Guerin (2010) describe the complexities of 'challenging behaviour' and how the person can present with behaviours that can meet with one or more of the following criteria:

- The behaviour causes repeated injury (e.g. bruising, bleeding, tissue damage), or repeated risk of injury, to self or others (e.g. hitting, head butting, biting, scratching others, spitting, biting, punching, hair pulling, kicking) and/or causes damage to property (e.g. throwing objects and stealing) or is stereotyped behaviour (e.g. repetitive rocking or echolalia).
- The behaviour seriously limits the use of, or results in the person being denied access to, ordinary community facilities (e.g. inappropriate sexualised behaviour – public masturbation or groping).
- The behaviour causes significant management problems (intervention requires more than one member of staff for control and/or the behaviour causes daily disruption for the duration of at least one hour (Fitzmaurice 2013: 182).

While the above highlights behaviour that may be viewed within certain social care settings it is important to note that challenging behaviour is often not as pronounced as this. Indeed, it can be obvious or antagonistic behaviours (see Mark and Jess in the Case Study below) or more negative actions that are indirect and undermine the relationship (see Kelly's Case Study – passive aggressive). Community Mental Health for Central Michigan (CMHCM 2012), in its training programme for managing crisis behaviours and de-escalation, describes challenging behaviour as conduct that can be considered under the following categories.

- Behaviour can be considered challenging when it affects an individual's life in a negative way, or the behaviour has a vast bearing on how others relate to them. For example, if the person is 'labelled' as having a behavioural problem or being 'difficult/challenging'.
- Behaviour can be considered challenging if:
 - It causes actual harm – physical, psychological or emotional – to the individual or to others.
 - It causes damage to property or belongings of self or others.
 - It prevents the person from learning new skills, forming or maintaining relationships.
 - It prevents the person from participating in social and recreational activities or if carrying out regular typical activities such as sports, drama, music, social groups necessitates risk management or a high degree of forward planning to carry out the activity (CMHCM 2012).

Task 3

Read the four case studies and answer the following questions: what do you think is happening, how do you feel about the event, what behaviour is being expressed, and what action will you take?

- Mark* (9 years old) returns from school, asks 'Where are my headphones, you moved them, you took them, you bitch you robbed them, I'll burn the place down, I'll wreck it.' He begins to shout and kick, and punches the door beside where you are sitting.
- Dean* (16 years), a young man who presents as sullen and often on edge, comes into the club. It's his birthday and no one in his life has mentioned it. You start to sing (badly) 'Happy Birthday' and dance around with a chocolate muffin and candle while he responds, 'Shut up, you're thick and you can't sing.' One of the other lads starts to make negative comments about him – 'He's built like he's six, not sixteen' and Dean begins to get agitated and walks over to the young person who made the comment with fists clenched.

- Kelly* (38 years) refuses to answer your question about dinner, turns her back on you, stares at her phone, will not make eye contact, rocks back and forth while uttering something that you cannot hear. This is the third time this week this has happened when you speak with her. Then she makes a comment to another day service user who is nearby.
- Jess* (14 years) on late return to the house (emergency accommodation) from missing in care turns the radio on loudly in the kitchen, slams cupboard doors, opens and shuts presses, hums when you try to speak with her and begins constantly tapping the butter knife she removed from the drawer on the sideboard, 'This would cut, you know, it would hurt.'

* Names and Details have been changed.

Underlying Causes of Challenging Behaviour

As social care workers, the very 'challenge' in challenging behaviour may be to remember that the person's behaviour is a form of communication and at that moment they are trying to communicate something to us. According to Fitzmaurice (2013: 182) there are five elements to consider when developing a support plan for behaviours that challenge, which may help us as workers to understand what the person is communicating through the behaviour. These are biological, social, environmental, psychological and organisational.

Biological

This is behaviour as communication of pain or feelings of distress, anxiety, depression, neglect or frustration (Fitzmaurice 2013). From birth, infants are completely dependent on another person for their survival. Babies are born with three basic survival strategies – fight, flight, freeze responses – supported by the limbic system in the brain, which is triggered in reaction to different situations (Carter 1998). Through socialisation, upbringing and life experiences, people learn how to read situations, respond to people and control emotions and actions when in difficult situations or facing what may be perceived as confrontation. As adults, we keep the limbic system under control by rationalising and making judgements on the best outcome based on previous experiences. If an adult or child has experienced trauma, poor attachment or any experience that may have caused developmental delays, any new event that is perceived as stressful or

challenging may cause the limbic system to become overwhelmed (Cairns 2002). In this case, the person or child begins to react without engaging the thinking part of the brain and responds with a fight, flight or freeze response (Carter 1998). Consider the Mark case study: What happened that day for Mark? Was there an incident at school? Is he tired or upset by something? At nine years old, is his biological system developed enough to manage profound emotion?

Social

This relates to adverse family situations, communication difficulties, boredom, maltreatment, seeking social interactions, the need for an element of control or independence, lack of advocacy, anxiety caused by lack of understanding in relation to community rules and appropriate behaviours, insensitivity of staff and services to the person's wishes and needs. These can all impact on behaviour (Fitzmaurice 2013).

As human beings we have an innate need for relationship, a sense of belonging to, attachment with, a 'container' to hold our thoughts, feelings and emotions (Bion 1962). For service users, or people who are acting out in a challenging manner, developing new relationships is a difficult process. By forming relationships with social care workers, and other professionals, they risk opening themselves up to the potential of caring and being cared for and the possibility of being hurt. Closeness or proximity to other people can cause a sense of uncertainty, raise emotions and trigger a sense of danger. It is often easier to be defensive, to lash out, to attack than to admit or be able to consider why they feel this way. Paradoxically, the human connection or closeness that can aid our healing, support us in times of crisis or keep us safe from harm, can be the trigger for the challenging behaviour. Think of Jess (who has returned home). You welcome her back, say, 'I am so relieved you're safe. Are you okay? Let me make you something to eat – what can I get you?' As a social care worker you want to 'care' – what happens when you try to display this care to Jess, if her previous experiences of relationships has been neglect, lack of care or inconsistent trust? How does she respond to you in this social situation and why?

Environmental

This relates to external stimuli, such as noise, lighting or change in routine,

limits imposed by a structured setting, or an unsuitable physical environment. Winnicott (1965) highlighted the significance of a 'facilitating environment' in order to provide a safe space for children and young people to heal. Lack of a facilitating environment means the real work of healing, processing and building a relationship to soothe hurts cannot happen or becomes stuck. This does not necessarily mean that the environment must be physically perfect, but that at its core it has warmth, openness, a flexible structure ready to adapt to the needs to the persons accessing it or living within it (Ward & McMahon 1998). Things such as a favourite food on the shopping list or in the fridge, being able to incorporate people's favourite colours in a bedroom or shared living space, and knowing the way a person takes their tea or coffee or if they prefer juice. Remember Kelly and her response to dinner? (What happens if you have been asked by six separate staff members over two days what you want to eat? What if no one remembers what you like or don't like for meals, or you struggle to make even simple decisions? How would you respond?)

Psychological

Feelings of isolation and exclusion, feelings of loneliness, being devalued, labelled, disempowered, others' limited expectations, not having someone to listen can all result in acting out and challenging behaviour (Fitzmaurice 1982).

Angry, violent, aggressive responses can be frightening, especially if the person – adult or child – is unaware of the source of their rage. The very behaviour that they are using to defend themselves against pain, or as a method of communication to say '*hear me, see me, help me*' becomes the very behaviour that drives people further away and results in more loss and exclusion. Small steps or one piece at a time is the only way to build a foundation for significant work with vulnerable people. This is only going to transpire if we can hear beyond the words and actions to what they are really trying to convey. Dean saying 'Shut up, you're thick and you can't sing' could be perceived by the staff member as a personal insult at the thoughtfulness a birthday song and a muffin, if not viewed through the lens of a hurt, ignored child by those attuned to him. If unaware, the staff member could internalise Dean's reaction as an insult, with the result that an effort will not be made again. With recognition of the child's lived experience, a simple gesture could be viewed as a psychological hug or handshake – a feeling of being recognised, of being seen, and a special day valued. Furthermore, staff reminding the other young people in the club who made negative comments,

‘Ease up, guys, remember we don’t speak to each other like that here,’ or, ‘Well, if you want a song, just say so – I can serenade you too’ not only recognises Dean and his bruised emotions but also deflects the attention from him and the extra hurt that the comment may bring to him, unintended or not. Awareness by a professional of the psychological underpinning of aggressive behaviour in this situation is not defending negative reactions or a cure-all for the possible hurt, but it is a prompt to remind individuals of expectations, allowing the person who is spilling out to have space to recover, to not lose face in front of others but also to realise that they are truly seen and understood.

Organisational

Braye and Preston-Shoot (1995) highlighted reasons for difficult behaviour stemming from the organisation itself, they voiced concerns regarding service provision in itself been oppressive, examples in practice can be limits imposed by a structured setting, by an inadequate physical environment, by an over-controlled routine, and lack of choice and freedom. At the beginning of the chapter the question was posed – how did you feel if you were not able to use your voice, if you felt unheard? Did you want to react, to hide, to freeze, and have repeated conversation in your head about what you should do? Did you want to shout, feel frustrated or angry? If the problem is down to communication, this can frustrate the individual. Examples of these challenges could include difficulty in processing information that they are given – the information not being explained in a way that is specific and appropriate to the individual; not being able to express their feelings and difficulty in discussing issues they are worrying about; lack of control over their decisions and their independence. Unstructured time can be problematic, as can over-sensitivity or under-sensitivity to sensory stimuli.

Challenging behaviour is often a reaction to not being heard; it is a challenge not only to the staff and the service but to the organisation as a whole – to the system at large: ‘Hear me, I want you to listen, I want to make you understand!’ Van der Kolk (2015) outlined that in order to thrive we need relationships and opportunities to feel heard. We must move beyond the superficial conversation, but only if the place, people and system allow it. If the organisation, system or staff are felt or perceived as not understanding, not acknowledging, inflexible, the emotions, beliefs, thoughts held by a child, adolescent or adult, especially those who often feel at the mercy of a system, must escape somewhere. This

fountain of emotion can no longer be held back and spills over in excessive anger, freezing or disengaging, or violent behaviour to self or others, as anger is often easier to experience than pain. You may see the organisational reasons that lead to the behaviour witnessed in Mark, Kelly and Jess ('not my own home, different adults every day asking the same questions, can't leave my things lying around, report keeping; everyone writes things down about me all the time – my whole life is a book'). Braye and Preston-Shoot (1995) advocate for 'a balance of power' in the relationship between staff and client – through self direction, respect and tolerance for the clients to participate in their own service design and delivery.

Behaviour Management Planning

The life of a vulnerable person in our care is not always an easy one and we need to recognise that all behaviour has a function, and there could be several reasons for it. The ability to see, understand and acknowledge behaviour is the opportunity to witness the child's, adolescent's or adult's inner world. Furthermore, if we are attentive, we can acknowledge that the behaviour, whether conscious or unconscious, is describing the service user's lived experience. To develop a relationship, and to offer structured supports and strategies to aid positive change, begins through learning from experiences of challenging behaviour. Managing behaviour, especially challenging and potentially aggressive behaviour, begins with a recognition of triggers and stress points. During relationship-building, look at what the person's baseline (or everyday) behaviour is like, and what they experience as triggers (things that upset them, make them angry or that they struggle with). Listen to the service user when they are calm and work with them on how to avoid future overreactions. Examine de-escalation or support strategies to help them communicate what they need us to understand. Examples of de-escalation techniques include humour, taking time out or space alone, going for a walk, having someone to talk with, or using a punchbag when they feel heightened.

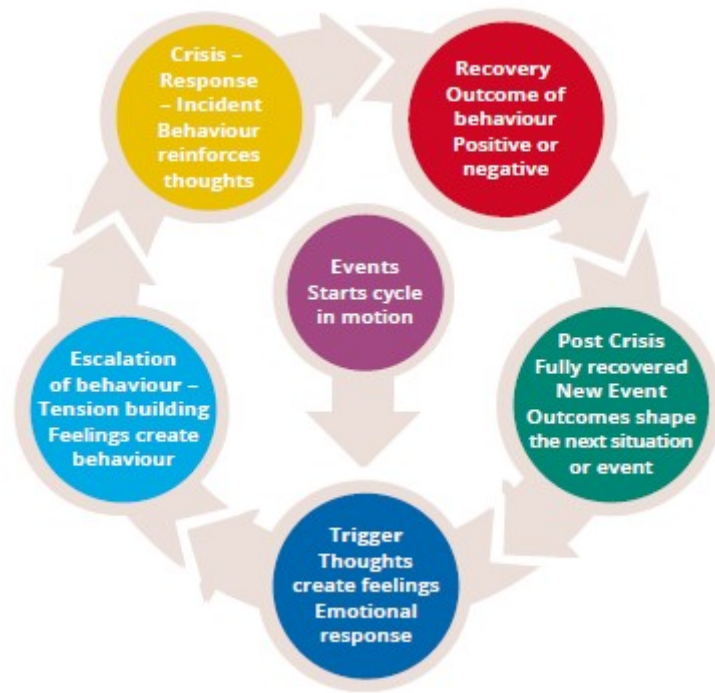
We need to remember that the individual should *always* be at the centre of all interventions, as one approach does not suit everyone. The most fundamental way of ensuring this is to ask the person what works or does not work for them at a time when they are calm or when they are able to explain in their own words. 'What upsets you or makes you feel more angry or like running away?'; 'Are there things that make it worse?' Reflect for yourself what it feels like when you are

angry and someone says to you, 'Calm down'. Ask the question, 'What makes you feel a bit better; do you like to be left alone or does it help to get out of the room/house?' There is always an opportunity for learning; it may be just planting the seed within the person that YOU are the one who knows best, YOU have control over this, we want to support you in learning the skills to apply what you know.

Our aim should always be to improve the individual's overall quality of life. As professionals in social care, it is our responsibility to protect the individual not only from any potential risks but also from themselves and others around them. By treating them with respect, using a measured response and working with them to understand that such behaviour is not acceptable, and a range of other appropriate communication methods *are* acceptable, you can ultimately help reduce flare-ups by helping them understand why they felt they need to act this way in the first place. Challenging behaviour can only realistically be handled with positive responses and a full understanding of the real cause behind it.

Behaviour Management Strategies

The employment of a specific approach to behaviour management by an organisation endeavours to make sure that the safest possible work practices are followed with positive consequences for the continued emotional and physical wellbeing of all the people in the organisation, staff and service users alike. But when we think about challenging behaviours and our experience of challenging behaviours, we recognise that behaviour generally occurs in a cycle which is known as the assault cycle (Kaplan & Wheeler 1983). It consists of: trigger; escalation; crisis; recovery; and post-crisis.



Author created diagram based on the Assault Cycle by Kaplan & Wheeler (1983), illustrating the cyclical stages of behavioral escalation, crisis, and recovery in response to triggering events.

By using the assault cycle as an analytical tool it can support us in understanding antecedents and reasons for behaviours. It can support us develop a range of strategies to help reduce or remove the triggers that cause challenging behaviour and to teach more appropriate behaviours. It can also assist us in providing positive and negative reinforcement and consequences of behaviour that will encourage more appropriate responses. The Mansell Report in 1992 classified four essential features that would inform organisations on how to respond to challenging behaviour. These were 'prevention, early detection, crisis management and specialised long term support' (Fitzmaurice 2013: 183). This was the beginning of the development of a model of care that offers normalised, individualised and personalised support, which has been influential in the creation of the approaches and combined strategies used today.

It must be recognised that for the safety and wellbeing of all and in relation to positive role modelling within a service by staff it is never appropriate to ignore behaviour that is potentially abusive, destructive, threatening or dangerous. The decision to intervene and manage injurious behaviours requires professional judgement (Fitzmaurice 2013). The assault cycle (Kaplan & Wheeler 1983) as a system reflects the basic premise that underpins many of the therapeutic

behaviour management programmes. The main ethos of all behaviour training programmes is not just avoiding and managing the situation but working with and developing life skills to aid individuals in regulating their behaviour that will have lifelong positive outcomes for those involved. There are a range of behaviour programmes for social care professionals to upskill and as part of their continuous professional development. Under the National Standards for Children's Residential Centres (HIQA 2018) and the Policies and Procedures for Children's Residential Centres (DoH 2009; TUSLA 2013). It is mandatory for all staff to complete behaviour management training, a full course initially and then a refresher course within one year.

Working with Challenging Behaviours

In working with and managing challenging behaviour, especially high-level chaotic or aggressive behavioural disturbance, social care workers may take the following into consideration:

- *All behaviour has meaning:* What is this behaviour trying to communicate? When Mark was kicking the door, saying you stole his headphones, what did he want to verbalise but was unable to? A difficult day at school? What does he feel is missing/has been taken from him? Does he need some individual attention? The *Therapeutic Crisis Intervention Handbook* (Cornell University 2012: 27) asks, 'What does this person feel, need or want?'
- *Timing:* Always try to intervene at the escalation of the behaviour to offer strategies for the person to vent the emotion, discharge the feeling in a manageable way and return to baseline before the situation gets out of hand, e.g. 'Mark, you sound and look really upset and angry, can you tell me why?' or 'Come on, will we go kick the ball in the garden and we can chat?' Or in response to Dean, 'I'm aiming for the next season of *The Voice* but while I'm practising my act will you take out the cups and we can have a cuppa to go with your birthday muffin?' *Read the environment and the situation at hand:* Early intervention can often stop escalation. Review the people, the situation and the environment. If the situation may calm down, leave it alone and do not interfere. All individuals need to find a way to regulate and manage differences with others. However, also read the room: was there an antecedent that has resulted in the person's behaviour beginning to escalate, or is the person still becoming heightened, e.g. pacing, fidgeting, foot tapping, muttering under breath? (Think of Jess returning from being missing in care, the potential impact of her being reported missing, the possible consequences for her, fear of reprisal. This may need intervention to prevent the situation developing.) Choose the

time, place and moment to intervene; the main focus is safety and aiding a return to baseline behaviour. Consequences for actions and process work can be done at a time and in a space that is right – which may not be right now. ‘Jess, it’s very late and we’re all tired. We can talk about this tomorrow – for now let’s get you sorted and get a good night’s rest, we’ll figure it out together tomorrow.’ If necessary, distance yourself physically from the situation. This is not an admission that you are not able to manage the situation, but being astute and intuitive enough as a social care worker to recognise that this is not the correct time. Active engagement around an emotive topic now may be more detrimental than helpful in the long term.

- *Conscious use of self:* Asking yourself ‘How do I feel now? What are my thoughts?’ might seem impractical when a situation is becoming difficult, but taking a second to check in with yourself may prevent a situation from becoming more uncontained (McDonnell 2010). As practitioners it is fundamental to be able to read our own internal responses to a situation, acknowledge our own emotions, reaffirm our ability to manage the situation and be aware enough to know when more support is required. Even though the content may be channelled at you, the motive behind it is not usually you. Instead, it is related to the person’s prior experiences and how something has resulted in them being triggered, and their inner child is reacting in the only way they know how – fight, flight, freeze. If we are not attuned to this, how might we respond to a distressed person? Our tone of voice might be too sharp if we are irritated or tired; we might interrupt, use too many words or name consequences because we feel threatened or anxious; we might blame the person for the consequences; our body language might be unhelpful, e.g. staring, showing defensiveness by crossing our arms, putting out our chest, raising our voice to make our point?
- *Awareness of the value of relationship and the individual’s strengths, challenges, trigger points and baseline behaviours* (Kemshall *et al.* 2013). Familiarise yourself with the individual’s crisis management plan (ICMP) or behavioural support plan. Consider which tool to use at that particular moment to allow the person time to pull back, to deflect the agitation or reduce tension, e.g. humour, just being present with, ignore, etc. With Kelly, you might ignore the interaction with the other resident and return to it at a later time, and use encouragement and humour – put on an apron, use the chef’s voice from *Sesame Street* or tell her dinner is going to be a game of ‘Come Dine with Me’ or the ‘Blind Taste Test’ – you cook and the young people must guess what it is, those who guess correctly winning a takeout

night. Intuition might tell you that the individual may need particular attention at that moment but is seeking it in a negative way.

- *Kinesthetics*: Body language, eye contact. How you approach a situation, the tone of your voice, your language and body language are crucial factors in helping or hindering (McDonnell 2010). For example, 'I want to talk with you' could be construed as 'trouble'; having other people around as an audience can impede the work. Visualise Kelly – she may feel that she cannot be seen to 'give in' to staff. Ask the second young person if you can have a moment with Kelly, sit beside or in proximity to her (being in front of a person can often be viewed as too confrontational), use a low, gentle tone of voice, make eye contact if possible, but vary eye contact (staring can be disconcerting), and ask open questions – 'What's happening at the moment?' – or 'door openers' such as 'What's up?' – which require more than a yes or no answer (Cornell University 2012).
- *Ignore or redirect*: On occasion a behaviour is best dealt with at that moment by the simple expedient of ignoring or redirecting it. You might choose not to engage Kelly at that particular moment in relation to her behaviour around dinner or you could offer alternatives, e.g. you will do 'pick and mix' for dinner, but does she want to get her chores done before or after the meal? With Jess you might say, 'Well I'm sure it would hurt very much, Jess, getting cut with a knife, but imagine the blood – red is not my favourite colour' or 'I'm going to have a toastie, would you like one? Would you butter the bread?' or 'It's late now and you must be tired, we can chat about this in the morning.' This is not ignoring the behaviour but offering space to rethink the situation as needed, and calming the environment; you can return to the event and reflect on it at another time when there is the opportunity to spend time processing the reasons for it, its impact, what could be amended (Briggs 2002).
- *Distraction*: Can you change rooms, or get some other activity going that will minimise the emotion in the situation and support the person to regulate? Diverting the individual's attention elsewhere in the preliminary stages of a behaviour that challenges by focusing on other movements, environments, activities, can defuse tension. For example, with Jess: 'Do you want to take a shower or get into some comfortable clothes?'; with Mark: 'Come on, I'll help you look for your earphones, I'm sorry they're missing, but don't worry, we'll hunt them down' (CMHCM 2012).
- *Silence*: Not every silence needs to be filled with noise, if appropriate, sit with the emotions, allow the person to vent and your presence alone will be enough. Sometimes people need time to process their thoughts or think

out loud or have a sounding board. If needed, reassure the person that you are there and you are listening to them – ‘I am here for as long as you need.’

- *Alternatives and directives:* Many people, when caught up in emotion, become ‘stuck’ in the fight, flight, freeze loop. They may be unsure what to do or be unable to consider other rational alternatives to acting out or how to extract themselves from the situation. Consider what choices are available and what method best fits the person – remember, individuals are key. Some service users will respond to direct language, short, concise and direct, e.g. Dean – ‘Please move back from ...’; Mark – ‘Please stop kicking the door.’ Other situations and persons may be best met with options – offering a choice but also giving back a sense of control. Offer limited choices; too many will add more turmoil, e.g. with Mark, ‘I can see you’re upset. We can do two things – one, let’s go look for the earphones together now; or two, come into the garden and we can figure this out together.’
- *Compassionate movement:* This is not a reinforcement of negative behaviour but a recognition of the person and their distress. Assess whether this is appropriate or could escalate the situation more. Any physical touch is dependent on your relationship, your experience of the young person and their history. Approach the person from the side, not the front, as it is less confrontational, sit down as opposed to standing when chatting with them. If the situation is between two young people, can you sit or stand between them as a buffer? A hand on the forearm or shoulder can be enough to say, ‘I’m here and I am holding you (metaphorically).’ Remember, physical touch is completely dependent on the person’s wishes and level of distress at the time. It should never be used when a person is moved beyond irritated and agitated and very heightened (Cornell University 2012).

As professionals in social care it is important to recognise that all attempts to manage challenging behaviour must happen in the context of duty of care to both the vulnerable people and the staff with whom we work. Management of challenging behaviour, whether it is mild, moderate or severe, must take into account the personal attributes of the vulnerable person based on a needs assessment of the physical and social environment in which the person’s care takes place. All challenging behaviour is communicative and happens within a social context: *it always has meaning*. As social care workers we need to always remember that the service user can be helpless and vulnerable to exploitation and harm, therefore special attention needs to be paid to managing respectfully and safely the challenging behaviour presented by the individual and understanding what they are trying to communicate to us. As social care workers

we also need to acknowledge that the effects of working in crisis situations every day can be arduous and demanding. Continuous professional training, personal supports through a team system and reflection through professional supervision is vital in helping us to identify and cope with the personal and professional challenges implicit in this often highly stressful aspect of social care practice. By acknowledging our strengths and vulnerabilities and through mutual respect, planning effective, consistent strategies together will support us in working and responding appropriately and in respecting individual differences within our professional team and with people with challenging behaviour (Fitzmaurice 2013).

TASK 4

- Be a self-reflective social care practitioner. What behaviours are you at ease with? What behaviours challenge you most? Can you consider why?
- Review one previous event in relation to a difficult behaviour you experienced. How did you handle it? What went well or perhaps what did not? What could you do if it happened again?
- Be creative. Look at the interests of vulnerable individuals and recommend activities that are enjoyable that could be used as an antecedent to a behaviour.
- Choose a service user who has challenging behaviours and look at friendships. Recommend activities using a 'buddy systems' approach where s/he supports another service user in the activity or another service user supports them. Observe them together to see if they regulate their own behaviour or each other's behaviour and identify if they find this behaviour management easier or less conflicting than with a staff member.
- Study the management approaches used by the organisation and examine how they are realised in the services Challenging Behaviour Policy. Make a time in the day where everyone within the service can sit down together to share a challenge or a pleasurable experience of their day and discuss how it made them feel.



Tips for Practice Educators

A founding requirement for the achievement of this proficiency is the student being able to recognise all behaviour, including challenging behaviour, as a form of communication and demonstrate an understanding of the underlying causes in order to apply appropriate strategies.

- To help a student comprehend behaviour as communication, ask them to describe a recent experience when they felt they were not heard or could not communicate their point, how it

made them feel and how they reacted to this experience.

- Then encourage the student to talk with a service user about how they communicate their feelings to the staff and what type of communication method is the most beneficial to them in their lives. If the student is working with service users for whom verbal communication is challenging it might also be useful for them to talk to staff and gain assistance in adapting to the service users' communication techniques.

As well as understanding that all behaviour is communication it is also important that the student has a level of self-awareness about what to them constitutes challenging behaviour.

- What are their own comfort limits in relation to experiencing or dealing with challenging behaviour? We must be aware of our own boundaries and limitations in order to support others to learn theirs.
- Additionally, for practice educators an intellectual understanding of challenging behaviours in social care and the main forms and multiple factors that underlie challenging behaviour is essential. If social care workers do not have a grasp of the root of behavior, we cannot anticipate the events that may be triggers.

Having the conversation and asking the student to explain it from a factual/theoretical experience first and then to give examples of challenging behaviors practically – where they observed it and how it was managed – will allow you to informally assess the link between the student's understanding of challenging behaviour and their observations on the behaviour management strategies used by the organisation. Remember, because of the complexity of challenging behaviour and the professional judgement by staff on how a behaviour is managed, for example when a behaviour is ignored, redirected, averted or reported on for assessment by a specialised team, can be confusing, so you may need to guide the student through this multiplicity of decisions on challenging behaviour cases. If a deficit in the student's understanding is identified, you can either direct them to review knowledge they encountered in their academic study or provide them with reading material associated with challenging behaviour. It is imperative that you provide a time frame in which you will follow up on the reading, thus creating a cyclical learning relationship between task ascription, task completion and professional development.

Once the student can converse about the multiple factors that underlie challenging behaviour and how it is used as a communicative mode, you can ask them to consider the challenging behaviour management method used within the service and the strategies they have observed staff use since beginning placement.

- You could ask the student to personally reflect on their concept of challenging behaviour and how it might inform or challenge their practice as a professional and the experience of the vulnerable service user. While potentially uncomfortable, it is important that this analysis happens so the student can use in-action reflection, thereby maximizing the opportunity for service user support, respect, safety and care.
- An aspect of professional practice the student needs to adapt to is the responsibility to adapt practice, so that service users experience a high level of support through the means of their individual communication methods.
- As the student grows in confidence it is important to encourage them to identify activities that could potentially support the prevention or aversion of a behavioral outburst and to discuss them with the key staff working with specific vulnerable individuals.
- Within supervision these opportunities could be considered in terms of viability and included in the service users' personal behavioural plans or in the organizational strategy.

Part of analysing activities is to identify if they are feasible, useful and relevant to specific individuals – has the student observed and accurately interpreted the service user correctly?

- The student may provide suggestions and creative activities, but it is not the student's responsibility to enact these activities.
- Ask the student to create a picture communication booklet with a service user (or group) that represents the service user's interpretation of feelings and emotions when communication is acceptable and they feel heard or where they felt frustrated where they feel not listened to and misunderstood. The booklet should include activities that promote positive behaviour and that help with behavioural balance, and strategies to support or regulate the behaviour. **This could be fruitful as a means of increasing the student's awareness of the proficiency or a way to demonstrate their capacity to enact the proficiency.**

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DOMAIN 3 - SAFETY AND QUALITY

Social care workers are responsible for providing safe, evidence-informed services. This includes carrying out comprehensive assessments, using sound judgement, monitoring outcomes, and adapting interventions accordingly. They must be skilled in risk management, quality assurance, and promoting safe environments in line with current legislation and best practice.

Domain 3: List of Contributors

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

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

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

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

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

Fiona Brannelly is a social care Leader with over sixteen years' experience working in the disability field. Fiona received a first class honours master's in Advanced Social Care Practice from Athlone Institute of Technology in 2020. She completed her research on 'An exploration of end of life care in frontline staff supporting adults with intellectual disabilities in community residential settings'.

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

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

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

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

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

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

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

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

Dawn Murtagh graduated from Athlone institute of Technology with a BA (Honours) in Social Care Practice and an MA in Child and Youth Studies. She

has worked with young people in residential care. She is currently working for ChildVision the National Education Centre for Blind Children. She works with young people who have visual impairments and additional needs, supporting them in their education and helping them to gain the skills necessary for independent living.

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

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

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

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

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

Chapter 41 – Audrey Moore (D3SOP1)

Domain 3 Standard of Proficiency 1

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

KEY TERMS
Identifying
information
required
Safeguardi
ng
information
Gathering
information
Alternative
sources of
information

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

Identifying Background Information Required

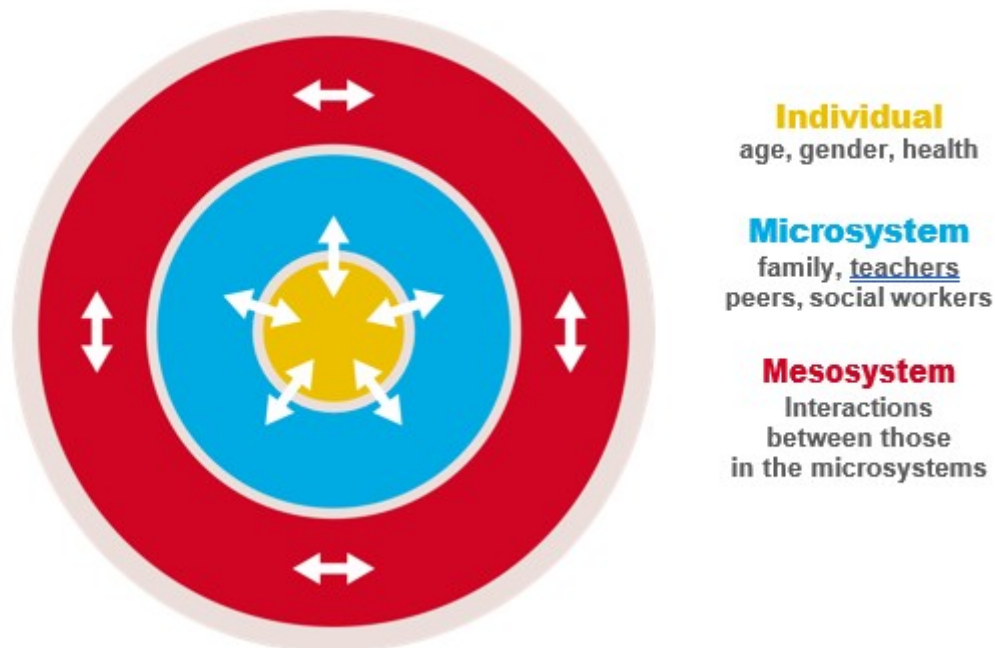
Social care workers endeavour to engage with and ensure the best service is offered to service users. This cannot be achieved without all appropriate background information. Relevant appropriate background information refers to information needed to support and assist the service user. This can include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

The background information required varies depending on the type of social care service on offer and on the individual's health and social care needs at that point in time. For example, background information necessary to provide

supports for a person living in full-time residential care can be much broader than the information required to provide supports for a person receiving support in a community day service. Each type of service is unique in the background information it requires.

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

Figure 1: Bronfenbrenner's ecological systems



Author created diagram based on Bronfenbrenner's Ecological Systems Theory, illustrating the interactions between the Individual, Microsystem, and Mesosystem in shaping human development

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

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

Factual and Opinion-based Information

Factual Information

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

Opinion-based Information

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

Reflections on Practice

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

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

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

Support plans and programmes were developed and implemented despite some gaps in information. Some gaps in information were filled as the relationship and trust grew between social care worker and family or quite by accident during conversation with a family member or other professional. For example, relevant yet unknown past medical history was revealed by a parent while chatting with a social care worker, despite the parent having been asked for medical history information when the service user was admitted. While it is not always necessary to gather significant amounts of information about a person's health and social care needs, large

gaps in information can hinder the support provided to a service user and therefore action may be needed. The process has helped me to learn how to gather information in a tactful and non-threatening manner with individuals, professionals and families and realise that different approaches may be needed depending on the person being approached.

Safeguarding Service Users' Information

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

Practitioners must be aware of and practice within the legal boundaries of data protection legislation¹ by protecting the personal data of service users. See Box 3 for an explanation of some relevant terms related to data protection legislation. Data protection principles ensure that personal information is processed in a lawful, fair and transparent manner, only for the purpose specified to the individual when collected, is accurate and kept up to date, is only stored for as long as necessary for the specified purpose and is done in a way that ensures security, integrity and confidentiality. In order to collect personal data from or about a service user, consent must be freely given, specific, informed and unambiguous. Documentary evidence of consent must be maintained and the individual has the right to withdraw consent at their will. Children under 13 years of age can only give consent with permission from their parent. See dataprotection.ie for further information.

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

General Data Protection Regulation Terms Explained

Personal Data

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

Processing Personal Data

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

TASK 1

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

Gathering Information from the Individual – Interviewing

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

GOOD PRACTICE TIPS FOR INTERVIEWING

Ensure the area allows adequate privacy for the conversation, with limited distractions.

Sit at the individual's level and make eye contact if it is culturally appropriate for them.

Sit in a relaxed position and use open body language during the interaction.

Speak to the individual's level of understanding; avoid jargon and organisation-specific abbreviations.

Listen attentively and stay centred on the conversation – use active listening skills.

Open questions are useful when exploring. For example, 'Tell me about your experience at school.'

Closed questions are useful when seeking specific answers or clarifying. For example, 'What year did you complete your education?'

Document responses as you go, by taking brief notes. Write up the appropriate details of the interview as soon as possible afterwards. Writing brief notes will assist recall later, while writing too much when interviewing may impede the flow of information.

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

Alternative Sources of Background Information

There will be times when gathering information from an individual service user

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

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

Sources of background information



Author created diagram illustrating key sources of Health & Social Care Information.

Advantages and Disadvantages of Oral and Documented Sources of Information

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



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

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

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

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

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

The student can be encouraged to reflect on the following:

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

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Chapter 42 – Noel Howard (D3SOP2)

Domain 3 Standard of Proficiency 2

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

KEY TERMS

Assess – to sit beside
Assessment
Strengths-based assessment

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

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

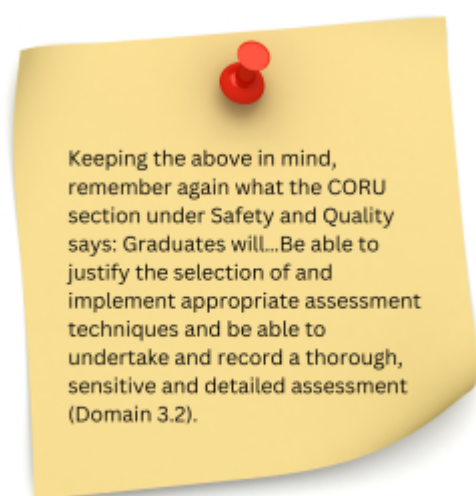
Assess – To Sit Beside

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

moments caught in time, and come about because of the relationship forged over time with the mutual ebb and flow of daily living and all its ups and downs.

Assessment

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



The first thing to remember is that whatever the age or situation of the individual being assessed, there are common elements, some obvious and perhaps some not so obvious, in all the assessment techniques available. In that context, and in order to choose the most appropriate assessment technique, it is important to be as certain as possible that what your assessment will yield will be understandable and clear for the person for whom it is intended. More

important still – the key element – is that it will ultimately benefit the person being assessed. Individuals in receipt of social care services deserve the very best we can put into their care but also the best, objectively, that we write about them. And of course, to do that effectively, we must know and understand, to the highest degree possible, what their view is too. The 2012 children's referendum has the voice of the child as a key component; this was very often not the case in the past. And we all know about Ireland's past and its treatment of children, which leads to the next point.

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

Doing Your Assessment

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

Strengths-based Assessments

The strengths, capacities, needs and preferences of the individual being assessed must be clear. This does not mean glossing over or minimising problems (which

a court or other agency may be well aware of in any event). While particular assessment tools, such as a Problem Profile Approach, may seem to be focused on looking at the problems an individual has it can be helpful when used against an underlying principle of a strengths based approach. A strengths based approach can concentrate on what is evidence based and possible, especially into the future, assuming that particular problems can be effectively minimised in order for positive goals to be achieved in the medium to long term.

Assessment Tools

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

Key features of the organisational culture needed to support social care workers in undertaking detailed and sensitive assessments:

- A knowledgeable and competent social care team supported by ongoing training and development.
- Social care workers need to develop a knowledge and skill base on assessment practice that includes an insight into the impact of current issues on the lived experience of service users.
- The impact of parental alcohol and drug misuse, mental health problems, domestic violence and learning disabilities on parenting capacity and children's health and development.

The importance of child observation.
- Resources – time and staffing, as well as services available – to allow social care workers to complete assessments and to plan and evaluate appropriate interventions.
- Good intra-organisational and inter-professional working relationships.
- An organisational culture that supports reflection and learning and avoids a 'blame culture'.

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

The Three Houses

The Three Houses technique was created in New Zealand. It is considered an effective assessment tool in child protection and is widely used in child protection and welfare services. It is a tool that aims to elicit the voices and experiences of children, young people and parents. The information gathered is

intended to guide professionals' decisions on child protection and welfare. The principles underpinning the Three Houses tool reflect the values of social care practice, the importance of working in partnership and collaboration with children, young people and families.

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

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

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

The House of Vulnerabilities or Worries

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

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

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

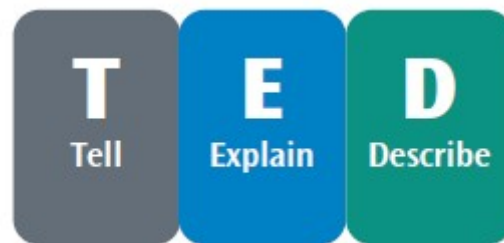
- So what is happening that is worrying you at the moment?

The House of Strengths or Good Things

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

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

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



Author created diagram illustrating the TED (Tell, Explain, Describe)

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

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

- Could you describe this picture a little more for me?
- Could you explain a little bit more about what you mean by that?

The House of Hopes and Dreams

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

Questions to elicit child views:

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



Tips for Practice Educators

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

professionalism.

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Chapter 43 – Lorna O'Reilly and Jamie Grennan (D3SOP3)

Domain 3 Standard of Proficiency 3

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

KEY TERMS

Five Pillars of Social Work Services
Role of Social Care Workers in the five Pillars
Case study

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

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

Five Pillars of Social Work Services

Social care workers in Tusla require a level of professional decision-making to be able to assess situations and plan interventions. To begin, let us give you a breakdown of the current Tusla structure and where social care falls into this. As

of 2015, Tusla Social Work Services have been divided into five pillars. These pillars are:

1 Duty social work team: Often referred to as the ‘front door’, this is the team that deals with all child protection concerns reported in the area. This team is further broken down into two sub-teams: the *screening team*, who screen every child protection concern reported and decide on the most appropriate action; and the *initial assessment team*. If the screening team feel that the level of concern meets the threshold for further assessment, the initial assessment team will then carry out an overall assessment on the family, looking at the risk of harm to the children and identifying areas for possible support.

2 Child protection social work team: If the initial assessment found that the children are at ongoing risk of harm attributable to parenting, they will refer the family to the child protection team, often referred to as the ‘long-term team’. The social workers on this team work with the family around reducing harm, linking them to appropriate supports and measuring the family’s engagement and progress with these supports.

3 Children in care (CIC) social work team: If a child has been deemed to be at ongoing risk of significant harm and all possible supports have been exhausted, in some situations Tusla then has to look at bringing that child into state care. When this happens, the child will be allocated a social worker from this team. The social worker will devise and work within the child’s care plan, attending to any of their presenting needs.

The child’s care plan covers areas such as:

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

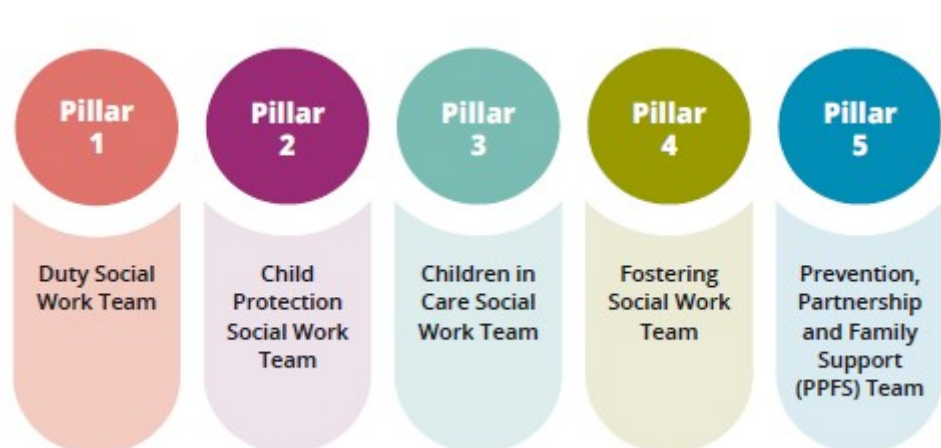
The CIC social worker will also support contact between the child and their family, attend court when needed and assess whether reunification with the parents would be possible in the future.

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

matching of foster carer to the child's needs is very important to the success of the placement.

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

5 Pillars of Tusla Social Work Services



Author created diagram illustrating the 5 Pillars of Tusla Social Work Services

Role of Social Care Workers in the Five Pillars

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

Duty Social Work Team and Child Protection Team

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

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

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

Prevention, Partnership and Family Support (PPFS) Team

When working on the PPFS team, there is a requirement to be able to assess and plan an intervention for a child and family. The models we mostly use in our assessments include Signs of Safety (Turnell & Edwards 2017), Meitheal and My

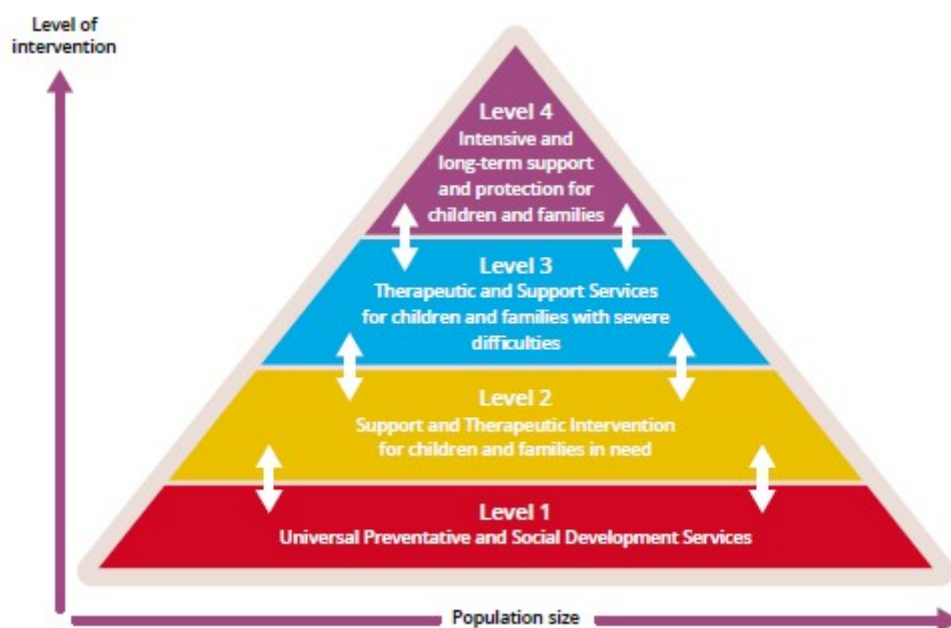
World Triangle. We are always mindful of theories in psychology and sociology such as attachment theory, systems theory and scaffolding. Our interventions are based on various models of practice. These include Karen Treisman's trauma-informed practice (Treisman 2017), which takes the trauma experienced by a child into account in assessing and planning an intervention for them. The adverse childhood experiences scale (ACES) is useful when assessing trauma present (CDC 2020). The Circle of Courage and Purposeful Use of Daily Life Events are also models of practice that we follow.

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

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

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

Hardiker model (DCYA 2012: 16)



Author created diagram based on the Hardiker Model (DCYA, 2012: 16), illustrating the four-tiered framework of intervention in social care, from universal preventative services to intensive support and protection for children and families in crisis.

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

In our practice, we have found that when we begin our assessment and work with a family, focusing on relationship building gives a good basis from which to deliver a meaningful programme to the child and family, which in turn will help bring about positive change. A positive relationship will also allow the family to be more open with you, which will enable you to get a more accurate assessment

of the family and the progress they are making by measuring how this support has positively changed any aspects of family life.

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

Case Study 1

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

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

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

When describing her eight-year-old son Ryan, Laura said that he is a quiet boy and that he is afraid of Peter. Laura said that when Peter begins to become aggressive towards her, she will usually contact her brother and sister-in-law to take Ryan for the night so that he is not in the home when Peter becomes heightened. Laura stated that on the night in question, Peter returned late from being out with friends and became abusive towards her. Laura did not have the opportunity to call her family for support at this time. In having family available to support her in this way, Laura is being proactive in putting safety in place for her son Ryan. In completing the IR, Mary reviewed

closed files and established that there had been two previous referrals to the social work team five years ago regarding domestic violence from the children's father

Shane towards Laura. Laura stated that Shane is no longer in the family's life. Laura is also concerned about Ryan having witnessed this domestic violence, as he has begun to ask her questions about 'the time when daddy used to hit you'. Mary informed Laura about the supports available to her from the PPFS team. Mary described the role of the social care worker who could support Peter and Ryan individually in relation to their needs. Mary also explained the role of a family support practitioner who could offer support to Laura in her parenting as well as accessing her own supports for her past experiences. Laura stated she would be happy to receive this support and gave consent for a referral to be sent to the RED (review, evaluate, direct) meeting for this support. Mary closed the case to duty at this time as Laura had family support to help her when Peter becomes aggressive and has consented to a referral for support for the family.

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

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

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

The social care worker used this information and her newly formed positive relationship with Peter to work on steps to get Peter to his goals. In exploring his drug use, the social care worker

gave Peter the space to speak about this and for Peter to identify that drugs are having a negative impact on his life and that he wants to quit. Peter agreed for the social care worker to make a referral to the Midlands Youth Drug and Alcohol Service (MYDAS). The social care worker supported Peter in engaging with a worker from MYDAS around harm reduction and eventually abstinence from drugs.

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

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

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

TASK 1

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



Tips for Practice Educators

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

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

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

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Chapter 44 – Victoria Mc Donagh (D3SOP4)

Domain 3 Standard of Proficiency 4

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

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

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

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

Regardless of the social care setting, some type of assessment will need to occur, in order to be able to support and work with the service user. This assessment may look different depending upon the setting you are in, which includes the different interventions and approaches underpinning the work there. An *intervention* is taking action or completing a task with a service user that is designed to improve their needs and situation. An *approach* can be described as a particular way of working with a service user or in a particular situation, for example using a person-centred approach. This in turn may inform the type of

assessment carried out and the assessment tools used to support this process. Assessment tools act as a means for the social care worker to carry out a full analysis and evaluation with the service user to identify their needs and, most important, evaluate how the service can best support them. Before we consider what the assessment process may look like, we first need to consider the terms 'analyse' and 'critically evaluate' in relation to social care work.

Analyse to Assess

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

Critical Evaluation

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

ensure we are reviewing and interpreting information correctly, and evaluating the information we gather.

Assessment Process and Tools

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

1 The Care Plan and Placement Plan

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

2 Holistic Needs Assessment

Another type of assessment used by a social care worker is a holistic needs assessment, which can be used in a service working with those experiencing homelessness or at risk of homelessness. This type of assessment examines the service user as a whole, considering their needs from physical, social, psychological, emotional and spiritual dimensions (Schaffer *et al.* 2000). The assessment does not just focus on the problem/issue of homelessness, but considers all the different factors for that person, in order to understand the

best way to support and work with them. Since it takes into account many different considerations of need and support required, this type of assessment may require the engagement of different professionals working together to support the service user.

3 Strengths-based Approach and Tools

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

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



Author created diagram illustrating the 'Who Am I' assessment tool, designed to promote self-reflection and awareness of personal strengths through guided questions

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

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

Good Day/Bad Day

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

What does it look like?

How do you know you are having a bad day?

What does it look like?

TASK 1

Watch the video on how to use the good day/bad day tool from Helen Sanderson Associates at <https://www.helensandersonassociates.com/good-day-bad-day/>

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

TASK 2

Download the decision-making profile from <https://www.helensandersonassociates.com/decision-making-profile/> and fill in the questions as shown in the sample below.

Decision-Making Profile

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

Author created table designed as a self-reflection and support planning tool.

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

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

TASK 3

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

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

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

Case Study 1

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

Social Care Setting

The setting is a disability service that comprises a day service and has independent living units/houses for residents. The service is situated a short walk from a village. The service strives to provide a safe and homely environment for all in its care. It uses a person-centred and partnership approach, in which the individual is at the centre of their support and care needs. The service has links to the local community and provides a therapeutic setting in both its day and residential services. It has some large gardens, which are used as part of the programme for service users, to garden and grow vegetables. The service has access to many professionals, depending on the

needs of each individual, including occupational therapy, speech and language therapy, physiotherapy, advocacy worker, social care worker, psychology and GP care. Each individual will be supported with an individual support plan to support their needs and goals.

Service User Profile

David is a 32-year-old man who has just started at the day service with a view to moving into one of the longer-term residential units. David has Down syndrome and his primary carers are his elderly parents, with some shared care from his siblings. The idea of a transitional approach was suggested by his social care worker, who has worked with the family in supporting them to meet David's care and needs. This is to promote future planning for the time when David's parents come to a point where they can no longer care for him. David's family also want to empower David to become as independent as possible, as David has expressed this desire for his life.

David has experience of attending a previous community workshop, which had similar aspects to the day centre in this service. It provided a social outlet for David to meet new people and make friends. The community workshop also provided training and employment opportunities in the local community. David enjoyed this and loves the social aspect of attending such a group service. He also has experience of respite care for periods of one and two weeks, to provide his parents with a break from their caring role. David also attends weekly physiotherapy appointments. David's family describe him as a kind and social person who loves a chat and a cup of tea. David also loves to cook and enjoys growing vegetables and listening to music. David has a very keen interest in sport, particularly rugby, and his favourite team is the Munster rugby team. At home with his parents, David lives as independently as possible and loves his routines. He has a daily schedule and tasks and enjoys the routine and consistency this provides him with.

He likes to keep busy, and he carries out a number of chores and jobs around the house that support his daily living skills. David's family have a dog, Rolo, and David has explained that he will miss Rolo when he moves into his new home.

David's Current Individual Support Plan (ISP)

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

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



Tips for Practice Educators

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

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

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

Reflective Activity

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

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Chapter 45 – John Balfe (D3SOP5)

Domain 3 Standard of Proficiency 5

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

KEY TERMS

Safe
holding
spaces
Restorative
practice
Traum
a-
informed
practice
Pace in
practice
Connection
before
correction

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

Introduction

The lives of our most vulnerable in society require interventions from social care workers who hold the requisite qualifications and knowledge of the standards of proficiency. In addition, the ability to problem-solve and develop goals in partnership with people using a relational and emotional dimension is critical for best practice. In this chapter, I argue that the nature of social care work encompasses both short interventions with lasting effects and also long-term relationships that require structure and an ability to build effective relationships. The domain of Safety and Quality is under-explored in this regard and can be

interpreted to mean many things in different social care scenarios. In this section, I apply the concept of Safety and Quality of practice to that professional 'holding space' which social care workers can provide through a protective relationship using a structure of intervention, such as developing problem lists, action plans and goals. I use this particular proficiency as an example of how to maintain both short- and long-term relationships with the people we work with in social care settings by using a trauma-informed lens, concepts of PACE (playfulness, acceptance, curiosity and empathy) and a connection before correction philosophy of practice (Hughes 2011).

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

Professional Holding Space

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

clients. It is the partnership element of our work that is critical to understand when we develop problem lists, action plans and goals with service users.

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

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

Social Care Case Study: Michelle (Aged 17)

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

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

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

Consider this ...

- How would you feel if you were told that that you had to leave home and find your own accommodation with little support or knowledge of how to access accommodation?
- What if you were never asked what you wanted for your future and it was left for someone else to decide on your goals and plans? What if you didn't even know how to

make these life decisions but were afraid to ask for help?

- What would it be like to have ten different people in your life all at the same time telling you different things to do? How would that make you feel?

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

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

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

Smith (2018) discusses the dynamics of sustaining relationships where there is anger, mistrust and hostility present. One of the concluding observations is that to sustain a holding relationship, practitioners should respond empathetically to feelings of anger, rejection and hostility, and, critically, keep going back. My first encounter with Michelle was characterised by all these emotions but we didn't talk about courts or family or anything that would be threatening to her. Our meeting ended abruptly when she aggressively left the room saying she would never talk to me again! However, I came back the following week and every week for the next three years. The formal order of the court mandating that she meet

with me was invoking further suspicion and resentment and we needed to try something different.

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

Restorative practice is the study of how to improve and repair relationships between people and communities. Its focus is on building healthy individuals in communities to decrease crime and anti-social behaviour, repair harm and restore relationships (Wachtel 2012). One part of restorative practice is the concept of using restorative justice, which is an alternative to processing criminal cases through the court. When I met with Michelle, she was outspoken about how alienating the court system was for because she found it frustrating not knowing what was happening in her case. I proposed a restorative justice approach in this case to the court, with the consent of Michelle, and this meant she could speak openly and directly to the judge when her case was called. In this approach, the judge even cleared the court to allow her to discuss the more sensitive aspects of her case and her past. It also allowed for Michelle to make amends for her offences by returning the goods she had stolen, doing some work for the hair salon in which she had caused criminal damage, without feeling shamed, and coming away with a sense of wellbeing having corrected the wrongs she had committed. All these plans came about after much time building relationships with Michelle, presenting consistently, being transparent with information and reports and involving her in the process all the time. For example, when addressing the problem of what to do to make up for her offences it was Michelle's idea to return to the salon to do some work and to return the stolen items in person. All of this was done in the context of the relationship we had forged over time. As restorative practices focus on the relationship, Michelle was inadvertently identifying the problems in her life, making plans and achieving her life goals.

TASK 1

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

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

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

Trauma-informed Practice

A strength in the restorative practice approach is the use of the principles of inquiry and assessment that are based in trauma-informed and human rights concepts. This means that practitioners do not ignore or dwell on past childhood trauma but use this information to understand the client's current difficulties in the context of this past trauma. Trauma-informed practice aids practitioners in emphasising to survivors how their past influences their present and therefore empowers individuals to manage and problem-solve their lives better (Knight 2015). Therefore, the use of a trauma-informed lens can enhance the logical reasoning and problem-solving skills of social care workers by helping them to understand current behaviours in the context of past events. Such insight gives social care practitioners the ability to see the social world from the perspective of the client, in which feelings of powerlessness, insecurity, shame and a deep mistrust of others can prevail (McCann & Pearlman 1990). This insight and knowledge can enhance sound logical reasoning and assist in problem-solving skills when awareness of the trauma is utilised to understand current behavioural and emotional difficulties. One of the approaches that Dan Hughes uses is PACE in practice (2009). PACE is a concept used in dyadic developmental psychotherapy (Hughes 2011) and is based on a way of thinking, feeling, communicating and behaving that aims to make a young person feel safe. It stands for playfulness, acceptance, curiosity and empathy. By applying these concepts to our practice we are invoking a sound logical way of reasoning and working with individuals who are traumatised. Holding a stance of being 'curious

instead of furious' (Hughes 2009) takes blame and shame out of the interaction and encourages understanding of the individual's past. This is similar to applying the unique exception concept often used in family therapy (White *et al.* 1990). In this concept we look for the exception of good moments in the client's life when they achieved something, and build on the skills that were required to make this happen. This can be an interesting tool to model problem-solving skills and help people identify how they have overcome previous problems to master new ones.

Concluding remarks:

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



Tips for Practice Educators

When supervising students on placement, consider the organisational culture and the impact on the student and their work – consider the 'sanctuary model' by Dr Sandra Bloom on how to provide a trauma-informed organisational culture for the people and systems who provide care:

<https://www.thesanctuaryinstitute.org/about-us/the-sanctuary-model/>

Use this resource list about adversity, culturally, trauma-Informed, infused, & responsive organisations & systems here – <http://www.safehandsthinkingminds.co.uk/trauma-informed-trauma-responsive-organisations-systems/> and checklist from Dr Karen Treisman as a guide or check out her book *A Treasure Box for Creating Trauma-informed Organisations*; Chapter 14 in particular, on supervision and team meetings, is an excellent resource for practice educators.

Use a simulated educational game-based learning activity with your students – check out the Social Care CORU Standards of Proficiency Board game developed by Balfe (2021) in conjunction with FOCUS Games: www.focusgames.com. This will help both you and your students to understand the standards of proficiency in your supervision.

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Chapter 46 – Grainne Ridge (D3SOP6)

Domain 3 Standard of Proficiency 6

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

KEY TERMS

Evidence-based approach
Professional decision-making
Frederick principles

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

Evidence-based Approach

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

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

Professional Decision-making

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

The FREDA principles



Author-created Venn diagram illustrating the FREDA principles (Fairness, Respect, Equality, Dignity, and Autonomy) as outlined in HIQA (2019: 11), highlighting their interconnected role in ethical social care practice. Added with permission

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

Case Study 1

Mary is a social care worker in a residential care facility for adults with autism. She has worked there for 17 years and is part of a diverse staff team with different cultural backgrounds and practice experiences. The service users have autism and are non-verbal and she knows all of them very well. Mary described the service users as 'nearly like family' and said that she truly loved and enjoyed her work. As part of the interview, I discussed the daily running of the residential area and how the service users were involved in their home and the service delivery within it. She spoke so passionately about service users and her colleagues and the work that they did there. I asked about menu planning, grocery shopping and meal preparation. She proudly explained that the service users didn't need to worry about any of that, as it was all done for them. She described how the staff planned and compiled the dinners for the week, the staff were very efficient and went alone to the supermarket and did the grocery shopping, the staff prepared and cooked all the meals and all the

service users had to do was to come to the table when it was ready, it was luxury, nearly hotel-type service. When I asked about the service users' involvement in the process, she laughed and said, 'Oh God no, sure they have challenging behaviour, they wouldn't be able for any of that.' I then asked about their likes and dislikes food-wise, she replied again that the service users were non-verbal and had challenging behaviour, they wouldn't be able to tell them what they liked and they didn't and there had been 'no complaints' about the food or cooking, so it was all fine.

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

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

Respect 'is central to providing person-centred care and support. People who use services must be listened to, and what is important to them must be viewed as important to the service. The principle of respect must be upheld regardless of a person's impairment or loss of capacity'

(HIQA 2019: 25). According to the FRED A principles, if a person cannot communicate their opinions and tastes, you can ask family members and another person nominated to be their advocate. Asking family or friends what a service user likes to eat when at home can expand the selection of meals that are served in the residential home.

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

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

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



Illustration of the FREDA principles (Fairness, Respect, Equality, Dignity, and Autonomy) from HIQA (2019), visually representing human rights and ethical practice in social care. Included with permission.

Consider this ...

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

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

Decision-making in Practice

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

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

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

TASK 1

Apply the FREDAs principles to this example and discuss how you as a socialcare worker could support the man in the case.

Consider this ...

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

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

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

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

Ultimately, we need to leave our own personal preferences and biases aside

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



Tips for Practice Educators

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

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Chapter 47 – Orla Dowling (D3SOP7)

Domain 3 Standard of Proficiency 7

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

KEY TERMS

Safety versus risk
Maintaining and prioritising safety
Proportionality
Positive risk management
Safety culture

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

Introduction

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

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

TASK 1

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

Safety Versus Risk

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

Safety involves a risk being controlled or reduced to an acceptable level (Roeser *et al.* 2012). When we discuss safety, we consider both the physical and psychological safety of service users, staff members and members of the public. Physical safety can include the work environment, hazards and equipment. Psychological safety is when a person feels respected, that they can apply themselves to a task without fear of consequences and is comfortable voicing opinions. The presence of psychological safety in a challenging work environment can help social care workers overcome barriers to change and learning (Edmondson *et al.* 2016).

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

TASK 2

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

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

Maintaining and Prioritising Safety

When discussions of safety arise, we consider the guiding legislation and policies,

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

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

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

Case Study 1

While engaging with a young male, Noah (pseudonym), aged 15 years, I noticed a subtle change in his non-verbal communication. I had been working with Noah for two years and we had developed a strong professional relationship. The goals for engagement that day included assisting Noah in meeting with his social worker. Noah had compiled a list of questions and had been working on remaining calm during the meeting. At the beginning of the meeting Noah expressed himself well and put forward his questions. After a few minutes, I noticed the right side of his jaw twitching, a very subtle change. I suggested that we take a break and went outside with Noah. Once outside Noah began to speak about his frustrations with the conversation and noted that he

had felt himself becoming extremely angry, stating, 'I was about to pick my chair up and throw it at him.' An open discussion was had with Noah and he was soon able to return to baseline and recommence the meeting. Reflecting back on this experience, it was evident that the safety of Noah, the social worker and myself may have been in jeopardy. My ability to pick up on the subtle change in Noah's non-verbal communication was attributable to the relationship I had built with Noah and my ability to notice his triggers and provide a safe space for him to explore his emotions and return to baseline.

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

Case Study 2

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

An open discussion was had by the team, and some noted that these changes are concerning. It was discussed that Georgina did not normally close the door as it made her feel trapped and caused flashbacks of previous traumatic experiences; and that Georgina usually greeted staff in an upbeat and friendly manner. But as prompting was needed it seemed as if she had withdrawn into

herself, that fixating on one thing, the movie, signified that Georgina was stuck in her emotions and also that sitting in a curled-up position and hugging her knees implied that Georgina was in need of comforting. These behaviours had been noted previously and had resulted in Georgina engaging in risk-taking and self-harm behaviour.

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

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

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

Task 3

Review the case study below and explore the following questions

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

The safety of service users and those involved in their care is deemed of equal

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

Case Study 3

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

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

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

Proportionality

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

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

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

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

Positive Risk Management

Positive risk management relates to building a culture within a service where risk management and safety is openly discussed and proactively managed (HIQA

2019). In society, risk-taking is an accepted part of life; however, for some of the service users we work with it is often discouraged. In the case of people with a disability, taking positive risks may be avoided because of perceived fears in relation to ability or capacity. But safety considerations must be balanced with some risk-taking, as there are positive outcomes that benefit a person's quality of life. Positive risk management involves identifying the risks, looking at potential benefits and developing actions to minimise the risk while helping a service user achieve the desired outcomes. It is also acknowledged that contingency planning should be put in place if the risk becomes unacceptable.

Case Study 4

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

TASK 4

Look at the above case study and determine the following.

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

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

TASK 5

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

Safety Culture

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

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

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

- **Organisations learning through practice.** An organisation is transforming continuously as it learns from past experiences and best practice. This knowledge should be transferred throughout the organisation.
- **Management's commitment to safety.** Managers who are perceived to have safety considerations at the forefront of their work influence the safety conditions on the ground. If a manager does not encourage safety practices or dismisses concerns, staff members will have greater exposure to risks.
- **Shared concern and care for hazards.** Safety concerns are shared among the staff team, discussed openly at team meetings and agreed actions are followed by all. All staff members report concerns of hazards to managers.

- **Realistic practices for controlling hazards.** As an organisation, putting in place control measure that are realistic or SMART contributes to the success of avoiding the hazard. Control measures should be more easily accessed by all staff members.

TASK 6

Review the case study below and explore the following questions.

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

Case Study 5

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

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

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

- Bill completed a risk assessment on the case, held a team meeting where an open discussion was had and safety measures agreed. He also sourced a second worker for the case. Bill then offered an opportunity for Sonya to attend supervision to reflect on the process.
- Bill listened to Sonya's request and explained that the case was one-to-one and that this would not change. Bill also noted that the disclosures Gemma made related to misconduct, not to any form of abuse, and therefore were not of a concern to the organisation. Bill also sent Sonya some suggested activities that she could use to engage with Gemma.



Tips for Practice Educators

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

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Chapter 48 – Jacqui McCann (D3SOP8)

Domain 3 Standard of Proficiency 8

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

KEY TERMS

Strengths-based approach
Positive behaviour support
Opportunity and support
Hope
Motivation and role modelling
Reflective practice and learning

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

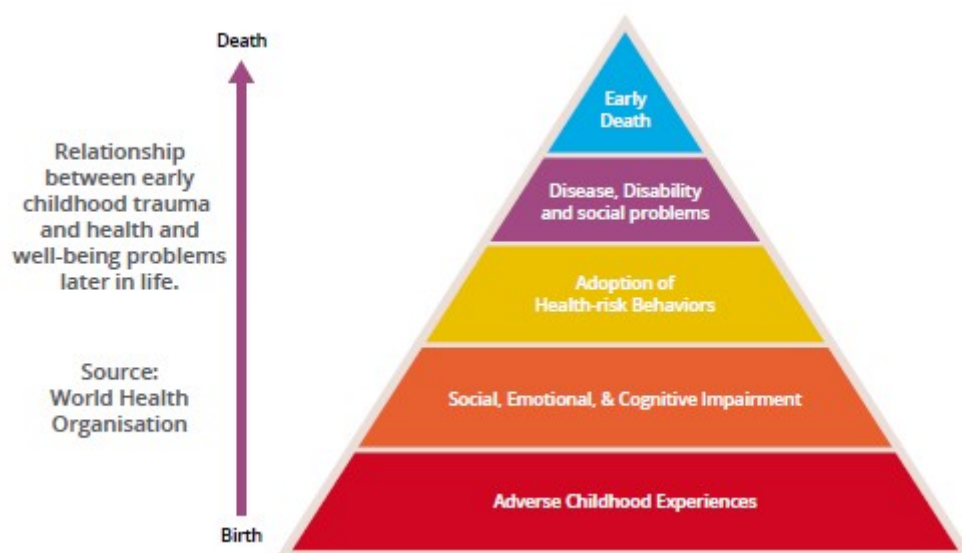
Social care practice has evolved to create many different pathways of working with individuals in their life space to respond to their care needs. At the forefront of this practice is a drive, not just to respond to these needs, but to 'do better' and provide high-quality standards of care. In terms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

In this chapter the provision of special care in Ireland as an intervention will be

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

The care system in Ireland has the unique role to provide for and respond to the needs of these young people at the fulcrum stage of their development 'during their childhood'. This is a critical period of our lives that shapes our adulthood. Young people who are placed in care have a complexity of needs. Alongside their primary emotional, physical, social and educational care needs, young people who have been placed in residential care, and specifically special care, also require intensive support and intervention regarding risks associated with their behaviour. But how do we identify what they need and what to prioritise? How do we intervene and provide the care they need? How do we identify the outcome and impact? How can we keep them safe from harm?

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



Author created pyramid diagram based on the Adverse Childhood Experiences (ACE) framework, illustrating the lifelong impact of early trauma on health, well-being, and mortality. Source: World Health Organization.

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

What is Special Care?

Residential and special care, under the care provision system in Ireland, sets out specific intervention plans and strategies that accommodate and take into account the needs of the young people placed in these services. As part of this continuum of care, special care provides the highest level of intervention to those young people in care with the highest level of needs. Special care is the provision of care to young people (12-17 years of age) in a purpose-built secure facility. Young people with severe and complex emotional and behavioural needs

and deemed a potential risk to themselves and/or others, are detained under a High Court order. The placement is a short-term intervention to support their return to a community-based placement, usually residential care or, in some circumstances, foster or familial care.

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

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

Special Care as an Intervention



In Ireland the programme of care for young people in special care is legislated for under the Health Care Act 2007, the National Standards (HIQA 2015) and the Special Care Regulations 2018. These documents set out the framework of expectation that young people will be provided with safe care that responds to their individual needs. Since 2018, special care centres in Ireland have been legally defined as 'designated centres'. There is a legal requirement for them to maintain 'registration' that deems them fit for

purpose when inspected against the Special Care Regulations. These inspections

are carried out by HIQA. There is a full inspection every three years with annual inspections carried out in related to targeted or identified regulations.

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

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

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

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

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

Risk Assessments

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

Case Study 1

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

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

Placement Plan

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

by traumatised young people who display challenging behaviours that result in harm to themselves or others. The model is underpinned by and advocates adherence to the following principles.



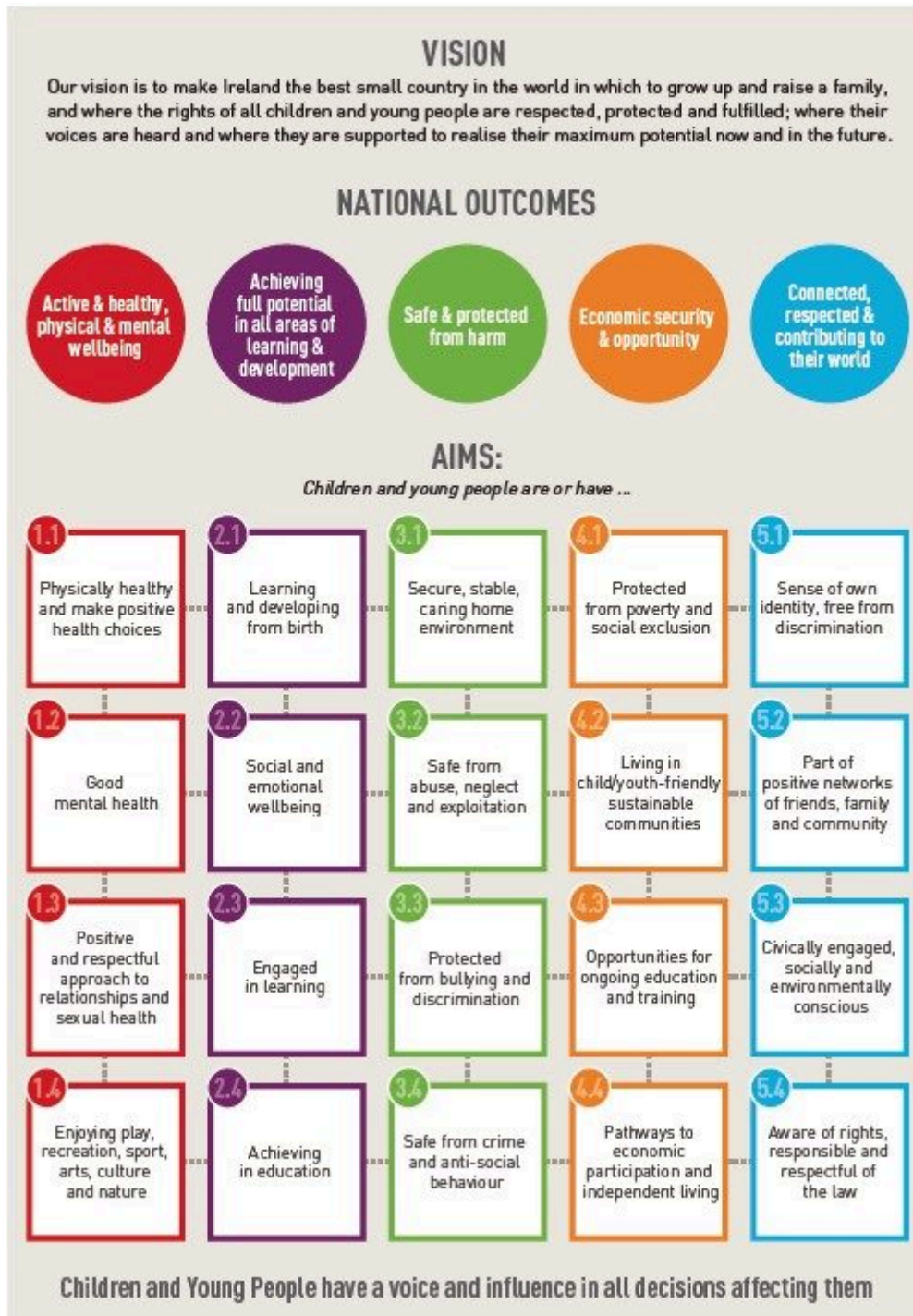
“Author created diagram based on the Welltree Model of Care, illustrating the interconnected principles of Trauma-Informed Interventions, Attachment-Informed Interventions, Wellbeing-Informed Interventions, and Risk-Informed Supervision in a holistic approach to care

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

The Welltree Wellbeing Outcomes Framework

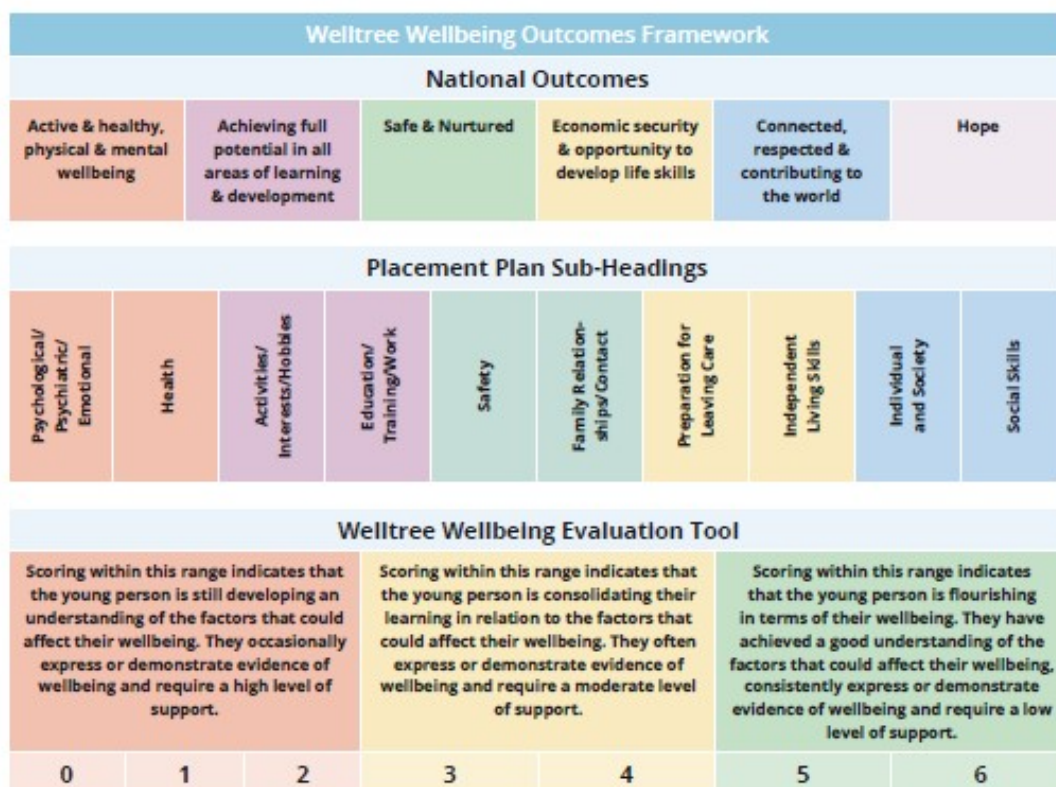
The Welltree Wellbeing Outcomes Framework was developed to support and accompany the Welltree Model of Care. The framework provides a structure for identifying goals related to wellbeing for the young person and how to measure

the outcomes achieved. It is based in Ireland on *Better Outcomes, Brighter Future: The National Policy Framework for Children and Young People 2014-2020*. This is a comprehensive statement that sets out how we intend to achieve the best for young people under five national outcomes that include identified aims.



Infographic from the Department of Children and Youth Affairs, Better Outcomes, Brighter Future Policy Framework (2014), outlining Ireland's vision, national outcomes, and key aims for promoting the well-being, development, and participation of children and young people

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



Author created diagram illustrating the Welltree Wellbeing Outcomes Framework. It details the six national outcomes, the sub-headings used in placement plans, and the scoring system for the Welltree Wellbeing Evaluation Tool, which measures progress from developing to flourishing in wellbeing

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

In most circumstances, young people are on admission in the low developing

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

How we engage the young person

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

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

demonstrates the skilled role social care staff have in using a relational and strengths-based approach to respond to the young people's high levels of risk and wellbeing needs.

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

How do we evaluate and review?

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

Achieving full potential in all areas of learning & development SCORE 2

Reason for indicators chosen:

Mary's educational attendance has historically been inconsistent and can often require support within Crannóg Nua

Mary appears to manage her behaviour better when she is kept active and channels her energy in a positive way.

2(a)The young person understands the importance of education or training and demonstrates this through their positive attitudes and behaviour

Action needed	Identified person required	Status
The staff team will continue to follow Mary's placement support plan, in relation to supporting her attendance in Crannóg Nua special care school. Complete individual work (1) on the importance of education and future education goals.	Staff team	Action in progress

2(b)The young person understands the importance of hobbies/ activities and demonstrates this through their positive attitudes and behaviour

Action needed	Identified person required	Status
Mary's assigned staff will continue to complete a daily plan with her. This will include identified pro-social activities, both on and off site – in keeping with her placement support plan. Complete individual work (1) on interests/hobbies and the benefit of participating in these within the community. This individual work is to be related to transition visits with onward placement and the importance of positive engagement in these, prior to transitioning back to their centre.	Staff Team	Action in progress

The scoring is completed and reviewed by the multi-disciplinary team, based on the evidence provided. The framework adopts a strengths-based approach and it can be difficult to apply in practice, but we encourage the professional team not to draw on the negative behaviours. However, the framework does also avoid this by looking at how much of the time the young person has been successful in demonstrating the behaviour. The framework has also supported changing the perspective from how many significant events has the young person has: the approach now supports and recognises how the young person has engaged positively outside these periods and also how they have managed

or responded when a significant event has occurred. The graphs demonstrate how the interventions implemented within special care are successful in improving these young people's wellbeing. There is a conscious effort to set out achievable goals to encourage the young people's participation and motivation to engage them and for them to be proactive in their overall placement plan. The scores of the outcomes are then included in graphs, which provide a visual aid in representing the improvements in the young person's wellbeing. If the young person is having difficulty, the scoring allows for a re-focus of the goals required and also for the multi-disciplinary team to review the cause of the deterioration.

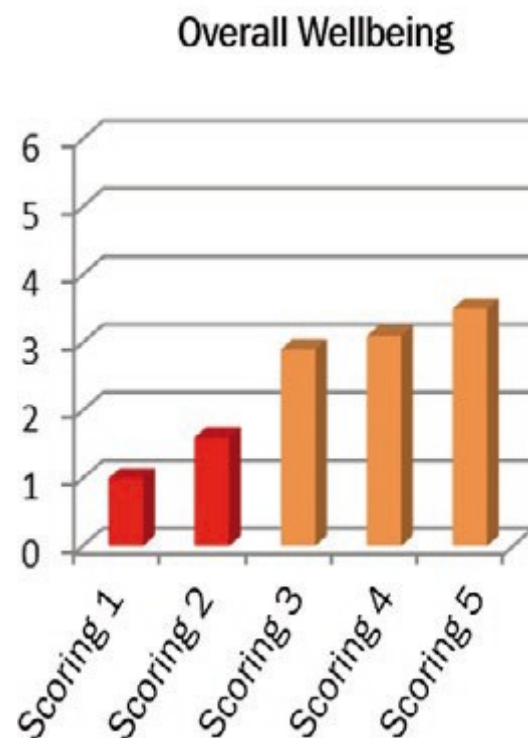
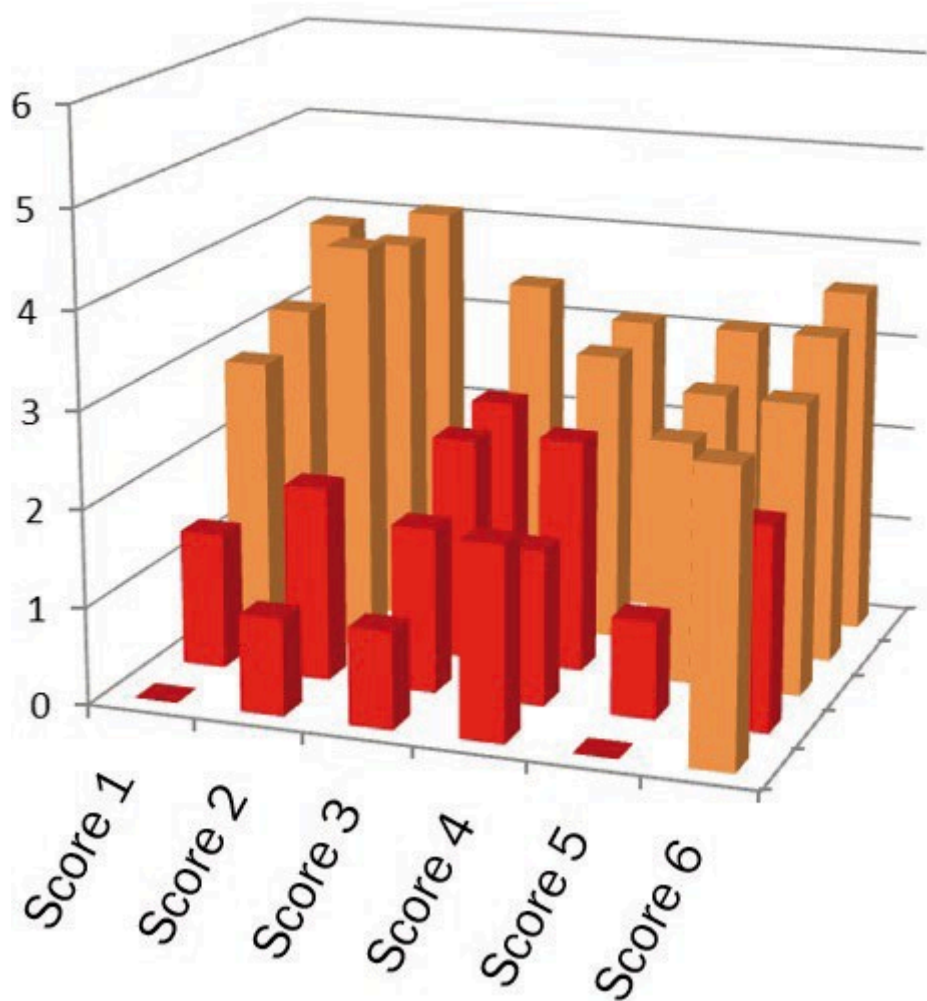


Chart showing the progression of overall wellbeing scores, increasing from Scoring 1 to Scoring 5.

Overall Domains



Complex 3D graph illustrating the performance of multiple domains across six different scoring levels

Staff actively encourage young people to participate in their scoring to develop an understanding of what supports them in their progression towards their placement goals. What has also been highly beneficial is where the placement that the young person has come from, or is going to, uses the Welltree Model of Care. Previously, when the scoring was completed on admission of a young person, the score was in line with the scores of the residential placement. This also means that the goals can be set out and adapted to promote joint working between the services and support the transition for the young person back to their placement. The scores also provide feedback to the special care centre regarding the overall progress in each of the domains. It allows for analysis of how the special care unit is doing with regard to improving the overall wellbeing of

the young people and also the individual domains. This is something which has not been available in the past in relation to providing data on the outcomes from the interventions provided in special care.

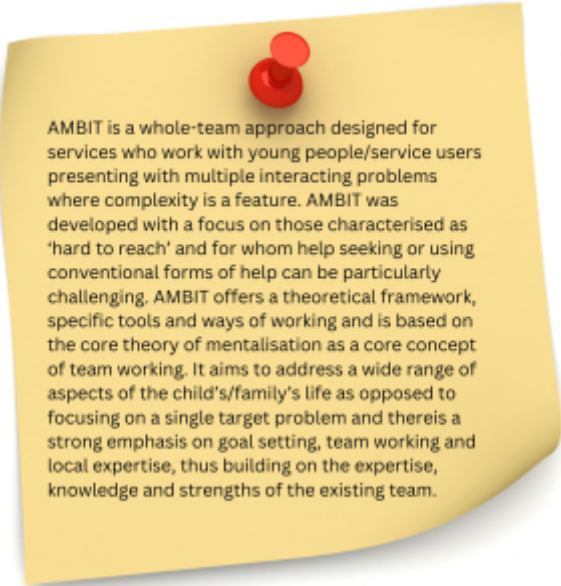
TASK 1

What does wellbeing mean to you? How have you promoted your own wellbeing? How has it been promoted by individuals in a social care setting

where you have worked? What intervention plans support this?

Individual Therapeutic Plan

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



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

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

How we engage the young person

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

On admission to special care, it is crucial that there is a culture promoting the benefits of the young person engaging in their therapeutic plan. Although young people should never be forced into therapy, it should have a

similar weight of importance as education. When staff actively promote their therapeutic plan, it can be influential for the young person. This is certainly enhanced when the staff team have a positive and proactive working relationship with the ACTS team.

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

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

How do we evaluate and review?

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

Finally, ACTS complete workshops relating to the individual young people at

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

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

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

Placement Support Plan

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

At an organisational level there are provisions relating to the application of therapeutic security principles in special care that support the daily implementation of positive behaviour support and behaviour management. The centres incorporate a number of safety features, including, among others, secure doors and windows, locked internal doors, CCTV, personal alarms for staff, and

identified safe rooms. The centre is designed to be able to respond to significant high- end behaviour to support both staff and young people to be safe. As a balance to this focus on safety, the environment is decorated to provide a homely and warm feeling so that young people feel welcomed and comfortable. The young people are encouraged to participate in creating the décor of the centre, including how they decorate their own rooms.

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

How we engage the young person

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

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

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

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

How do we evaluate and review?

The evolution and development of special care has led to greater sophistication in how we review behaviour management and promote positive behaviour support. In my experience this is an area that has developed significantly and has benefited from reviewing systems that ensure best practice and positive outcomes. It is imperative that risk assessments, positive behaviour support and behaviour management remain live and are updated and reviewed as required.

Staff in their practice are trained and guided in their responses to challenging behaviour. They are also prompted to take learning from each significant event and amend or update the PSP as required.

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

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

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

In the centre, in addition to the focused review of significant events, trend

analysis is completed. This looks at the statistics related to the data on incidents and behaviours presented. Each month, quarter and year there is a review to provide information on the rationale or antecedents to behaviour and to identify where high-end service-level responses or strategies are required. All of these reviewing mechanisms and reflective practice support the development and implementation of the intervention plan to promote positive outcomes. In special care, this top-level governance is required to ensure that the most appropriate and safest response is applied to the behaviour that occurs. Constant reflection and learning supports the young person's participation in the intervention plan. This is achieved through the consistent and competent actions of the staff in the form of trauma-/attachment-informed responses that promote wellbeing.

Task 2

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

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

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

After the centre re-opened as a special care service in 2017 it was evident

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

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

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



Tips for Practice Educators

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

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

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

- Meeting with the identified key team and case manager and agree some individual work in line with Welltree outcomes framework goals that the student can complete with the young person in the company of a staff member.
- Attend key training provided in the centre, if available. This may include behaviour management, including TCI, and Welltree.
- Using the outcomes framework, complete a scoring for a young person with a key worker and young person, if appropriate.
- Attend a staff meeting, ACTS meeting and SERG to see how intervention plans are evaluated and reviewed.
- Attend a child in care review if appropriate. This will give the experience of multi-disciplinary working and how the full programme of care is reviewed to update the care plan.

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

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Chapter 49 – Sheena O’Neill and Caroline Costello (D3SOP9)

Domain 3 Standard of Proficiency 9

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

KEY TERMS

Quality of practice
Evidence-based standards
Monitoring and evaluation
Implementation

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

Quality of Practice

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

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

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

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



HSE (2016) model defining quality in the Irish healthcare system. The diagram shows the relationship between Person Centred, Effective, Better health & wellbeing, and Safe care, leading to Quality of care

- **Service user/person we support:** The service user/person we support is the most important stakeholder and must be supported/facilitated by using appropriate models of participation and be given the opportunity to have an input into relevant reports, for example programme planning and HIQA audits. It is important to ask ourselves, if we never ask someone about their experience of receiving a support service, how will we know if it is right for

them? If persons providing support become familiar in their social care role or 'know' what needs to be done, it can be easy to stop asking and start assuming. The service user has as much of an essential role in ensuring quality of practice as the person who uses the service. Each person using a service has a right to reliability, transparency and consistency, both in service delivery and practice approach, where their own responsibility is defined, as well as all parties involved in their support. This reinforces working in partnership and enables monitoring and evaluation to be a shared process. Working in partnership is critical to enabling and supporting the service user to be a participant in all parts of their plan of support, including monitoring and evaluation of quality of practice. The service user's voice is vitally important as they will experience how the social care worker carries out their work, and they are directly impacted by it. It is critical that the service user's voice and their feedback are captured.

- **Social care workers:** Social care workers must be guided by organisational and national policy and national legislation. They are bound by CORU's Social Care Workers' Registration Board Code of Professional Conduct and Ethics and must register with the professional body. Policies and procedures set out what is expected of the worker and provide guidelines to follow to ensure safe, equitable, consistent, and quality practice. Examples of policies that guide practitioner practice include child protection, safeguarding vulnerable adults, policy and procedure, behaviour management, risk management, General Data Protection Regulation (GDPR), and health and Safety policy.
- **Funding bodies:** In Ireland social care provision is delivered through statutory bodies such as the Health Service Executive (HSE); Tusla, the Child and Family Agency; community and voluntary services such as youth services or family support projects; and private companies that run residential facilities for people of all ages. Where government funding is provided to non-statutory organisations there is a requirement to engage with providers via a memorandum of understanding (MOU) or service-level agreements. These funding agreements are built upon compliance with organisational and national policy, along with national legislation. Each of these policies is supported by evidence-based research and seeks to enhance public safety.
- **Governance/regulatory bodies:** These authority structures are established

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

Evidenced-based Practice

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

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

Framing the Evidence

The *Framework for Improving Quality in Our Health Service* (HSE 2016) shares six drivers for quality improvement in health and social care services, and points to organisational culture as being critical to continuous quality improvement

(HSE 2020). Positive organisational cultures enhance positive outcomes (Braithwaite *et al.* 2017). The social care worker has influence in all aspects of the quality improvement framework, as can be seen in the following examples (HSE 2016):

1. **Leadership for quality:** This requires committing to leadership strategies, and to seeking support and supervision for social care leaders. Within all levels in organisations there must be a common goal to seek to provide quality services. A meaningful focus on creating a positive culture within the organisation is essential. Mission statements and organisational values should not merely be something within a strategic plan, rather they should be embodied by all members of staff.
2. **Person and family engagement:** This involves the service user and, where appropriate, family members in all aspects of person-centred care. Services must encourage, promote and develop strategies for participation, for example facilitating an appropriate and inclusive communication strategy. Advocacy groups play a vital role representing the interests of service users. Examples of advocacy groups include EPIC, an organisation that engages 'with and for children and young adults who are currently in care or who have experience of being in care. This includes those in residential care, foster care, relative care, hostel, high support and special care units or facilities' (EPIC website). Sage Advocacy is a support and advocacy service for vulnerable adults, older people and healthcare patients. When we speak about involving people in their care, we must demonstrate how this is facilitated. This may be achieved through a service user participation tool that is appropriate to the individual. It is equally essential to ensure that participation is meaningful. In youth work, the Lundy model of participation is used. This is a 'rights-based model which conceptualises Article 12 by showing what is needed to make young people's participation in decision-making meaningful for the young person' (Byrne & Seebach 2015: 10).
3. **Staff engagement:** It is essential that practitioners participate in all staff engagement strategies such as supervision, decision-making/problem-solving, continuous professional development and positive mental wellbeing. Once again, we must consider what this will look like in practice. It is of little benefit for staff to engage in, and supervisors to conduct, performance management and development interviews if they are meaningless. For example, if a staff team request training they feel will enhance the quality of practice, and the manager agrees to provide it, but the training is not provided, or staff rostering does not facilitate staff

attending the training, then this engagement is meaningless. Communities of practice are an important structure for social care sectors as they encourage peer support networks and sharing of good practice.

4. **Use of improvement methods:** Examples include plan/do/study/act (PDSA), SMART goals (specific, measurable, attainable, realistic and theoretically sound (evidence-based) or timed), the improvement method, and Lean Six Sigma. 'Building measurement into all improvement initiatives is essential so that we know when improvements have occurred and when they have not' (HSE 2016). It is essential that all steps in planning improvement measures are clearly captured/recorded, that timescales are established, and clear roles (who does what) are set out. It is essential to build in monitoring and evaluation strategies so that achievement can be measured, and changes made in a timely fashion where required. In addition, what is learned should be shared across the staff teams and any identified improvements implemented in a timely fashion.
5. **Measurement for quality:** It is essential to collect and store relevant data, such as records, when working with service users to measure quality and progress; for example, the service user's experience and achievement of all outcomes. This can, for example, be monitored at regular intervals throughout the implementation of a plan and evaluated at its conclusion. This data will inform improvements at a point in time and/or moving forward in your practice. The data gathered should be data that is purposeful, and in line with the requirements of the organisation. The burden of additional staff workloads will only be embraced by staff where the measurements are seen as more than a tick-box exercise, and there is a clear focus for improved outcomes. Plans/work practices must include clear measurement strategies: if we do not have clear indicators to measure quality of care, how will we know if this has been achieved?
6. **Governance for quality:** Social care workers ensure that they work in line with policies and procedures to ensure that their work is safe, effective and person-centred, and that they are accountable. Remember, policies and procedures are living documents and can always be developed and refined to ensure that the quality of care and the safety of all stakeholders is enshrined.

Social care workers play a key role in designing programmes of support and care that are individual to the needs of the person using their particular service, e.g., a support plan for a person with a mental health difficulty or intellectual disability,

a risk management plan for an older person, an education/ employment plan for a young person, after-care planning for a young person leaving care.

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

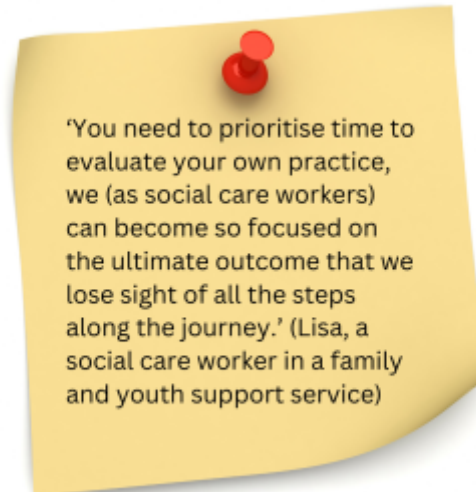
In our experience many of the pieces of work facilitated by social care workers are not apparent to a non-professional observer. For example, the relationship-building component of engaging with a service user is the foundation to identifying the service user's support needs. Sometimes this relationship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

Monitoring and Evaluation

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

such as whistleblowing and protected disclosures were invoked to remedy these failings.

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

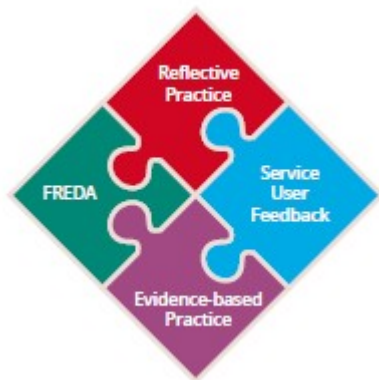


Monitoring and evaluation are essential components of quality improvement. Their purpose, in the most basic sense, is to seek what works, what does not work, and what improvements can be made for immediate implementation and forward planning. If you consider the quality improvement framework provided earlier, monitoring and evaluation should take place for each individual driver.

This process of monitoring and evaluation is central to auditing practice with a view to improving both the service and service user experience (HSE 2016).

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

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



Author created diagram illustrating key elements for service delivery

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

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

TASK 1

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

For example, I really enjoy having a coffee in a fancy café. My role is to walk in, order my coffee and special extras such as a shot of syrup or oat milk. I usually meet a friendly barista who asks what my preferences are and tailors my coffee for me. They have listened to me and then provide this service. Sometimes I feel it may be too sweet and I know it is because I have not communicated my preferences such as a half shot of syrup, etc. The experience would be better

if I communicated this preference, but I sometimes forget and would appreciate it if I had a choice about the quantity of the ingredients. I also feel that people are busy and forget to personalise the experience.



Tips for Practice Educators

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

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

best possible outcome, in a timely manner.

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Chapter 50 – Claire Barry (D3SOP10)

Domain 3 Standard of Proficiency 10

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

KEY TERMS

Risk factors
Risk management strategies
Reasoned decisions
Recording

Social care is ... providing calm and considered interventions

TASK 1

Reflecting On Practice

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

Introduction

Risk factors and risk management strategies are different in different care

settings. This chapter is based on my experience as the manager of a day centre providing services to adults who have an intellectual disability.

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

Consider This

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



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

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

Author created diagram: Risk management process

Risk Management

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

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



Author-created diagram: Risk Management Cycle

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

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

'Risk assessment and management policies and procedures are in place which enable staff to support people to manage situations where they may be vulnerable. The approach to risk management supports responsible risk taking and informed decision making, as a means to

enhancing the quality of life, competence, social skills and independence of people using the service' (HSE 2014).

Positive Risk-Taking

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

'HIQA acknowledges that promoting autonomy, and improving quality of life, may sometimes require a degree of risk. People who use health and social care services are entitled to the dignity and personal development associated with risk-taking. A positive approach to risk assessment acknowledges that risk-taking is part of a fulfilled life.

Positive risk assessment considers possible harms, and focuses on individual strengths and collaborating with people to meet their individual needs. HIQA supports positive riskassessment in appropriate settings when person-centred planning and associated necessary safeguards are in place' (HIQA 2014).

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

Ultimately, positive risk-taking focuses on the benefits to the service user of engaging in the risk. The potential loss to their quality of life is identified and prioritised.

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

Further suggested research into Positive Risk Taking:

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

TASK 2

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

Question

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

Answer:

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

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

Making Reasoned Decisions

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

TASK 3

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

Answer:

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

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

TASK 4

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

Recognising Risk Factors

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

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

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

Risk identification is not one single person's responsibility. A culture should be created where everyone feels involved in the identification of risk. Some risks will be identified by a Social Care Worker based on their knowledge and judgement. For example, through the key working role someone may express a desire to undertake something new which will involve an element of risk. Equally, risk

identification may come from other stakeholders (e.g. families, peers) or processes (Audits, Person Centred Planning, Incident Reports).

TASK 5

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

Answer:

You need to narrow down your concern to the specific risks involved.

Are you concerned that:

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

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

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

Risk Assessment

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

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

TASK 6

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

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

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

Risk Assessment				
Your Name:			Date:	
Task being assessed:			Review Date:	
Hazard	Risk	Control Measures	Person Responsible	Risk Rating

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

Author-created risk assessment form

3. The risk rating. This looks at:

- a. the severity of the **impact of the risk**. For example: the potential injury from a trip hazard is low compared with the severity of impact of exposed electrical wiring
- b. the **likelihood** of the risk occurring.

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

TASK 7

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

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

4. If the risk rating is too high and it is at an unacceptable level of risk, we may have to go back to our control measures and add **additional controls**.

5. These additional measures may reduce the level of the risk, so we will assess the risk rating again.

6. **Review date**. All risks should be reviewed regularly.

Task 8

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

Question:

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

Answer:

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

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

Monitor Courses of Action

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

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

Record Decisions and Concerns

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

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

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

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

Conclusion



Author created pie chart: Risk management steps

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

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

TASK 9

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



Tips for Practice Educators

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

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

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

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

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

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

Resources

ABC (Antecedents, Behaviour, Consequences) downloadable Form from the National Autistic Society. https://www.bexleyvoice.org.uk/uploads/3/9/0/4/3904704/abc_chart_1_.pdf

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

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

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

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

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Chapter 51 – Michael McCarthy (D3SOP11)

Domain 3 Standard of Proficiency 11

Understand the principles of quality assurance and quality improvement.

KEY TERMS

Quality in social care

Quality framework: interdisciplinary and inter-agency planning

Quality assurance in social care

Quality improvement in social care

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

Quality in Social Care

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

Quality as a proficiency in social care work addresses some of the most

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

Quality Social Care Frameworks

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

Table 1 Quality support planning

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

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

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

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

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

Quality assurance measures compliance with standards and policies based on service user safety, quality of life, the rights of service users, ensuring that service users are treated with dignity and respect at all times and in employing an appropriate balance of interdisciplinary working¹ and inter-agency working² when required (HIQA 2018).

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

Quality improvement systems that capture service user experience and daily

1. Interdisciplinary working is a team approach to care whereby the social care team within an organisation provides supports and services to individuals through shared decision-making. It demonstrates accountability and shared leadership and adopts a holistic and inclusive way of working with marginalised individuals or groups.
2. Inter-agency working refers to information-sharing and working in a partnership approach to care between different services outside your own organisation. It is sometimes referred to as inter-agency collaboration.

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

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

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

Post Challenging Behaviour Incidents instead of After Challenging behaviour Incident

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

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

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

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

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

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

Lone Working Risk Management

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

- Potential hazards, which include threatening, abusive or potentially violent situations which may lead to social care worker injury.
- Allegations made against social care workers by their service users in lone

working situations of a verbal, physical or sexual nature.

- Objects, things or even animals used to carry out threats against a social care worker.
- Risk of infection from service user pets if they are untreated for flees.
- Risk of needlestick injuries.
- Blood splashes from a service user who has self-harmed.
- Effects of passive smoking on social care workers.

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

TASK 1

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

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

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

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

As part of our duty of care we need to use our common sense, our general intelligence (IQ) and, most important, our emotional intelligence in order to be able to identify what is going on for an individual (Robinson & Clore 2002). This involves being able to read the emotions of the person and the environment. If

one's own emotions become heightened in a difficult situation the following self-assessment may help improve the situation:

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

Quality in planning and delivering policy

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

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

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

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

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

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

The quality of the key working process is another factor that can be assessed in terms of service users' level of need and level of engagement with the supports offered (Share & Lalor 2013). Key performance indicator information³ is then forwarded by local managers to the service manager or their equivalent (Parmenter 2007). For example, in a residential service, key performance indicator's (KPIs) can keep track of service user 'move-ins' to the service and of successful outcomes in terms of service user 'move-outs' from the placement to longer-term stable accommodation.

Quality in the Provision of Social Care

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

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

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

1. The Quality of Education

- CORU (the Health and Social Care Professions Council) is the body responsible for regulating health and social care professions established under the Health and Social Care Professionals Act 2005. CORU's role is to protect the public by promoting high standards of professional conduct, professional education, training and competence among health and social care professionals.
- In Ireland, the minimum requisite qualification to practice as a social care worker in the publicly funded health sector is a three-year Level 7 degree. Many social care professionals will complete a Level 8 undergraduate degree in social care and some will go on to do a Level 9 master's in a related human services field.
- When a social care worker gains employment in their chosen area of social care the accessibility of good supervision, training and continuing professional development is crucial.
- Hands-on practical experience, education and training will help develop a person into a social care practitioner who is well rounded and balanced in their approach to care. This will aid the development of additional skills such as case management proficiency and the capacity to carry out the necessary administrative tasks to a high standard.

2. The quality and regularity of good supervision

- A social care leader is responsible for organising good supervision with their supervisee (Munsen 2002). A good supervision model guarantees the collective reassurance that CORU values, ethical codes and guidelines are uniformly adopted and explored as part of the supervision process (SCWRB 2019).
- Good supervision should not just be a line management exercise in which each service user's case is discussed, problems identified or solutions offered. It should be much more than that; it should boost reflective practice.
- High-quality supervision practice should convey how excellent supervision identifies with employee satisfaction, commitment to continuing personal

development and employee retention.

- Quality supervision should facilitate conversations that the social care worker might like to have not only in relation to the work but also in relation to their feelings or personal matters outside the professional sphere that might be presenting issues for them (Lynch & Happell 2008). For example, the break-up of a relationship can be emotional for an employee and they may need time off. At times when childminding is an issue, patience and understanding should be shown by the supervisor and a plan put in place until the matter has been resolved.
- Conflict with other social care workers may arise from time to time and supervision offers a unique opportunity for a supervisee to feel listened to and valued and to have their perspective on the situation understood (Matthew 2009).

3. The organisational culture and personal growth

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

Quality Improvement and Task Fulfilment

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

- **Case management:** This may require holding a caseload of a number of service users, e.g., fifteen to twenty cases. The author previously worked in the family homeless action team assisting families who were living in emergency accommodation. As a case manager the work was both challenging and rewarding. To ensure that all service users' needs were

adequately met a joined- up case management approach was adopted. This involved carrying out family assessments and holding initial key working meetings in order to identify family support needs.

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

organisational level (SCWRB 2019). For example, candour and disclosure when somebody is at risk to themselves or others or the steps to take when there is a death in-service.

- **Quality communication:** This means being able to assess and manage situations in such a way that the process is clear to the service user. Communication styles may need to be modified from time to time (verbal and non-verbal communication) to suit the specific needs of the service user at the time.
- **Cultural competence:** Social care workers should also think carefully about language barriers, the culture of non-Irish service users or members of the Travelling community and the various physical and mental health needs of service users. Social care workers should be able to comprehend the importance of building and sustaining professional relationships with other workers on the team and to contribute to decision-making within an interdisciplinary team environment.

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

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

- **Empowerment:** Social care workers should endeavour to empower service users to reach their goals and to manage their own wellbeing as much as possible (Anuradha 2004).
- **Quality managerial frameworks:** Social care workers should be able to produce documentation that is concise, factual and objective (HIQA 2018). This will involve applying digital literacy skills or other technologies such as the use of email or synchronised online meeting forums such as Zoom or

Microsoft Teams. These are particularly pertinent in the current COVID-19 climate.

- **Quality safety measures:** Social care workers should have the capacity to gather all relevant background information regarding service users' history, health and wellbeing. For example, conducting needs assessments; seeking a social history or placement reports.
- **Assessment techniques:** Social care workers should be able to implement assessment techniques and to subsequently record a detailed assessment. For instance, family assessments for homeless families before they secure long-term, stable emergency accommodation. This is essential for building relationships with families who are only able initially to access emergency accommodation on a night-by-night basis. In this regard, advocating with the relevant local authority is essential in order to have their assessment and required paperwork finalised as part of their local authority assessment. At the point where it has been accepted that they are homeless, the family is eventually placed in longer-term emergency accommodation in which they will gain access to a dedicated case worker or child support worker if required.
- **Risk factors:** Social care workers should be able to recognise significant risk factors and to use this information to devise a quality-based risk management strategy in order to arrive at reasoned decisions when making interventions or when discontinuing interventions in favour of something new if previous strategies have failed to yield positive results.
- **Quality of practice:** Social care leaders need to comprehend the absolute necessity to monitor and evaluate the quality of social care worker practice through quarterly in-house audits in preparation for HIQA or Tusla audits. This is useful in order for social care workers to be able to critically evaluate their own individual practice as a case worker/key worker/after-care worker/team leader against evidence-based standards. This is further advantageous in terms of implementing changes and improvements to both standardised tools and relational-based practice based on the results and findings of review meetings and audits.
- **Health and safety:** Social care workers should be able to carry out and participate in and engage service users in fire safety checks at least twice a year. They should also carry out regular building checks to mitigate against possible damage that may be caused by hazards in the workplace. This also involves doing regular room or apartment checks in residential services to ensure the safety of both service users, visitors to projects and to employees.

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

Background:

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

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

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

Move on, Interventions and Outcomes:

In early 2018, M moved to a residential placement for under 18s. It was a difficult adjustment moving from foster care to a residential service. M had to get used to living with other young people and had to adjust to 24/7 social care cover. Over time, through the consistency of the staff team in explaining the rules of the service and the rights and expectations on both sides, M began to settle in well to the placement and the staff generally found him to be pleasant.

Prior to moving in a needs assessment and a social history was forwarded to the social care manager, who reviewed the information. The team met with M and his allocated social worker and

he was assigned a key worker. His key worker, Jake, slowly built a relationship with M. This involved developing trust and maintaining professional boundaries at all times whilst balancing this with showing due respect and care to M's needs. An after-care plan was started in order to prepare M for leaving care as part of the national after-care policy for leaving care based on the principles contained in the Child Care Amendment Act 2015, the UN Convention on the Rights of the Child and the Child and Family Agency Act 2013.

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

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

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

TASK 2

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

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Chapter 52 – Grace O’Flynn (D3SOP12)

Domain 3 Standard of Proficiency 12

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

KEY TERMS

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

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

Tip

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

Risk analysis

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

When assessing risk, it is important to ask:

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

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

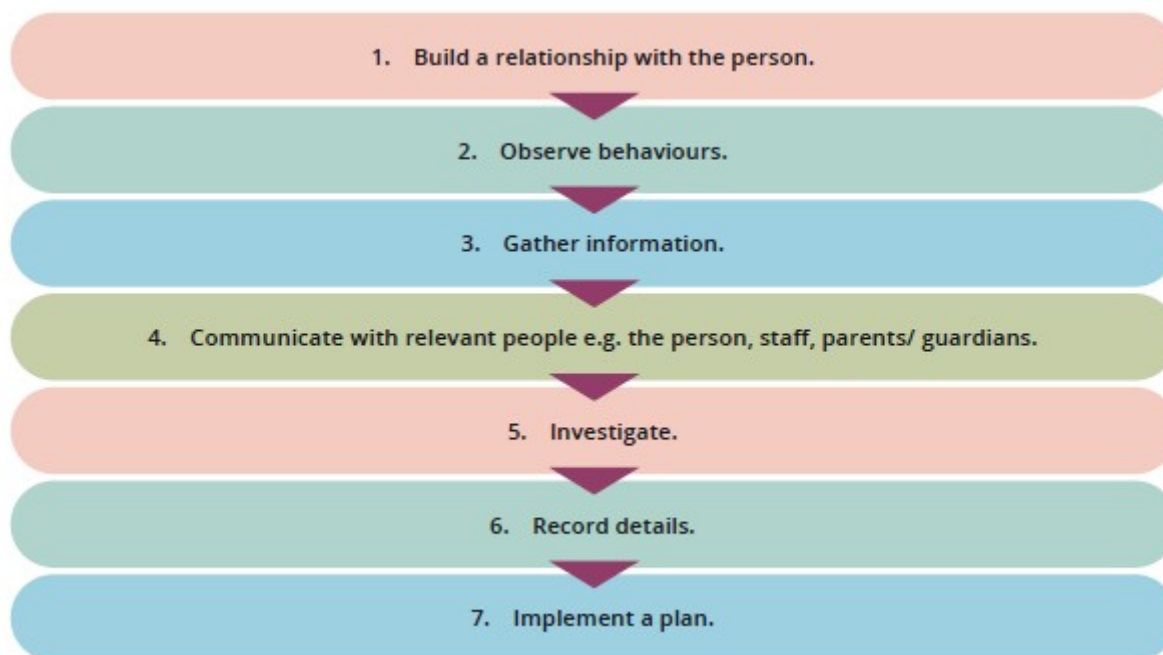
$$\begin{aligned} &\textbf{Likelihood x Impact = Risk Rating} \\ &\textbf{Likelihood (3) x Impact (4)} \\ &\textbf{= Risk Rating 12} \end{aligned}$$

Sample risk matrix from HSE (2018)

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

Sample risk matrix from HSE (2018), used for risk assessment

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



Author-created flow chart for working with individuals.

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

Remember: Not every activity must be risk-assessed.

Effective Risk Management

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

There are two approaches to risk management; preventive and reactive. Social care workers may aim to take a proactive and preventive approach by putting supports in place **before** the activity or action occurs (HIQA 2014: 4). For example, if a person you are supporting has decided to take up a new hobby or start a new

job, you may look at the risks associated with this action. If there are evident risks, it is your role to put adequate supports in place to minimise this risk. This is a preventive measure. Before the person begins doing the activity, you have clearly identified the hazards and provided additional measures to reduce the level or likelihood of harm.

PREVENTIVE = BEFORE

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

REACTIVE = AFTER

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

Tip

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

Communication

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

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

Documenting risk assessments

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

require to support a person to do an activity safely. It also communicates how the person themselves likes to be supported to engage in this activity.

Recording accidents and incidents

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

Reviewing and monitoring risks

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

Risk register

In addition to recording adverse events and documenting individual risk assessments, services often use a risk register. This is a list of all the identified risks associated with that service. They may include a record of all the risks

identified with the people we support and staff- or service-associated risks of working in that environment. The register will often rank the risks from high to low, placing the priority on those that have the highest risk rating. Colour coding is often used to indicate the priority, for example a traffic light system of red = high risk rating, orange = medium risk rating and green= low risk rating.

Recap



Author-created risk management cycle diagram.

Case Study 1Mark

Mark

Mark is a 30-year-old man with an acquired brain injury. He lives in an assisted living service in

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

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

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

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

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

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

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

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

Tip

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

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

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

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

Positive Risk-taking

Positive risk-taking refers to weighing up the advantages of carrying out an action versus the level of harm associated with the action (HIQA 2016: 7). The activity may provide an opportunity for growth and development. If we as social care workers decided that this risk was too high and said that Mark could not engage in this activity, not only are we restricting him, we are also infringing on his human rights.

The activity allows Mark to maintain positive meaningful relationships, and provides opportunities to plan and organise activities, develop his area of interest, and support time management and money management skills. It provides time to utilise assistive aids and acknowledge that they can enhance his independence. It also allows him the opportunity to design and implement problem-solving skills. If this activity were removed from his weekly plan on account of the level of harm associated with it, Mark would have reduced opportunities to learn and grow.

The positives outweigh the negatives in this scenario. Mark travels independently to town every Friday to meet his friends and go to the cinema. He gets off at the wrong bus stop one in ten times and often seeks support from staff via the telephone to redirect him. Mark highlights the nearest monument/road sign to staff and is supported to get back on the bus to get to the correct place. Mark is still at risk of becoming lost but has established problem-solving

skills that support him to continuously engage in the activity independently. The impact of getting lost has reduced as Mark has developed ways to rectify the issue and get back on track. While the risk level may still be considered 'likely', the level of harm associated with it has reduced as Mark has developed the skills to return home without becoming lost.

Generic Risk Assessment Form (HSE Website)

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

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

		• Staff to redirect Mark back to the bus stop by using familiar landmarks.		

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

Staff-associated Risks

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

The assessor aims to answer the following questions:

- **What is the risk?** Lone-working.
- **Who is at risk?** Staff and people we support.
- **Why are they at risk?** Staff are at risk of false allegations. People we support

are at risk of abuse/ misconduct of the staff member.

- **Where and when are they at risk?** Staff when working alone and people we support when living in a service where staff are lone-working.

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



Tips for Practice Educators

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

Resources:

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

References

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

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

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

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

Chapter 53 – Dawn Murtagh (D3SOP13)

Domain 3 Standard of Proficiency 13

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

KEY TERMS

Compliance
Health and
safety legislation
Inquiry reports
Accessing
reports and
recommendations

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

Introduction

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

social care, explained through practical tips and links on how to access findings and recommendations of relevant reports.

Compliance

What it means to comply



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

smooth running of an organisation and to guarantee that everyone understands what is expected of them, as well as ensuring that everyone follows correct procedures.

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

TASK 1

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

Everything we do in social care encompasses health and safety legislation and

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

TASK 2

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

Health and Safety Legislation

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

TASK 3

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

Risk Assessments

TASK 4

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

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

STEPS INVOLVED IN CONDUCTING RISK ASSESSMENTS

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

Case Study 1

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

anaphylaxis. An emergency protocol must be put in place to follow in the event of an adverse reaction.

Safety Statements

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

TASK 5

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

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

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

There can be some drawbacks to health and safety guidelines. For instance, the requirement for emergency exit lights and safety signs in disability and residential care facilities can create a cold, clinical look in a place that is supposed

to be inviting and homely for young people. This has become more evident during the COVID-19 pandemic as services have been required to display social distancing graphics and COVID-19 information posters.

The nature of service provided and the needs of the people we work with must be taken into consideration when implementing health and safety regulations as, on occasion, the implementation of a safety requirement can create risk in itself. For example, in relation to fire safety, it is a requirement under the Health Act 2007 (as amended) for residential houses to have automatic closing fire doors (HIQA 2021). While these are vital in the event of a fire for preventing its spread and allowing time for evacuation, they can be hazardous. These doors are expected to be kept closed when not in use. Fire doors are very heavy, which creates an obstacle for people with physical disabilities. Measures need to be put in place to eliminate impediments or dangers. For instance, a hold-open device can be installed to ensure that the fire door does not create a barrier for people with disabilities or mobility issues. When a fire alarm goes off these doors will close automatically.

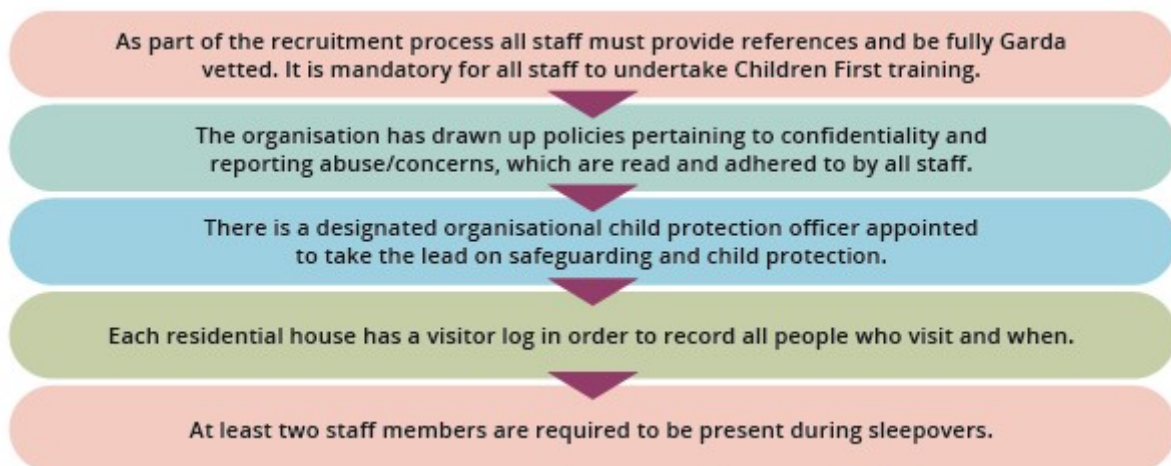
This poses a difficulty for the students with visual impairments I work with, as they are unable to see that the doors are closing. To ensure students don't collide with the doors, they are reminded during regular fire drills to take care when approaching the doors as they will be swinging closed. Personal emergency evacuation plans are in place that take into consideration the needs of each individual when evacuating a building.

National Standards

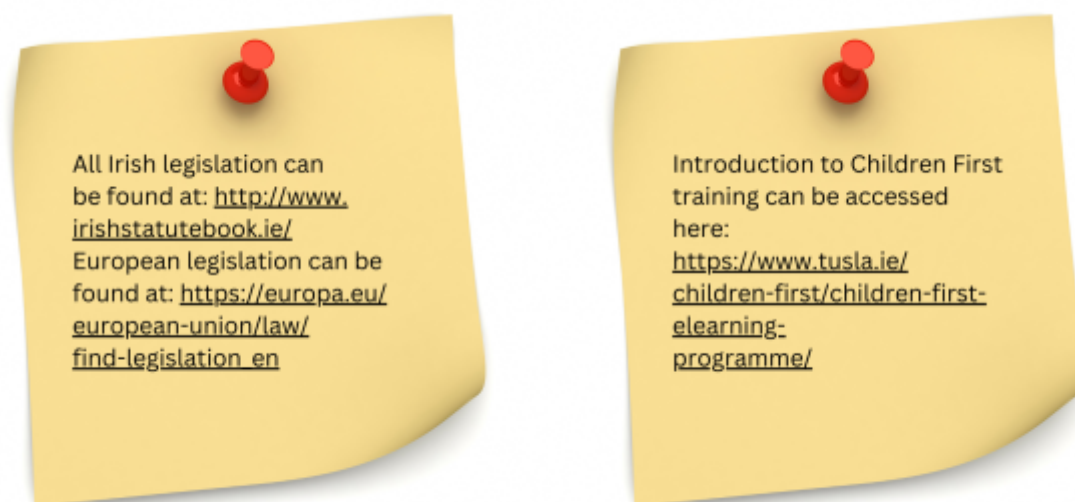
Both the National Standards for Children's Residential Centres (2018) and the National Standards for Residential Services for Children and Adults with Disabilities (2013) set out by the Health Information and Quality Authority (HIQA) emphasise the provision of safe care, and protecting people from harm, neglect or abuse. The standards mandate that all incidents that occur are managed and scrutinised to inform practice and prevent future harm. Additionally, the standards require the promotion of wellbeing and ensure that people's individual health needs are met. The Children First Act 2015 was aimed to make better provision for the protection of children. Under the Act, all children's services are required to have a safeguarding statement. The act enforces the obligation of mandated persons to report any concerns to Tusla, the Child and Family Agency. Furthermore, the Act provided the legal basis for *Children First: National Guidance for the Protection and Welfare of Children* (2017). This

document establishes clear guidelines for recognising and reporting abuse and neglect. It describes the four main types of abuse and how to identify them. It highlights the steps involved in reporting concerns. The role and responsibilities of a mandated person are established, along with protocols for social workers working in Tusla.

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



Author-created flow chart of safeguarding practices.



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

4.1 promoting the health and development of each child:

Jack is a 14-year-old boy who has recently started living in a residential house for students with visual impairments. He lives in the house from Sunday to Friday, attends school and goes home at the weekends. At home, he lives with his parents and older brother. Jack has recently lost the majority of his vision. Before attending the service, Jack's needs were assessed in order to put an individualised plan in place to address these needs, establish goals to work towards and provide meaningful care and support. The service provided Jack with an ophthalmology exam to assess his vision and eye health. A personal medical care plan will be written to address Jack's medical needs. Access to nurses, dental screening, occupational therapy or physiotherapy will be available to if desired. Jack takes medication for high blood pressure. All staff have received medication training. Two staff must be present and medication administration protocol must be followed when giving Jack his medication. Jack will be supported to self-administer his medication. Medication audits are carried out on a regular basis to guarantee that proper procedure is being followed. If a medication error occurs this must be reported immediately, the nursing team must be informed to provide medical advice and an error form is to be filled out. As Jack has recently lost vision, he is receiving orientation and mobility training to gain the skills necessary to navigate his surroundings without accident or injury. Jack has expressed an interest in learning how to access local shops and parks and travelling to school independently. These objectives will be added to his care plan and an orientation and mobility specialist will work with Jack to achieve his goals.

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

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

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

Inquiries, Reports and Recommendations

As we know, a plethora of inquiries and reports have had a major influence in shaping the landscape of social care practice in Ireland. These reports include

the Kennedy Report (1970), the Madonna House Report (1996), the Newtown House Report (2001), the Ryan Report (2009) and the Child in Care Death Report (2012). The recommendations of these reports, along with others, have brought about significant change leading to improvements in the provision of care for the people we work with. Inquiries help establish what happened in the past and learn from mistakes (LRC 2005).

However, many have criticised the effectiveness of reports (Burgess 2009, 2011; Mackie 2012; Stutz 2005). Burgess (2009) has claimed that inquiry reports have been ineffective, overly time-consuming, expensive and ineffective. He also argued that these reports placed too much focus on laying blame and introduced too many regulations without considering possible consequences. Howard (2012) has debated that while regulation and maintaining records is vital for transparency and accountability, over-regulation and excessive recording of information can often take the humanity out of care.

Professionals often work in fear of allegations being made against them and have to balance the conflict between meeting the demands of paperwork and caring for the people they work with. Young people are acutely aware of the level of recording conducted. 'Are you going to write that in my daily log?' and 'What are you going to write about me?' are questions I have regularly been asked by young people I work with. We must consider how this makes them feel. The Ombudsman for Children (Muldoon 2017) says, 'It is important that Tusla operates in a way that protects the child rather than the system.' From their research, Buckley and O'Nolan (2013) advised that future inquiries should limit their recommendations and place emphasis on key learning points which could be integrated into future practice across all organisations.

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

Accessing HIQA inspection Reports



Author created diagram: Finding HIQA inspection reports

TASK 6

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



Tips for Practice Educators

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

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Chapter 54 – Marie Nolan (D3SOP14)

Domain 3 Standard of Proficiency 14

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

KEY TERMS
Safe
environments
Minimising
risk
Infection
prevention
and
control

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

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

Risk and Safe Environments

Establishing safe environments in social care practice is very important, especially when some service users may not have the capacity to be accountable for their own safety. In social care settings, the responsibility to provide a safe environment lies with both the employers and employees. The social care sector

is driven by a changing legislative and practice framework. Guiding policies include the Health Act 2007, the Health and Social Care Professionals (Amendment) Act 2019, and the Equal Status Acts 2000-2018. Social care workers are faced with the challenge of maintaining a safe working environment that is consistent with changing policies, procedures and legislation. For example, the understanding of risk is influenced by the litigation that shapes it.

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

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

The term 'risk' is commonly used in association with an action that has an element of danger or potential loss. We are involved in the process of assessing risk when we ask ourselves the question, 'Is this too risky?' Some people choose to take more risks in their everyday lives than others. Equally, some people choose to take actions without considering any risks at all (Anderson *et al.* 2014). However, in the professional context of social care, frontline staff are expected, and have a duty of care, to undertake risk assessment and risk management every day. All services that provide care to vulnerable groups are regulated by a relevant statutory body, such as the Health Information and Quality Authority (HIQA), Tusla or the Mental Health Commission. These bodies' mandatory monitoring systems place a legal obligation on organisations to implement and adhere to policies and procedures that promote safe environments for service users. These policies include medication management, risk management, fire safety, finance management, safeguarding of vulnerable persons, and health and safety. It is therefore vitally important that all employees who are new to a service should receive an induction on and become familiar with all relevant guiding documents adapted to that service before they begin work.

There are other, less formal, contributing factors to establishing a safe working environment. Possessing an in-depth knowledge and understanding of the individuals being supported can be significant in the delivery of safe and effective services. Social care workers need to be aware of the environment in

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



Author created diagram: Risk & Opportunity vs. Danger.

Minimising Risk

A risk assessment can be developed either orally with a colleague or written on a relevant template. Risk assessments should be based on the premise of creating opportunities for an individual rather than used as evidence to prohibit an activity taking place. The format of a typical risk assessment includes the

identification of the risk/hazard; a description of the control measures put in place to minimise the risk; further considerations and an action plan; benefits to the individual of accessing the risk; and a review date.

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

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

behaviour support plan, such as proactive and reactive strategies implemented to identify and manage behaviours of concern.

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

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

Illustration included with permission.



TASK 1

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

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

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

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

Case Study 1

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

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

Discussion

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

Infection Prevention and Control

Infection prevention and control is the process of preventing infectious disease,

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

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

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

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

TASK 2

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

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

Standard precautions include:

A focus on education and training for frontline staff in infection prevention and control and cross-contamination

Provision of relevant information to staff and service users in relation to specific infection

Access and information on available vaccines and supports

Providing and wearing appropriate personal protective equipment (PPE), including putting it on and taking it off correctly

Maintaining clean and disinfected working environments and equipment

Setting up the work environment with clear systems/protocols in place to guide staff in safe practice

Prompt execution of effective reactive strategies.

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

At the onset of the pandemic and to respond to the pressures it presented to social care providers, the Department of Health published the ‘Ethical framework for decision-making in a pandemic’ in March 2020. The framework is aimed at assisting frontline workers, management and policymakers in health

and social care settings with decision-making in difficult circumstances. It identifies seven ethical principles that should be considered when planning for and responding to decisions in crises.

Two of the principles – minimising harm and proportionality – are relevant when considering infection prevention and control:

1. The principle on *minimising harm* reiterates the point that health and social care workers have a duty of care to inform and support service users in engaging in certain behaviours that reduce potential risks associated with the spread of infection; for example, supporting service users to avail of vaccinations.
2. However, the principle on *proportionality* advises that restrictions to one's liberty, as a result of control measures introduced to minimise risk, should not exceed what is required to address the actual level of risk to those whom the restrictions are designed to protect. For example, during a national lockdown, the highest level of restrictions should not be maintained longer than necessary just because it is felt that this is in the best interests of the individuals supported. Hence, government advice should be interpreted consistently with typical citizens of society, albeit occurring in a more strategic manner (DoH 2020).

TASK 3

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

In the unfortunate circumstances that an infectious disease is contracted in a care setting, an appropriate response plan is required to manage the spread of infection. Systems such as contingency-plans and risk assessments on cleaning, laundry and waste management should be considered. Standard precautions should be intensified. Maintaining a calm approach and clear communication with service users, staff and family is key to collectively overcoming a potential outbreak.



Tips for Practice Educators

In supporting students to achieve proficiency 14 under domain 3, it is helpful to commence placements by identifying risk assessments that are currently in place, and by providing information on any relevant policies and procedures present. The risk assessment folder contains significant information on safety and can be useful as a starting point for students to become familiar with the work environment and service users. As available, provide any inspection reports for the service which highlight areas of compliance in providing a safe environment; for example, HIQA inspection reports and annual audits. This will help students put the proficiency into perspective from a frontline point of view. If possible, protected time should be provided at induction stage, i.e., time allocated just to read files and interpret new information.

Students should be provided with the appropriate means to perform high standards of infection control practices while on placement. For example, they should know how to access PPE such as gloves/masks when needed; be informed about current systems pertaining to infection control procedures, e.g., COVID-19 management plans; be aware of any potential risks associated with infectious diseases such as hepatitis B for which they require additional protection; and be familiar with any cleaning procedures necessary.

When setting placement goals, it would be beneficial for the student to be assigned a goal specifically to develop a risk assessment. It is important that students can apply current risk assessments to their work practice but are also able to identify an activity that requires a new risk assessment or a review of an existing one. Practice educators could arrange for the student to assist planning an activity which requires a risk assessment in advance. Assess whether the student can identify potential hazards, determine the level of risk involved, accurately record findings and identify control measures that either minimise or eliminate the risk, while taking consideration of practical use of available resources, local policies and procedures and possible modifications of activity as required. On completion of the activity, the student should be given the opportunity to reflect on what worked and what could have gone better, and how the risk assessment impacted on the success of the activity.

Relevant training is required and beneficial for specific roles. As most training programmes are accessible online on HSELand or via other online resources, an achievable training plan should be developed at the outset to help the student fulfil their role while on placement as best as possible.

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Chapter 55 – Deborah Brady and Fiona Brannelly (D3SOP15)

Domain 3 Standard of Proficiency 15

Be able to identify and document the unmet needs of individual service users and demonstrate an ability to select the appropriate escalation route working with colleagues and the service user to resolve the gap in care.

KEY TERMS

Unmet needs
Communication and needs
Documenting needs
Escalation routes for addressing unmet needs
Complaints procedures

Social care is ... advocating for the rights of people to have the life according to their will and preference by being innovative and creative in eliminating barriers.

Unmet Needs

Unmet needs occur when supports and services are unavailable or inadequate to meet a service user's will and preference, irrespective of the service. This chapter is written from our many years' experience as social care workers in disability services. People with disabilities are at a greater risk of their rights and needs not being identified and addressed. These unmet needs can relate to issues such as inadequate access to food sources, exposure and lack of protection from abuse and neglect, inadequate access to housing and respite, and limited family

and social relationships, to name a few. In some situations, service users have the skills and abilities necessary to identify and communicate their will and preferences with their family or social care worker (SCW). For a service to meet the needs of the service user they need to gain in-depth information of 'what is important to the person and what is important for the person', which is usually contained in their personal plan (HSE 2018: 13).

Personal Plan Diagram (A National Framework for Person-Centred Planning in Services for Persons with a Disability 2018: 13)

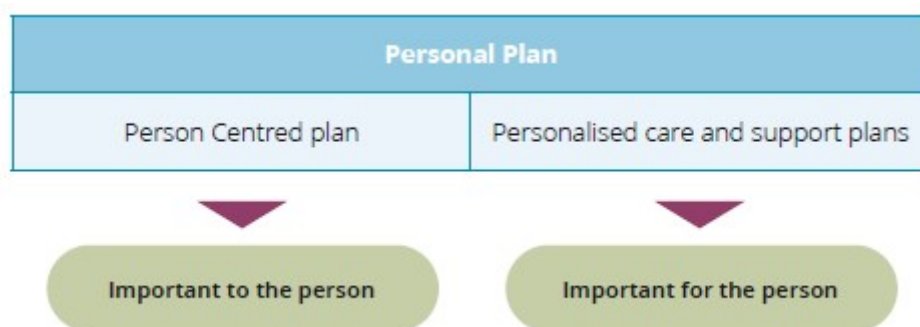


Diagram reproduced from 'A National Framework for Person-Centred Planning in Services for Persons with a Disability 2018: 13', showing the structure of a Personal Plan.

This approach puts what matters most to the service-user at the centre of the service in relation to the quality of care and support they access and what needs to happen to ensure they have the life they want. As an SCW you may be appointed as a key worker with responsibility for ensuring that these plans are updated and maintained to reflect the needs of the person you are supporting. These plans should be reviewed regularly and updated to highlight the changing needs of the person. This is done by the SCW, with the service user, their staff team and family/carers to ensure that the service they are receiving meets their current needs. These plans address not only the care and support the person requires but also their will and preference, hopes and dreams.

In the past we have seen many cases and reports of abuse in care such as the Áras Attracta Swinford Review Group 2016 report, which provides evidence of the negative impact of what can happen when the needs of people with disabilities are not addressed and how it can impact on the culture of an organisation. People with disabilities want nothing more than to have a say in their own lives and to gain access to the supports they need to be included in their

communities to live an ordinary life (HSE 2018). For years people with disabilities were, based on their cognitive impairment, denied their legal capacity to make their own decisions. This had detrimental effects (Davidson *et al.* 2018), making them very vulnerable to exploitation and abuse as they were deemed incapable of expressing their wishes or lacking capacity to make their own decisions (Killeen 2016). Decisions were made by professionals and families in their 'best interest', not taking into account their will and preference (Carolan 2018).

Examples of this range from lack of the service user's consent in relation to medical treatments, the services they received, and where or with whom they lived. To ensure a quality service that is meeting the individual's needs, personal plans are developed with that individual, their families and/or carers which contain valuable information about the individual to ensure that they will receive the service they want. If these plans consistently highlight needs that are not being met, there are different avenues you can take to rectify this. We have used fictional case studies in this chapter to illustrate how we identify and document unmet needs within our sector.

Case Study 1

Identifying Unmet Needs

Social care worker John has been Mary's key worker for the past three years. Mary has a hearing impairment and is non-verbal with a moderate intellectual disability. She uses a hearing aid and a picture exchange communication system (PECS) to communicate.

One day Mary came into her day service from her home and didn't follow her usual routine. It is important to note that when someone cannot communicate verbally, staff awareness of the individual's body language and routines are heightened, as changes in these can be an indication that something is not okay. Mary had a cup of tea but then went up to the physiotherapy bed and lay down. Mary is very inquisitive and likes to be in the company of staff members, so for her to do this is out of character to those who know her well. There was a locum staff working that morning and a permanent staff member who was with another service user. John was at a meeting and afterwards came into the kitchen, where staff drew his attention to Mary. They told him that she may have had a late night and was tired. However, John, who knows Mary very well, became very concerned. He went up to the physiotherapy area and asked Mary if she was okay. When he looked at her he knew she was seriously ill. John quickly informed staff of his concerns and made the decision that he needed to get Mary to hospital and there wasn't time to wait for an ambulance. He instructed staff to get Mary's hospital passport and list of medications while he organised transport. John brought Mary to the hospital and even though Mary could not communicate her illness and appeared well to the nurse, John advocated for her to be seen straight away – sometimes service users like Mary do not present symptoms of illness in the same way as the general population.

Mary was diagnosed with sepsis from an untreated urinary tract infection and ended up spending two weeks in hospital. On discharge, a care plan was drawn up for Mary by her service team that included regular urine tests and a referral to urology. A historical search of Mary's medical files showed a history of UTIs which was not noted in her recent medical notes, so this was added to her current care plans. Additionally, her communication passport was updated to acknowledge the importance of knowing Mary's routine and body language.

To be able to identify an unmet need for service users who cannot communicate verbally, you need to have a good knowledge of the person's will and preference, which is reflected in their normal routines and behaviour. The ability to identify an unmet need early and act on it quickly is an important part of the role of a social care worker.

1. On reflection, what are the key issues you identified in this case study and how would you as a SCW address them?
2. What strategies and documentation would you have in place to prevent this situation from reoccurring?

Communication and Needs

Needs can be communicated through verbal language, objects of reference, picture exchange communication (PEC) or other communication devices or aids. Consequently, it is vital that family and SCWs have received the necessary training in communication tools and assistive technology. However, in the disability field, we frequently support people with limited communication abilities that can lead to difficulty in identifying and addressing a person's unmet needs. Therefore, in such circumstances it is important that staff are familiar and have a relationship with the people they are supporting. It is also essential to have the necessary training and skills to enable SCWs to decipher the subtle cues (body language, facial expressions, different vocal tones) that service users use to communicate. It is sometimes through these subtle communication cues that we as SCWs can identify and understand a person's will and preference and thus identify their unmet needs.

Case Study 2

Staff were working with Ann for a number of years. Ann was non-verbal and although social care staff, along with the speech and language team, trialled several communication methods including objects of reference and PECS (through verbal communication and record keeping), Ann would not

engage with the process. Consequently, staff would have to rely on their knowledge of Ann and her body language and facial expressions as cues. Several staff recorded that there were several incidents when Ann would stand while on transport. This was a new occurrence, so staff called a meeting as it was a health and safety issue.

TASK 1

What are the key issues you identify in this case study and how would you as an SCW address them?

After the meeting it was decided that we would seek the support of the behaviour specialist. We investigated any changes on the bus: Had the other people on the bus recently changed from where they would usually sit? Was there conflict between service users? Did this happen all the time or only when certain people were on the bus? We also investigated if there was anything from a medical perspective that we needed to address. The staff team are aware that all behaviour is communication, and medical issues/pain can present in many forms in the disability service. After routine blood tests and a scan, it was determined that Ann had gallstones. The appropriate medication was administered, and she were placed on a waiting list for surgery. Since the administration of pain medication, there have been no additional recorded incidents of Ann standing while on transport.

Documenting Needs

To ensure that a person's unmet needs are addressed, it is vital that SCWs, staff teams and family establish a clear and open communication process. This communication process is supported through the use of written reports and care plans. As part of our duty of care, we are legally obliged to keep written records and these records must be safely stored in line with legislation. Report writing and record keeping are two important elements of the SCW's professional role in line with current best practice and legislative requirements. It enables SCWs and their co-workers to provide safe and effective services and a continuum of care, while ensuring accountability. In order to ensure that our reports are written to a professional standard there are a few key points you should note.

How to Write an Effective Report
Report writing must:
Be understandable, clear and concise.
Use objective and neutral language. Reports should not include emotive language or abbreviations.
Be completed in a timely manner.
The Benefits of Quality Report Writing
Report writing allows us as SCWs to provide chronological facts based on practice evidence which support and inform our provision of care and promotes accountability
Reports provide effective communication between staff and the multi-disciplinary team.
They ensure continuity of care and assist in the detection of risk/complications.
They facilitate collaboration between service user and professionals (Parr 2013).

In line with ‘a person-centred approach’ to service delivery, written records are maintained which contributes to a quality continuum of care for service-users and families. These records are important for the service user and their family and, under the Freedom of Information Act 2014, can be accessed by them. Records can be maintained in a variety of formats, e.g., written notes, emails and documents on iPads, etc. As SCWs it is important that we safeguard the service users’ personal information. The European Union General Data Protection Regulation (GDPR) and the Irish Data Protection Act 2018 provide the framework for record management. One key principle of record keeping is knowing what information to keep, why we require this information, how it may be used, where it came from, how long it should it be kept for and where it should be filed/stored. As SCWs we have a legal obligation to store this information securely. Record keeping is central to accountability, provides the basis for interventions, a context and reasons for decisions made and allows practices to be monitored.

Overall, records should provide clear evidence of the care and support that the service user receives and requires. They should also include their will and preference, their hopes and dreams, changes identified, and that the information is shared with the appropriate individuals. This has clear benefits for early detection and can address potential unmet needs for the person, which in turn may prevent behaviours of challenge or highlight the lack of resources such as speech and language therapy or physiotherapy.

Escalation Routes for Addressing Unmet Needs

When an unmet need has been identified by an SCW from the documentation (such as individual notes, team meeting minutes, monthly progress updates, personal plans, etc.) there are different ways to address the issue. The SCW brings this information to the attention of their social care leader (SCL) individually or at a team meeting where each individual's progress is discussed. Team meetings should happen regularly, and at these meetings information is shared and concerns are highlighted on each person in the service, to ensure that they are supported by each member of the team.

Taking on board the nature of the unmet need, the SCL will then identify the most appropriate escalation route to address these concerns. This can mean a referral to a member of the multi- disciplinary team (MDT) or, if the individual is already receiving input from a variety of professionals, an MDT review can be called. The MDT will include a number of professionals such as psychologist, behaviour support specialist, occupational therapist, social worker, speech and language therapist and physiotherapist who work together to assess, plan and provide support to the service user and their staff team. SCWs are an integral part of the MDT as they work directly with the service user and can advocate, on behalf of the service user, for unmet needs to be addressed. At an MDT review, a SCW can highlight their concerns, with the support of the SCL. Additionally, if the unmet need is a restriction to the service user's rights, there will need to be a referral to the human rights committee or social worker in the organisation or externally through an independent advocate from the National Advocacy Service (<https://advocacy.ie>). Alternatively, the SCL/SCW can support the service user to go directly to their area manager to highlight the unmet need, especially if there is a gap in resources to support the person. A huge part of an SCW's role is to promote self-advocacy and empower the person to communicate their own unmet needs. Advocacy can be provided through different forums; individually, or part as a group in the person's day or residential centre, which then can feed into a larger advocacy group where senior management will meet with the group regularly throughout the year. Access to self-advocacy and advocacy supports in general is very important for service users. Taking into account everyone's input, the manager will then seek resources through completing a business plan for the HSE to attain additional funds to meet those needs. (If there isn't currently an advocacy group in your service, you can contact the National Advocacy Service.)

Complaint Procedures

If the unmet need is not rectified at a local level, the person can be supported by the SCW to make a complaint. These complaints can be heard and addressed either internally or externally. Most services have an accessible complaints form which can be completed by the person themselves or with support from their family or SCW and forwarded to the local manager and/or complaints officer. Every service should have a complaints procedure in place and SCWs need to be familiar with the correct procedures and policies in their service. These complaints have to be addressed in a timely manner. However, if you are still not happy or if your service does not have an accessible complaints route, then there are different avenues to report their concern such as the HSE's 'Your service your say' complaints process (<https://www2.hse.ie/services/hse-complaints-and-feedback/your-service-your-say.html>). Or there is also the confidential recipient Leigh Gath, who deals with concerns of abuse, negligence, mistreatment and poor care practices (<https://www2.hse.ie/services/hse-complaints-and-feedback/report-a-concern-about-a-vulnerable-adult-in-care-to-the-confidential-recipient.html>).

It is important to remember that the service user's quality of life should not be based on the resources of the service. As an employee of a service, you have many routes to go through to highlight an unmet need (e.g. local or senior management, MDT, advocacy, etc.). However, if you have exhausted all available avenues, there are alternative options outside the service to support people with a disability, such as an independent advocate. Just remember that if the person is not at the centre of the service, they will continue to live a life of someone else's choosing through the lens of 'best interests' until systems are put in place to support and protect their expression of will and preference and their rights (Croucher 2016). As an SCW, you are in an influential position to empower the person you are supporting to advocate for the life they want.



Tips for Practice Educators

An important requirement to assist the student in achieving this proficiency lies within the practice educator's ability to assess at what stage of professional development the student is currently practising.

For this reason, it is important that educators are knowledgeable and have an understanding of the 'student development model'. One familiar model is the Kolb reflective cycle (see diagram below). Other well-known models are Artur Chickering's seven vectors of identity development and William Perry's theory of intellectual development.



Author-created diagram illustrating Kolb's Experiential Learning Cycle, showing the four stages of learning from experience.

One useful tool that practice educators can use in assessing the student's stage of professional development is regular support and supervision. When the student's stage of development has been established, the student and practice educator can set learning goals to help them achieve this proficiency. There are several key steps in doing this.

First, throughout the practice placements and on-site learning, students should be exposed to the various ways in which service-users communicate. As mentioned, communication routes can include direct verbal communication, use of PECs, objects of references, Lámh, etc. Each service user may have their own unique way of communicating and it is important that students are exposed to these and have training in communication and different types of assistive technology if required. Training of record keeping and GDPR would also be very beneficial.

Second, students should be encouraged and given opportunities to link in with the staff team to discuss the experiences of staff and how they identified and addressed service users' unmet needs through past experiences. Students could also read the service user's personal profile to observe the recording of unmet needs and how this was rectified; however, this will depend on the organisational policies relating to GDPR and consent given by the service user.

Third, the practice educator and student could use a supervision session to discuss a hypothetical unmet need. During this session the student and educator could discuss what tools were used to identify the unmet need, how it would be recorded, the escalation routes used to address the unmet need and what organisational policies and process they should follow. It would also be useful to discuss and explore what national and international legislative laws within which we are bound to practice as SCWs, for example the Assisted Decision-Making Act 2015 and the UN Convention on the Rights of Persons with Disabilities (CRPD).

Finally, the student should be encouraged and given the opportunity to participate in an active case where the staff team are currently working together in supporting a service user to identify and address an unmet need. This is important to enable and enhance the professional growth of the student. The student should be encouraged to participate and offer solutions. Students, where possible, should attend team meetings and MDTs and have sufficient access to the necessary paperwork. The practice educator should encourage the student, along with the staff team, to discuss how the unmet need was addressed, acknowledge the positives and discuss any learning or further training that may be required to ensure future unmet needs can be appropriately and timely addressed.

Suggested Reading:

HSE, *New Directions – Day Services for Adults with Disabilities*: <https://www.hse.ie/eng/services/list/4/disability/newdirections/newdirections.html>.

HIQA, *National Standards for Residential Services for Children and Adults with Disabilities*: <https://www.hiqa.ie/sites/default/files/2017-02/Standards-Disabilities-Children-Adults.pdf>.

Assisted Decision Making (Capacity) Act (ADMA) 2015: <https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/assisteddecisionmaking/assisted-decision-making.html>.

HSE, *Time to Move on from Congregated Settings*: <https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/>.

Department of Health, *Value for Money and Policy Review of Disability Services*: <https://www.gov.ie/en/publication/ed3564-value-for-money-and-policy-review-of-disability-services-in-ireland/?referrer=/wp-content/uploads/>.

HSE, *National Consent Policy – Quality Improvement Programmes*: <https://www.hse.ie/eng/about/who/qid/other-quality-improvement-programmes/consent/>.

United Nations Convention on the Rights of Persons with Disabilities (UNCRPD): <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>.

HSE, *A National Framework for Person-centred Planning in Services for Persons with a Disability*: <https://www.hse.ie/eng/services/list/4/disability/newdirections/framework-person-centred-planning-services-for-persons-with-a-disability.pdf>.

National Resource Center for Supported Decision-making (USA): <http://www.supporteddecisionmaking.org/>.

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Killeen, J. (2016) 'Supported decision-making: Learning from Australia', Winston Churchill Memorial Trust. Available at <<https://www.wcmt.org.uk/sites/default/files/report-documents/Killeen%20J%20Report%202016%20Final.pdf>> [accessed 20 November 2018].

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DOMAIN 4 - PROFESSIONAL DEVELOPMENT

Lifelong learning is essential in social care. Workers must engage in ongoing professional development, critically reflect on their practice, seek feedback and supervision, and participate in performance management processes. Recognising how personal experiences influence practice is also vital for ethical and effective service delivery.

Domain 4: List of Contributors

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

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

Caroline Coyle is an artist, poet and social care lecturer at the Technological University of the Shannon Midlands Midwest, and a PhD candidate at the Women, Ageing and Media (WAM) Research Centre, University of Gloucestershire, UK. Her study utilises autoethnographic and poetic inquiry to explore older women's identity through their participation in rituals at the Celtic Festivals of the Seasons at Uisneach, County Westmeath. In 2021, she co-founded Global Perspectives in Social Care/Child and Youth Care, which held its inaugural (virtual) symposium that June under the theme of 'Reimagining the Relationality of Social Care/CYC Practice in the Pandemic through the Arts, Nature, Spirituality, Education and Other (ANSEO)'.

Delores Crerar is the Co-ordinator of Athlone Family Resource Centre. Delores has extensive experience as a social care worker in the family support and community development sector. Delores is an active member of Creativity and Innovation in Social Care Network, the Midland ACEs Hub and the Family Resource Centre Midlands Regional Forum. She has an MA in Family Support Studies and an advanced diploma in Expressive Arts Therapy. Her research interests include inter-agency collaboration in the community development and social care sectors; the importance of supervision; the position and role of

women in society; and effective relationship-based practice when working with vulnerable population groups.

Francis Gahan qualified as a social care worker with a BA (Hons) in 2013. He has practice experience in disability service provision and residential childcare. He holds an MSc in Applied Social Research from Trinity College Dublin and is currently undertaking PhD research at Technological University Dublin. He also continues to work on the Applied Social Studies (Professional Social Care) programme at Carlow College, St Patrick's, where he attained his undergraduate degree.

Ado McKenna is a frontline social care professional and has worked for many years with young people and adults in residential care, detention services, mental health services and post-adoption services. He currently works on the homeless services management team of a large Dublin-based charity. He is a member of the Social Care Workers Registration Board, the collaborative forum for former residents of mother and baby homes and related institutions, Social Care Ireland, Social Justice Ireland. He is a Servant Leader trained professional. He has qualifications in social care management, applied social care, psychology, counselling and disability studies.

Cathy Murphy is a social care worker who began her career with Beam Services Carlow. She left Beam Services to work in Delta Centre for four years before returning to Beam Services as a social care worker. She has worked on the national New Directions committee. She is currently studying Management and Leadership in the University of Limerick.

Imelda Rea divides her work in Technological University of the Shannon: Midlands Midwest (formally AIT) between lecturing in Social Care degree programmes and working as a community connector with the College Connect project, connecting with people who experience multiple marginalisation, supporting them on their journey into higher education, and beyond, as a student support worker. Imelda has worked in residential care, youth training initiatives and is a volunteer in community radio. She has an MA in Child and Youth Care and degrees in both Social Studies and Community Development.

Chapter 56 – Cathy Murphy (D4SOP1)

Domain 4 Standard of Proficiency 1

Be able to engage in and take responsibility for professional development.

KEY TERMS
CPD
Professional
reflective
learning/critique
Supervision
Responsibility
Engagement

Social care is ... an ever-evolving rollercoaster of new skills and professionalism. You are often going to hear the words upskilling, training, retraining and refresher course. These words will become your best friends in upskilling. Where and when you find employment, you will generally be provided with a lot of these training sessions, which is good; but just remember that these are regulatory training sessions – ticking a box – another great phrase you will soon get used to.

Welcome! Student, this is where your training begins and never ends. Your social care education only starts with your formal academic training; it continues throughout your career as a social care worker, in the form of continuing professional development (CPD).

Try not to think of professional training as 'just ticking the boxes'. Whether you are working with the Traveller community, adult or child disability services, alcohol and drug misuse or homeless services, you will be forever learning about yourself and your profession. Embrace it, learn from it and use it. In your line of work, you are going to meet a lot of people with a variety of different needs. Essential to your professional development is the question of how you can further develop personal and professional skills in order to assist a person in his or her life.

Throughout my career I have involved myself in CPD, including:

- Mandatory training: SAMS (safe administration of medication), epilepsy

training, safeguarding – this is very important

- Studio 111 – training that involves behavioural support for people with challenging behaviour
- Autism training
- Probation reviews
- Supervision
- Self-research – when I hear something I have never heard of before I tend to ask about it or research it
- At the moment I am attending the University of Limerick and studying a management course
- I have also worked on the national New Directions policy, which will eventually encompass all areas of day service (New Directions is a vital part of your training; you will find a lot about it on the HSE/New Directions website).

All of this can be achieved if you believe in yourself. When asked if you would like to take part in some kind of training or to be a part of a team working on a new project, go for it. This is how you learn. We have all been in a situation where we feel we do not know enough about a certain subject, but the only way to learn is to immerse yourself in it. Remember that other people in that room all started the same way – you learn on the job. Also, as a side note, interviews are great for CPD, but do not be disappointed if you do not get the job. Ring your interviewer and ask for feedback. If in the future there is an opportunity for advancement in your workplace or another area of the job you would like to try, GO FOR IT! Not getting the job does not mean you are not good enough; it just means you need more experience.

Continuing Professional Development (CPD)

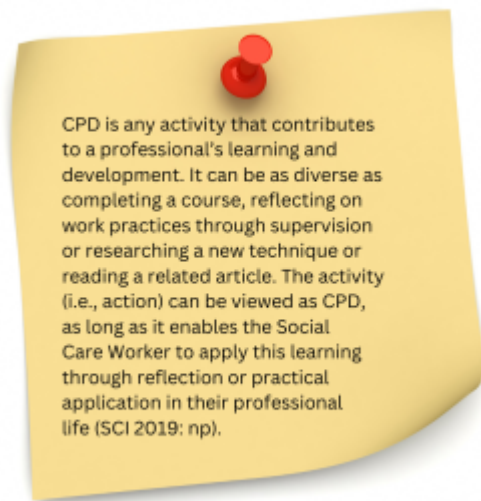
CPD is a combination of methods and techniques that will enable you to manage your professional growth. It looks at the person in his/her totality – remember, in social care you are working with people and your personality and experiences are going to contribute to your learning and understanding. CPD happens in many different ways in different services. My CPD experience has been through probation reviews, supervision meetings, and also those times when you think ‘I should have done that differently’ or ‘I did not handle that very well’. I once worked with a service user who was quite obsessed with using

the computers. He would come in first thing in the morning and stay there all day. Which of course was not healthy. So I decided that he should not have the computer any more. Without any consultation with the service user, I explained to him that there would be no more computer time. Of course, this did not go down well. The computer did not survive that day as the service user tipped it on the floor and broke it. In reflection, I understood that I had no right to tell anyone when they should and should not do what they want. It was all about the language I used. Instead of saying 'no more computers', I could have had a conversation and asked him what he would like to do instead of using the computer, or asked him to sit with me and make a visual timetable that included the computer but other activities as well. It turned out the service user was bored and found it difficult to engage in other activities.

This reflection on your experiences and how you learn from them is part of CPD. As you sit in class, in your bedroom or kitchen, or wherever you might be reading this, it is very difficult to understand how this works in practice, to be able to visualise what actually happens when physically working in the area of social care.



Author created diagram illustrating Gibbs' Reflective Cycle (1988), highlighting key values such as Purpose, Leadership, Collaboration, Respect, Commitment, and Flexibility in the reflective process.



CPD is any activity that contributes to a professional's learning and development. It can be as diverse as completing a course, reflecting on work practices through supervision or researching a new technique or reading a related article. The activity (i.e., action) can be viewed as CPD, as long as it enables the Social Care Worker to apply this learning through reflection or practical application in their professional life (SCI 2019: np).

If a social care worker is not engaged in CPD, this can be detrimental to the service user. One resource to support you in understanding how learning is continual is Gibbs' reflective cycle, which can provide you with the building blocks for reflecting on your professional practice to date and areas you can develop. Social care is so diverse and changeable: very often policies and procedures are updated and developed, and these have to be read and understood. If there is a policy on fire safety, for example, it is your responsibility to read and understand it. These policies are there to help you and the service users. This is CPD. Many times, a new service user will attend your service and you will need to get to know this person, their way of communicating, their diagnoses (if it is something you haven't heard of, research it) their life experiences, their family life, their school life. You will also have to think of the ways you communicate so that you are understood; you will have to think outside the box and adapt. This is why we as professional social care workers are constantly learning and updating our work practices.

Professional Reflective Learning Using Gibbs' Reflective Cycle

Graham Gibbs developed his reflective cycle in 1988 (Gibbs 1988). It was intended to give structure to learning from experience. It offers a framework for examining experiences, and given its cyclic nature it lends itself particularly well to repeated experiences, allowing you to learn and plan from things that either went well or didn't go well. Essentially, Gibbs suggests that there are six sections in the reflective cycle: description, feelings, evaluation, analysis, conclusion and action

plan. The reflective questions in the following diagram were created by John Murphy of Beam Services, Carlow, to support staff in a day service for adults with an intellectual disability, to reflect on their professional reflective learning.

Pick one of the following case studies and use Gibbs' reflective cycle as a guide for professional reflective learning.



Author created diagram based on Gibbs' Reflective Cycle (1988), outlining six key stages of reflective practice: Description, Feelings, Evaluation, Analysis, Conclusion, and Action Plan, with guiding questions to support deeper learning and self-reflection.

Case Study 1

John has been working in a new service for three months. He has been a social care worker for

ten years but this is only his second place of employment. John has never had a probation review before. He feels a little nervous about it. John's line manager, Tony, is conducting the probation review and he has asked John to write down how he feels he is doing in the job. John feels he is doing fine. Tony explains to John that there are few areas he would like John to improve; for example, his paperwork needs to be more up to date. Tony also states that he feels John works very well with the service users. At the end of the probation review Tony writes action plans for John on areas that he feels he may need to improve and dates by which these are to be achieved. Your first probation review may seem a little stressful, but it is not a moment where someone tells you how bad you are at things, it is for you to understand the professional critiquing and how to reflect on the information you receive. CPD means setting yourself professional objectives and goals and measuring how you reach them.

Case Study 2

Mary is an 18-year-old who has just finished school and has started in her first day services. Mary is verbal, autistic and has sensory processing issues. Mary has been attending St Andrew's day centre but has been relocated to your centre. She arrives with a small file. You introduce her to everyone and they ask her lots of questions. Mary starts to become agitated, then Tom, another service user, turns on the radio quite loudly and walks over to Mary and asks her to dance. Mary responds by physically lashing out at Tom, hitting him on the arm, then she covers her ears and begins to shout. All the other services users become very upset and feel unsafe. Another staff member removes all the other services users to a different area where it is quiet and turns off the radio. Once Mary begins to calm, staff members bring her to the multi-sensory room to aid her in self-regulating her anxiety.

TASK 1

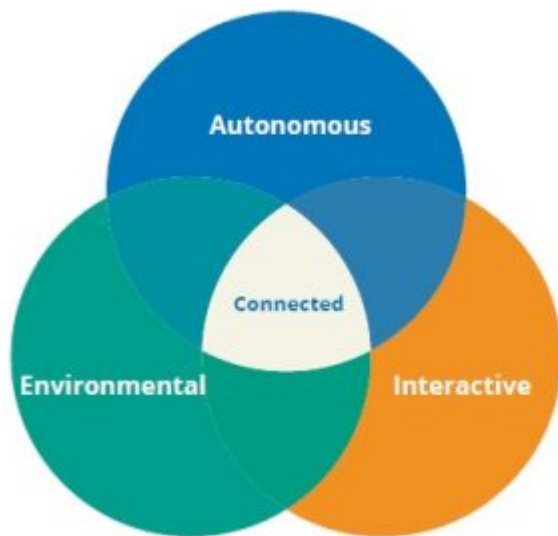
Using Gibbs' reflective cycle, write about an event or situation, explain how you felt at the time, analyse it, evaluate it and reach a conclusion about the event. Do this in your own time. Now set out an action plan using the template below:

Objectives	Activities	Indicators of Success

Supervision

Supervision in its basic form is where management or leaders support your professional development so that you provide the best standards of care. Supervision should take place at regular intervals. In a supervision meeting, your last supervision meeting will be examined and the goals and action plans that you have had to achieve will be looked at. This can feel a little daunting, but once you establish a beneficial and supporting relationship with your manager/team leader it will be of great benefit.

The functions of supervision include:



Author created Venn diagram illustrating the interconnected relationship between Autonomous, Environmental, and Interactive elements, with Connected at the center representing their integration

- Supportive

In this area your manager/team leader is there to support you when work becomes a little difficult; if you are finding certain areas hard, such as time management, dealing with other staff or service users. It is not a counselling session but a way of helping you get ideas on how to manage these situations.

- Educational/development

This area focuses on a skill you may lack that either you or your manager/team leader has noticed. You may be asked to take a course, or maybe they would like to offer you a course. Do not be afraid to ask for educational development. If you see a course that you feel may help you in your job, ask about it. This shows great enthusiasm and willingness to develop new ideas within the organisation.

- Supporting problem-solving

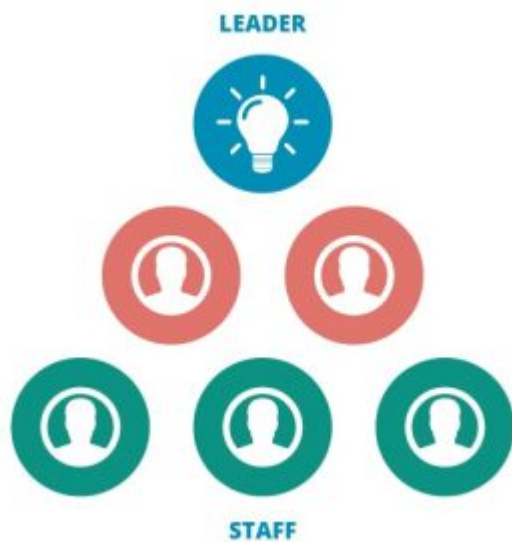
You will sometimes find yourself in a situation where your problem-solving skills need to come into play. We do not as individuals have all the answers all the time; this is where you tackle a problem and get your manager/team leader to advise on how to solve it. It is an opportunity for you to ask whether your idea would work or not.

- Line management: observing development

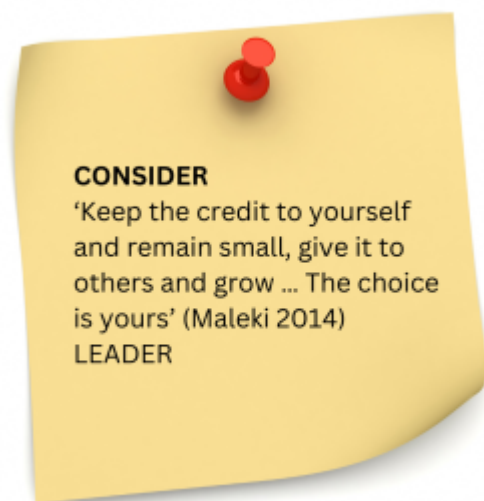
More often than not, in any type of workplace, line managers will observe your work. This enables the manager/team leader to understand the areas in which you need extra support. It is not a test – it is for your CPD. A good supervisor should be able to observe you and support you to work to the best of your ability (Hughes 2010).

In my workplace you can choose to have informal or formal supervision. The difference is that in informal supervision you can meet with your supervisor at any time, when you feel it is required or when your supervisor feels it is required. Formal supervision involves more work but is very rewarding. It involves three- or six-monthly meetings. My supervisor will email me when the appointment is set. At this point I go back over my last meeting and make sure that any goals that have been asked of me are completed. If I have not reached all my goals I will be honest with my supervisor and explain that maybe I needed a little more support in these areas. My supervisor will then ask what kind of support I need to achieve these goals and these will be set as goals for my next supervision, along with new goals. These goals can be as simple as making sure that the cleaning sheets are filled in properly or how to communicate with family members, psychiatrists, physios or GPs.

Good supervision is helpful, not only for professional development but also to give you a sense of job satisfaction and a willingness to perform well. Sometimes you might have 'bad supervision'. When this happens, you can be left feeling unmotivated. 'Burnout is also associated with workers' perception of their relationship with the supervisor, not just whether they received help or support. In Mena and Bailey's study of child welfare workers in the US, workers' sense of rapport within the supervisory relationship was related to job satisfaction' (Carpenter *et al.* 2012: 9).



Author created diagram illustrating a hierarchical leadership structure, with a leader at the top, intermediary roles in the middle, and staff at the base, symbolizing the flow of guidance and collaboration within an organisation



TASK 2 Look at the picture above (Leader and Staff). What do you think it is trying to say?

Supervision needs to be at the right time, in the right environment, with an experienced supportive supervisor and a committed supervisee (Hughes 2002).

- **The right time:** Supervision needs to take place when you and your supervisor have organised a specific time, so that neither of you is

distracted. This will also give you time to think about the areas you want to discuss.

- **The right environment:** This is very important, it can be difficult to have supervision when your supervisor is sitting across from you behind a desk. Supervision should be professional, but it should also feel relaxed, with no interruptions.
- **The right supervisor:** Supervision is not a counselling session; it is not a place to display all the things that are being done 'wrong'. It is a place to learn and grow. A good supervisor should be supportive and point you in the right direction. An experienced supervisor should be able to make you feel that you are supported and they should make you feel motivated to continue with your professional development for the good of both you and the organisation.
- **Committed supervisee:** This is where your CPD really comes into play. You are the guardian of your own development. Yes, you will have days when it is really tough, and you may feel that you have had enough. This can happen, especially if you are considering working in the area of challenging behaviour. You need to use all the resources around you, mainly your supervision. You need to be committed to the process of learning from experience, reflecting on situations and bringing this to your supervision.

Responsibility

When working in the area of adults with intellectual disabilities, challenging behaviour can be very common. It can be stressful and difficult, but that's okay – many jobs are stressful. That's where you need to be aware of how you feel and use your colleagues for support. For me, personally, I love my job. You will not find another environment where having a cup of tea and a chat with a service user and other colleagues is a big part of your day. Where life continues in different ways for everyone. When you realise that you are important and that you are making a difference.

When you begin your first employment don't be afraid to ask questions. Every individual is different and, no matter how much experience you have or may not have, it is important to use all resources available – new and historical files, risk assessments, personal care plans – read it all, and then read it again. Also, staff are a huge resource, *but* sometimes a culture in an organisation is hard to change, for example you may have a great idea for a programme to work with

an individual and you will hear 'We tried that before' or 'Good luck with that.' The difference is that the individual has never worked with *you*. No idea is a bad idea. This is where your professional learning comes into play: Did that programme work? Did it not work? What can I do differently to gain a better outcome for the service user? This is how you take responsibility for your professional development and learn to engage with it. Ask questions, use your supervision time to learn how to reflect and improve your professional development. Supervision is an excellent means of insightful learning.

It can be very easy to just go to supervision and sit and nod, 'tick another box'. Who would that help? It is your responsibility to use the resources that are handed to you. Social care is not born from a vacuum. It takes learning and evolving from all involved. You may have experienced three-way meetings and supervision meetings in college, and these are for your college development – for you to pass or fail – but supervision in the workplace is about you and the organisation. Work experience and three-way meetings will be the closest you will get to professional supervision – so *use them*. Your college experience and your professional work experience is where your CPD journey starts. Bring this learning into everything that you do, be it college, work experience or life. An idea can be triggered from your experiences that can give a service user as independent a life as possible. How do we engage in CPD? 'Active engagement in CPD is vital to ensure that health and social care professionals continue to have the up-to-date knowledge and skills necessary' (SCWRB 2018).

Engagement

Engaging in CPD basically means good listening and understanding; it is a record of your knowledge and of the skills you are learning along the way. It requires reflecting on good and bad situations, participating in your reflection. This does not have to be done at the time of supervision; it is an ongoing, evolving practice. You will get better at it over time – it takes practice. This is why you have to engage in and be the significant cog in the wheel of your CPD. Another way for you to engage is to take part in any training that is provided; research where and how you can upskill. My advice is to start looking now. Websites like www.HSEland.ie have free short courses you can pack into your CV.

I hope you found this chapter useful. I do understand it can be very difficult to visualise what it is like on the floor. Just remember that you are in control of your professionalism and your professional development as a social care worker. There

are days when you will question your choice, but let me tell you there are days when you will be so proud of yourself and your work, they will outweigh those 'questioning days'. Positivity begets positivity. Remember, life is short, so make sure that you laugh at least once a day while on the job!



Tips for Practice Educators

1. Focus on Reflective writing. Writing a paper academically is important, but students should try focus what the outcomes of learning are in relation to which field they hope to get into.
2. Try role playing different scenarios:
 - Look at scenarios of challenging behaviour, how a service user may become agitated over a loud noise and lash out and hit other service users or staff members. What should the student do?
 - Look at a scenario where a service user may disclose information of abuse; this can be used for sexual, financial, emotional or physical abuse. (Bring in safeguarding here.)
 - Keep it simple. For example: Service user A, non-verbal, would like to know how to make a cup of tea. This person is autistic, can understand but cannot verbally communicate. Ask the students to make a PECS (picture exchange communication system). Also have them work on 'now and then' cards.
 - All this information can be easily sourced from websites such as lessonpix or Aslam.ie.
3. Explain and explore the different areas of social care, what can you (the student) do once you leave?
4. What we as social care workers do out of college is very difficult for a student to visualise.
5. Make learning collaborative and hands-on.
6. Organise trips to different day centres, residential centres, homeless centres, etc. (Many organisations would be happy to give tours and explain what they do.)
7. Use a lot of situational case studies.
8. Collaborate with social care workers in the community, ask them to come in and explain what they do.

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Chapter 57 – Adrian McKenna (D4SOP2)

Domain 4 Standard of Proficiency 2

Understand the need to demonstrate evidence of ongoing continuing professional development and education, be aware of professional regulation requirements and understand the benefits of continuing professional development to professional practice.

KEY TERMS

Reflection
Why continuing professional development?
What's the benefit of CPD?
Where do I access CPD templates?
How do I identify what CPD credits I can use?
Integrating CPD into practice
Embracing regulation and CPD

Social care is ... about us as individuals taking opportunities to enhance the skills, knowledge and experience that we already have and to understand how we can better support ourselves and those we serve.

When we enter into the social care field we bring with us certain skills, knowledge and experience. If we are coming directly from college, a lot of what supports us can be theory-based, as we may have limited frontline and personal experiences of care to draw upon. If we have been working in services for a long time and we are now about to enter the register as a professionally qualified social care worker, we may have extensive frontline experience, life experience

and indeed may have extensive theoretical experience. Irrespective of whether you are beginning your studies in social care or have been working in the profession for many years, best practice requires continued learning through continuing professional development or CPD. The Health and Social Care Council defines CPD as 'the means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop professional qualities required throughout their professional life' (CORU 2013). Central to learning about your practice and professional life is a process called reflection.

Reflection

To be able to evaluate and reflect critically on your own professional practice you need to understand what reflecting or reflective practice is. Reflection, at its core, is stopping and taking a very in-depth and overarching look at any given situation. John Dewey defines reflective thinking as 'active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it and the further conclusions to which it tends, constitutes reflective thought' (Dewey 1933: 9). Reflecting on what we need to do to make sure that we are looking after our CPD needs can be a relatively simple process. You first need to identify the knowledge deficit in your current practice and analyse why that deficit exists; then you need to explore how this new learning would benefit your practice and those you serve; and then you need to look at the most effective way of gaining that knowledge. When you have reflected on all those areas you are ready to take part and evidence CPD.

Why CPD?

Why do we need to evidence our ongoing CPD? When you register with CORU you will be required to amass 60 CPD credits over a 24-month period. The credit system will be based on one credit for every hour you acquire 'new learning'. In other words, if, as part of your professional development plan, you decide that you need to do TCI or MAPA or some other crisis intervention training, and all you require is a refresher that will take seven hours on one day, you would not award yourself seven CPD credits for that refresher training, you would only award yourself one credit per hour for anything new you learned; whereas if you

were sent on a training course, took part in a seminar or went to a conference and it was entirely new to your learning, then you would award yourself one CPD credit per hour of that training.

TASK 1

Register at www.hseland.ie and complete the PDP e-learning module.

What's the Benefit of CPD?

One of the great skills in understanding the role of CPD is understanding and accepting the benefits of professional development and how it supports improvements in your professional practice. It is important for us as social care professionals to have a strongly reflective, analytical and critical look at our professional development as it is used to support ourselves and those that we serve in our services. CPD is entirely about supporting the very vulnerable individuals we work with and giving them the best and safest service that we can possibly give. If we do not take the position of evidencing through a CPD journal, we are letting down ourselves, the organisation and those we serve. The whole point of the CPD journal is to analyse what training you have, to look at what training you need, to dig deep into why you feel you need that training and then to plan how that training is going to look for you. (Below this piece you will see an example of a CPD portfolio.)

When participating in the supervision process your supervisor should help you look at your developmental needs. This is where the decisions can be made on how and what you will need to do next to develop your own CPD portfolio. You must first take a historical look at your experience, your education and your skills and when you understand what you have already, only then can you develop what you need to improve. We are not just talking about theoretical knowledge but a very wide breadth of skills, personal, interpersonal, theory, concepts, real-life skills and physical skills – it's a wide construct. When you've developed your PDP (personal development plan) and have looked at your continuing education as part of that, a decision can be made as to how you structure it; what are the learning activities? This is interesting because in social care everything is potentially a learning opportunity and, as mentioned above, one hour of new learning is one CPD credit.

How do I identify what CPD Credits I can use?

Ask yourself, what are your learning opportunities? Over a two-year period you will have to achieve 60 CPD credits. If you have supervision once a month over two years you probably do ten, maybe eleven, each year. If they are strong supervisions you would probably be able to give yourself half a credit for each, based on new learning, so over the 24 months you will amass 11 or 12 credits. If you do one team meeting a week, over the year you might attend 45 to 50 meetings. Again, if they are one hour long, you may get half a credit per hour, amassing 20 to 25 credits that year. If you attend conferences and are learning something entirely new to you, you award yourself one credit per hour of new learning. If you are writing something new, maybe a policy for your organisation, journal articles or blogs, and it's new learning, you have one CPD credit for each hour of new learning. If you return to study and do a new course at third level in something in which you have no experience at all, there's probably going to be a hundred contact hours and up to 50% of those will be new learning. This is how you try to integrate your new knowledge and skills into your CPD.

Integrating CPD into Practice

Once you've learned something new, you need to develop a way of using it in an experiential way, otherwise you just lose the ability to work with it. For example, if you're working in a service where communication for a service user is a difficulty and within that service they are using Lámh as a means of communicating and you don't have Lámh, then you put that in your CPD plan, talk to your supervisor, get some funding to do the course. When you have completed it, you will have to weave it into your daily life skills – now it is not just a theory or a concept but a very physical space, it's something that you need to practise, like a professional singer who needs to practise to maintain a high standard. The more practice you do, the better communicator you become and your client base will really benefit from that.

Case Study 1

When I worked in young people's services, I was key working a young person whose relationship with his mother was completely broken down and he had little or no contact with her. I knew I would have to engage with her quite a bit. I understood that if I built up a very strong and trusting relationship with that young individual, in time I could build a trusting, caring relationship with his mother; then, reciprocally, he would see that as being a positive thing. Over the period of three years we managed to put this young man's relationship with his mother back on a better footing. I had studied attachment theory and used some of my knowledge to support myself, the young person and his mother.

TASK 2

1. How would you integrate CPD into your supervision? Discuss.
2. Look at CPD opportunities over the last six months and decide how many CPD credits you would have awarded yourself.
3. Using the CPD template below, how you would plan your CPD for the next year? Look at what you know, what you need to know and how you can gain that knowledge.

Embracing Regulation and CPD

Regulation of social care is imminent. As social care workers our training enables us to be reflective and flexible practitioners. In our daily work we adapt and change practice to suit the ever-changing needs of those we serve. Adhering to the regulations will require us to embrace CPD and to weave it into our daily practice. As outlined above, we are constantly learning and part of that process will be in defining what our CPD requirements are, planning and recording how we complete the 60 credits and being honest about how we identify the new learning. It is not a difficult task because it is something we are already doing.

Example Record Templates – Adrian McKenna 2019/2020

Name:	Adrian McKenna	CORU Registration Number:
Audit period from:	July 2019	Audit period to:

Implement			Evaluate & Reflect	
Date and time spent When did you undertake this learning activity?	Type of Learning Activity What was the name of the activity?	CPD credits Approx. 1 CPD credit for every hour of new or enhanced learning achieved	Learning Outcome What have you learnt through completing this activity? How have your skills and knowledge improved or developed?	Impact on practice How have you integrated this learning into your practice? How has this learning made a difference to your capability and performance in your role?
August 2019	Supervisee Training	21 credits over 4 days	What a supervisee (can be SCW or manager) needs to bring to the supervision process, how we are influenced by our supervision history. What effective supervision looks like in a social care setting. How to work with the Kolb learning cycle and the competence matrix. Understanding what influences our learning styles allows me to find a way with my supervisor that best suits me.	Participating in supervision is what underpins the work we do. Understanding the process and how much influence the self has is at the core of self-development. Looking at my own practice in a safe supervision relationship allows me to explore my strengths and lesser strengths. I use the learnings both as a supervisee and supervisor.

Implement			Evaluate & Reflect	
August 2019	HR investigation	14 credits over 2 days	This training has taught me the importance of defining and setting the parameters for an investigation and sticking to that, of being conscious of natural justice in the work setting and of providing a fair and equitable platform for those being investigated and those being asked to take part in the process too.	This piece of training has reinforced for me how important boundaries are in social care settings. When conducting an investigation it is important to stick to the agreed parameters and if other related issues become apparent during an investigation that these are recorded accurately during the interview and may need to be followed up by another investigator at another time. In my current role this training has strengthened my resolve in tackling an issue that could lead to someone losing their job/career. I am confident that I can be thorough, fair and Impartial.

Implement			Evaluate & Reflect	
August 2019	CISM training	14 credits over 2.5 days	This training is international best practice in helping teams who have to respond to traumatic situations. It looked at structuring a response team and the skills required; how best to respond when a traumatic event or situation occurs; the time frame for an effective intervention; the responsibility of the organisation to the care of the workforce; and the initial defusing and moving on to the debriefing. It went on to look at how to assess the ongoing supports needed for a team in times of crisis and the supports the CISM team require themselves.	I have taken the opportunity to use the skills learned in this training in some recent traumatic events within the service I'm based in and externally in other services. Because this training is very structured and has a strong template to follow it is easily implementable. This training requires two CISM team members to support the individual/team involved and therefore there are natural built-in supports for us as well. The CISM training has enhanced my capabilities as a frontline manager and allows me have access to a support mechanism that is ordinarily only taught to frontline emergency crews.

Review	Plan
What do I want or need to learn in the next 12 months?	What learning activities v
Administration of Naloxone training	Participation in a one-day
Critical incident stress management (CISM) refresher training	Participation in a one day
Therapeutic crisis intervention skills (TCI) training	Participation in a one-day
Clinical supervision training	Look at available training



Tips for Practice Educators

1. Help your student to develop a PDP (personal development plan) outlining what they know and the gaps in their knowledge that can be supported during placement.
2. Ask your student to draw up a CPD template and record their 'new learning', as identified in the PDP.
3. Introduce a CPD communication session as part of your team meetings where each member of staff discusses the new learning they have received that year and gives a short presentation on the key points.
4. Ask the student to give a presentation to the staff team on their new learning on placement, for example theory to practice, where they select a relevant theory and discuss how this applies to the settling and the care provided.

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Chapter 58 – Delores Crerar (D4SOP3)

Domain 4 Standard of Proficiency 3

Be able to evaluate and reflect critically on own professional practice to identify learning and development needs; be able to select appropriate learning activities to achieve professional development goals and be able to integrate new knowledge and skills into professional practice.

KEY TERMS

Core values
and belief
systems
Impact
of your
past
Use of
self
Trauma
-
informed
Learnin
g
activities

Social care is ... a working relationship with self and others which is based on the right to respect, dignity, empowerment, choice and self-determination.

Underpinning this proficiency is an understanding that in order to reflect critically on our professional practice we need to understand the role of values, attitudes and beliefs. The importance of critically reflecting on our practice is a consistent theme in the social care literature; however, from my experience as a family support manager how we do this warrants more attention. This chapter adopts a three-pronged approach to critical reflection: values, attitudes and beliefs.

Values	A value is a measure of worth that a person attaches to something; values are reflected in the way we live our lives, e.g., 'I value my job.'
Beliefs	Ideas that are accepted to be true, even though they may be unproven or irrational, e.g., 'I believe in life after death.'
Attitude	The way a person applies or expresses their values and beliefs through words and/or behaviour, e.g., 'I hate college.'
Use of Self	The merging of a practitioner's professional training, knowledge and techniques with their personal self, which includes personality, belief systems, life experiences and self-awareness, to support a client in a therapeutic relationship.

Core Values and Belief Systems in Professional Practice

Core values can relate to a personal, business or professional setting. The importance of reflecting on our own practice starts with an awareness of factors that shape our practice. Values are inherent to a person and can help them to distinguish right from wrong. When a person or business cannot identify their core values, it can become very difficult to plan for or achieve a clear vision of the life or business that is wanted. When a person is clear on their values and beliefs, they can assess their actions and behaviour accurately. Some core values have been transmitted to us through the family or the community in which we live or grew up. Core values should not be viewed as a fixed asset or definitive list; they are malleable. Some core values may strengthen over time, while others are adjusted due to personal growth and development, the impact of life experiences, or the personal processing of societal pressures or influences. We make a conscious decision to adjust or change our values when they are no longer in alignment with who we believe ourselves to be or our future vision of the type of person we want to become. Below are some reasons why it is important for social care workers to be aware of the core values they hold:

- Define the essence of your character (who are you when no one is looking).
- Reflect the situations and topics you stand for and care about as a person.
- Communicate to others your philosophy of life.
- Guide your behaviour and influence the decisions you make in life.
- Guide your behaviour and influence your actions when working professionally with others.

TASK 1

Make a list of your most prominent personality traits. Identify how these traits can act as strengths and limitations when relating to those you support in professional relationships.

Studies have demonstrated that while a theoretical knowledge base and mastery of skills are fundamental to social care work practice, better outcomes with people are achieved when a social care worker demonstrates authenticity and can harness their personality traits as a therapeutic tool when working with others (Edwards & Bess 1998; Baldwin 2000). To do this effectively we as practitioners must take time for self-discovery, so that we are presenting our 'authentic self' at all times.

TASK 2

Reflect on the following points and discuss how this information is relevant to your professional practice.

What are my strengths and limitations regarding skills, knowledge and aptitude for professional practice within the social care sector?

What people and goals in my life are most important to me?

What aspects of myself am I unwilling to compromise in relationships or employment?

What are the factors that motivate me or drive me into action?

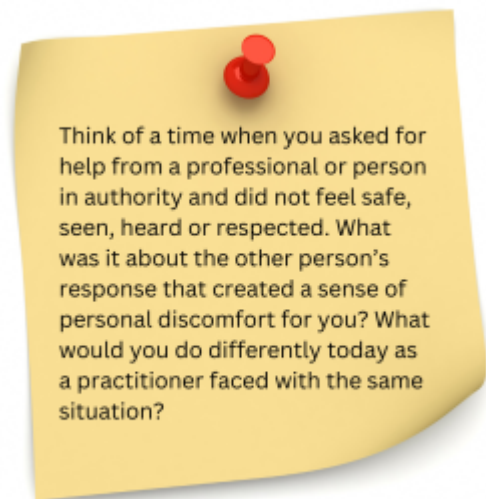
What does success look like to me?

Additionally, belief systems do not necessarily relate to our religious or spiritual orientation, rather they help us to organise and make sense of the world. It is important as social care workers to ensure that we are not imposing our own values or belief systems on those we work with; by doing so we fail to honour the individual's personal life journey and right to self-determination. We must be cognisant of developing strong foundations in all our helping relationships by demonstrating empathy, congruence and unconditional positive regard (Rogers 1957). Each person is unique, and each person has developed a unique worldview.

Impact of Your Past on Professional Practice

This section explores the impact of adverse childhood experiences (ACEs) and life experience on personal and professional identity formation and your practice. Since 1995, the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study has assembled evidence of the effects of ACEs on people's life outcomes. In the original study, two-thirds of more than 17,000 subjects who filled out confidential surveys about their childhood reported having experienced at least one ACE (ten being the highest number of ACEs the test accommodates). The ACE test is divided into three groups: abuse, neglect, and household challenge. People with higher ACE scores are at increased risk of experiencing anxiety, panic or depressive disorders, of becoming an alcohol or substance user, of engaging in promiscuous sexual behaviours, and of developing obesity, heart disease and cancer. ACEs in the general population are common and many individuals have experienced at least one ACE in childhood. Some population groups in society are more vulnerable to experiencing ACEs because of the economic and social conditions in which they live.

Anda *et al.* (2004) identified that employers and medical practitioners have difficulty managing relationship issues, absenteeism, emotional distress, substance abuse and somatic symptoms in employees who are not addressing the impact of their own ACEs on work performance. We cannot thrive as individuals or practitioners while we are still learning to survive the impact of our past life experiences and trauma. We need to acknowledge how common trauma is and to understand that practitioners and clients alike will have their own unique relationship with trauma. Becoming personally and professionally aware of trauma-informed practice requires us to make a paradigm shift from asking, 'What is wrong with the person?' to 'What has happened to this person?' (Harris & Fallot 2001) or indeed from 'What is wrong with me?' to 'What has happened to me?' As professionals we can commit to undertake training in trauma-informed care so that we become more aware of approaches to supporting ourselves and our clients in ways that enable us to feel safe, seen, heard and respected.



The nature of the social care system can often create a fast-paced and action-based practice whereby 'doing' is often a more predominant model than 'thinking' within the daily interactions with others. As social care practitioners we are required to work in a reflexive manner, and this does mean taking the time to stop and explore the conscious and unconscious factors influencing our 'doing' with others. Reflexivity enables us to identify what aspects of our life experiences are resonating with the

stories of those we support and what aspects are triggering uncomfortable feelings or unprofessional responses in our working relationships. This reflection is core to understanding the gaps in our knowledge, the areas of professional practice we need to improve, to identify learning and development needs.

Learning Activities

This section provides examples of learning activities and tools to help you identify and achieve your professional development goals and integrate this new knowledge and skills into your professional practice.

1. Frozen, Unfreezing and Flourishing Practitioners

Frozen practitioners are those whose values and belief systems are rigid and uncompromising; they view the world with a fixed mindset. They may be new to the field of social care or may have become rigid in their practice due to resistance to change, poor management, lack of supervision or compassion fatigue. Through the supervision process they may be encouraged or challenged to unfreeze their thinking and explore the interplay between their personal and professional values and belief systems.

An unfreezing practitioner has begun to develop a greater awareness of their personal attitudes and motivating factors which act as the foundational structures to their values and belief systems. With new-found knowledge and

insights, the practitioner develops new skills from which personal and professional behaviour changes can be seen. Over time and with commitment the practitioner can easily recognise how their values and belief systems can be utilised for the benefit of self and others within the field of social care.

A flourishing practitioner will be proactive in utilising supervision as a tool for self-discovery and deepening professional practice. This practitioner is acutely aware of their own values and beliefs but also ensures that they do not allow their personal biases or prejudices to impact on the working relationship with others. They adhere to strong ethical boundaries and self-care practices to nurture their relationship with self and others.

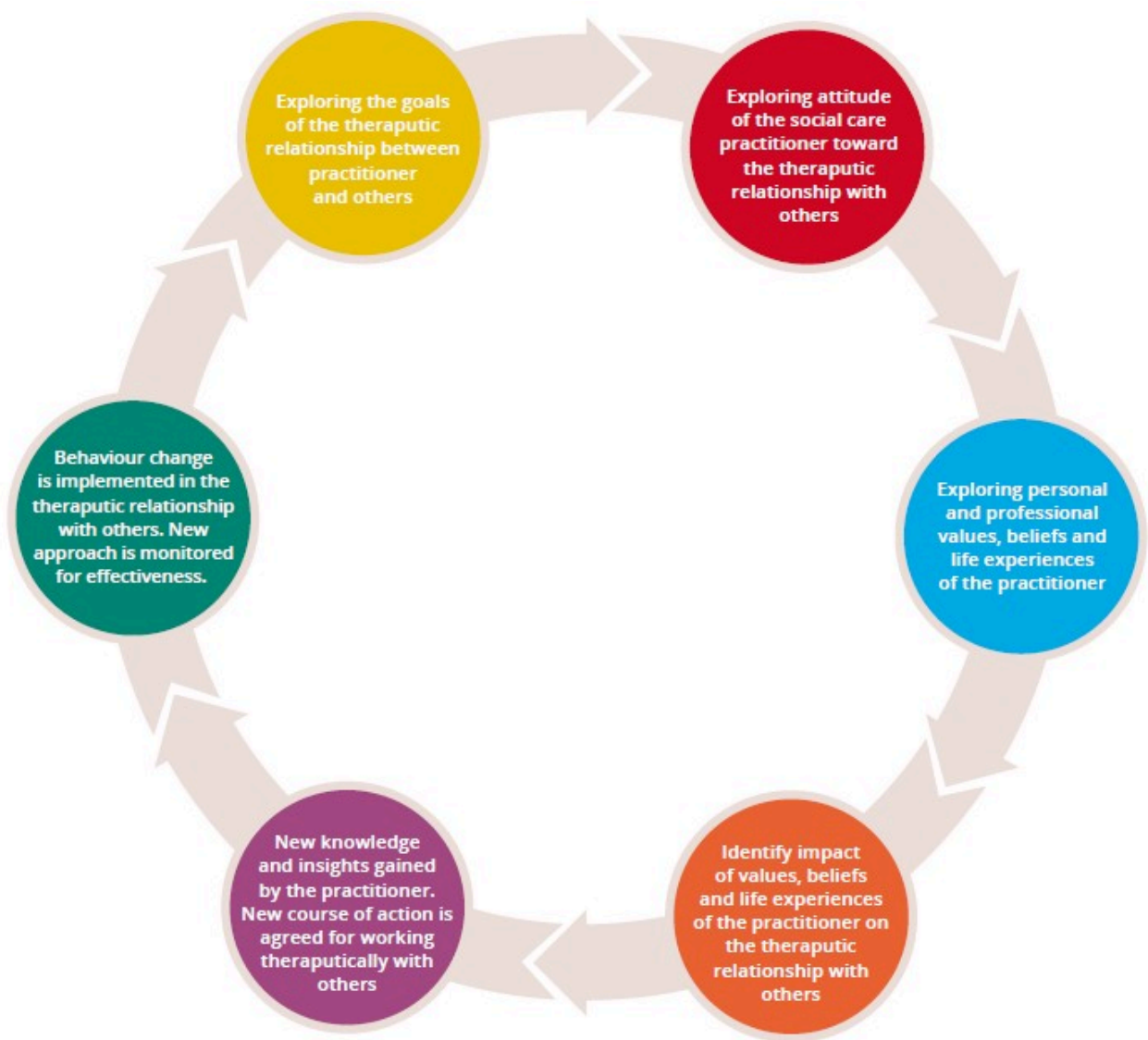
Characteristics of the Frozen, Unfreezing and Flourishing Practitioner		
Frozen	Unfreezing	Flourishing
Unaware of their personal bias and prejudice.	Is becoming aware of their personal bias and prejudice.	Ensures own biases and prejudices do not enter the working relationship with others.
Unaware of their values and beliefs.	Can identify some of their values and beliefs.	Can clearly identify own values and beliefs.
Cannot accurately assess own strengths and weaknesses.	Becoming aware of own strengths and weaknesses.	Clearly identifies own strengths and weaknesses.
Is resistant to feedback, constructive criticism or mentoring relationships.	Is open to feedback, constructive criticism, or mentoring relationships.	Sees feedback, constructive criticism or mentoring relationships as mechanisms for improving own practice.
Does not value the supervision process as a tool for ongoing professional development and discovery.	Is engaged in and appreciates supervision as a tool for ongoing professional development and discovery.	Supervision is viewed as a tool for deepening ongoing learning, development and discovery as a practitioner.
Responds to working with vulnerable population groups in a 'one size fits all' approach.	Is becoming flexible in their response to working with vulnerable population groups.	Experienced in design and delivery of evidence-based approaches to working with vulnerable population groups.
Refuses to utilise or disengages from opportunities for ongoing professional development.	Participates in opportunities for ongoing professional development.	Opportunities for ongoing professional development are viewed as mechanisms for improving own practice.
Does not engage in reflective practice.	Is becoming familiar with reflective practice as a means for learning and development.	Reflective practice is used to identify how the worker experiences themselves in the work they do with others.
Cannot identify when poor boundaries are present with staff, clients and stakeholders.	On reflection or with guidance can identify when poor boundaries are present with staff, clients and stakeholders.	Adheres to strong ethical boundaries when working with staff, clients and stakeholders without support and guidance.
Cannot identify when they are displaying characteristics of compassion fatigue or burnout.	Understands the key characteristics of compassion fatigue and burnout and monitors self accordingly.	Adheres to strong self-care practices to combat the onset of compassion fatigue or burnout.

2. The Supervision Process as a Tool

Effective social care workers know when to seek help with processing personal and professional concerns, stressors and experiences. The supervision process is an invaluable tool for social care workers through which self-discovery and professional development can take place. Within this space the practitioner is constructively challenged and supported to integrate new knowledge and skills into professional practices. Other chapters have focused on the role, purpose and functions of the supervision process (see Chapters 60 and 79). The focus here will be on how the practitioner can become more responsive and take responsibility for their own ongoing growth, development and needs within the context of the supervision process. Working in partnership with the supervisor, the practitioner looks at the therapeutic relationships they are engaged in, and they explore how their personality, values and belief systems are resonating with, supporting or impeding another's growth.

By focusing on the reflexive cycle, the practitioner is provided with space to identify key learning and to integrate this new-found knowledge with tangible working practices that will be mutually beneficial for the practitioner and client within the therapeutic relationship.

Reflexive cycle of supervision to identify how personal values and beliefs are impacting on the therapeutic relationship with clients (Crerar 2021).



Author created diagram illustrating the Reflexive Cycle of Supervision (Crerar 2021), mapping the process of identifying how personal values and beliefs impact the therapeutic relationship with clients through reflection, insight, and behavior change.

Case Study 1

The Reflexive Model of Supervision

Emer is a third-year student attending her placement in a local family resource centre. Emer has been asked to shadow the family support worker, who is currently working with a women's group whose members are predominantly single parents, with low educational attainment and who are long-term unemployed. The family support worker has noticed that Emer seems to have a low frustration tolerance with the group participants' viewpoints when topics such as barriers to

education and employment are discussed in the group. Emer has been noted as telling the ladies that 'there is plenty of opportunity to return to education' and 'plenty of jobs out there'. This has led to some group members feeling 'demoralised' and 'ashamed' of their life circumstances. One member of the group has refused to return to the next session unless Emer apologises for her comments. Emer does not see an issue with the comments she has made. Emer has been asked to use the reflexive model of supervision to identify how her personal values and beliefs have impacted on her therapeutic relationship with this member of the group.

Phase 1. The goal of the therapeutic relationship between Emer and the women's group was to provide Emer with practical experiences of understanding and supporting vulnerable client groups while attending field placement. The background history of the group, the group's socio-economic circumstance and the individual life circumstances of each member were discussed with Emer so that she could connect with the experiences of each individual.

Phase 2. Emer has identified that she finds the group conversations frustrating. She believes that each of these women had a choice to have children and have a choice to return to employment or education. She feels some are unwilling to change their life circumstances.

Phase 3. Emer has identified that she comes from a home where two parents are present and there is no history of unemployment. Her parents have instilled in her the values of hard work and study. Her parents are supporting her financially to attend college.

Phase 4. Emer recognises that her own family and life situation is not the same as those attending the women's group. Emer identifies that she has been supported during early childhood and adolescence to complete her education and continue her studies at college. Emer identifies that she has had role models to demonstrate the benefits of engaging in education and employment. She identifies that she has grown up in a home free from the effects of poverty.

Phase 5. The supervisor and Emer discuss the reasons for early school leaving and long-term unemployment which are actively presenting within the group. Emer develops a greater awareness of the complexity of the barriers which are preventing group members availing of education and employment opportunities. She acknowledges her previous opinions and beliefs relating to the group's dynamic were limited and biased. Emer agrees to sit with and listen to each group member's personal story at their next meeting.

Phase 6. Emer returns to the group and apologises for her low frustration tolerance with the group. Emer begins to actively listen to each person's story and connect with the impact of each person's lived experiences. She becomes

more compassionate towards the group members' situations. The group members note feeling 'less judged' by Emer.

3. Use of Self in Social Care

The term 'use of self' can sometimes be confusing for a novice practitioner to understand and to embody. The 'use of self' relates to the combination of values, skills and knowledge gained

through study, in conjunction with one's personality traits, belief systems, cultural heritage and life experiences (Dewane 2006; Lyons 2013). Understanding self is central to critical reflection on your professional practice. Schneider-Corey and Corey (2002) note that it is essential for those working in the therapeutic professions to be aware of one's own identity, feelings, limitations, strengths and frustrations so that they can relate to and support their client better. They assert:

'A central characteristic for any therapeutic person is an awareness of self – including one's identity, cultural perspective, goals, motivations, needs, limitations, strengths, values, feelings, and problems. If you have a limited understanding of who you are, you will surely not be able to facilitate this kind of awareness in clients.' (2002: 32).

Kaushik (2017) argues that knowing self is a precondition to knowing others. How do we learn to use self in the field of social care? There must be a willingness to construct and deconstruct our concept of who we are, our values and our beliefs as we grow and mature within our personal and professional identities. This journey of self-awareness requires space for critical reflection on our professional practice and space to identify learning and developmental goals that can equip us with new-found knowledge, skills and attitudes to support our maturing professionalism.

In the literature there is a clear message of what people value in the professional working relationship with practitioners (Lyons 2013). MacLeod (2008) notes that an effective practitioner is one who is experienced by others as a 'friend' and 'equal'. Beresford *et al.* (2008) define those qualities as going the extra mile and sharing aspects of oneself, which are both important for relationship-based practice. Understanding oneself and sharing one's life experiences can often be a powerful tool for effective change and validating the life experiences and trauma of people we support within the field of social care. Yet inappropriate self-disclosure can lead to the people we work with losing confidence in our abilities as social care workers. There is a fine line to walk

between effective and ineffective self-disclosure of our own life experiences. As a rule, we should always review with a line manager the appropriateness of the self-disclosure prior to presenting it to those we work with.

Reflexive Activity for Self-Disclosure

Is the disclosure for the benefit of the client? What is the goal of me sharing my experience?
How will this self-disclosure benefit the person I am working with? Am I sharing my experience because the client's story has resonated or triggered a response within me?

4. Self-Care as a Tool for Self-Discovery

All too often the last person a social care worker nurtures is themselves. Obstacles to self-care often manifest as a lack of energy or motivation, shouldering too many responsibilities and the unwillingness of the practitioner to appear vulnerable and seek help. The consequences of poor self-care can be detrimental not only to the worker, but to the clients and professional organisation in which one works. Failure to value the importance of self-care practices can result in emotional or

physical exhaustion – compassion fatigue – or vicarious re-traumatisation, which can ultimately lead to professional burnout and a practitioner leaving the field of social care. The development of a self-care plan will act as a protective factor against such issues. In effect one needs to provide space for peace and healing from the therapeutic relationship which you are holding and find ways to energise and thrive. Meeting one's basic physical, mental and emotional needs through rest, nutritious food and adequate exercise is essential. Thereafter, finding ways to generate love, joy and happiness through relationships, hobbies and life adventures can help us energise. Recognising that a practitioner's most foundational instrument is themselves should shift the focus from self-care being an afterthought to making it an essential element of one's own wellbeing, which should be valued and nurtured.

Worksheet 1 Self-Care Action Plan

SELF-CARE ACTION PLAN			
Communication and Connection Practices	Rest and Relaxation Practices	Survival and Stress Practices	Health and Hobby Practices
Current Practices:	Current Practices:	Current Practices:	Current Practices:
New Practices:	New Practices:	New Practices:	New Practices:
People who can support me:			

Personal Goals		
Short-term (6 months)	Medium-term (1-2 years)	Long-term (3+ years)
Professional Goals		
Short-term (6 months)	Medium-term (1-2 years)	Long Term (3+ years)

Conclusion

Social care professionals are human beings who are as vulnerable as any other to the life events and challenges we are faced with. Each practitioner enters the field of social care bringing with them a unique sense of self and unique life experiences from which their world view is shaped. To this end, it is important that we spend time with the 'self' and come to understand the values and belief systems from which we operate. The self we bring to the people we work leaves

a lasting impression on their life course. It is important therefore that we can truly empathise, connect and respond effectively to promote growth, healing and empowerment in others. Self-care and supervision are powerful tools that can provide a safe place for us as social care practitioners to explore and work through our own dilemmas while simultaneously refining the 'self' we bring to our therapeutic relationships. Additionally, the need for social care workers to share ideas and experiences in this area is pivotal for adding to the body of social care knowledge which students and practitioners can access and learn from.

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Chapter 59 – Caroline Coyle and Imelda Rea (D4SOP4)

Domain 4 Standard of Proficiency 4

Understand and recognise the impact of personal values and life experience on professional practice and be able to manage this impact appropriately.

KEY TERMS

Understanding
Recognising
Impact of
personal
values
Impact of life
experience
Professional
practice
Managing
impact
appropriately

Social care is ... the creative engagement of relationality as a therapeutic working medium used within the life space of an individual or family; to communicate, inspire, guide, support, advocate for, and empower that person or family to realise their potential in their unique life journey.

TASK 1

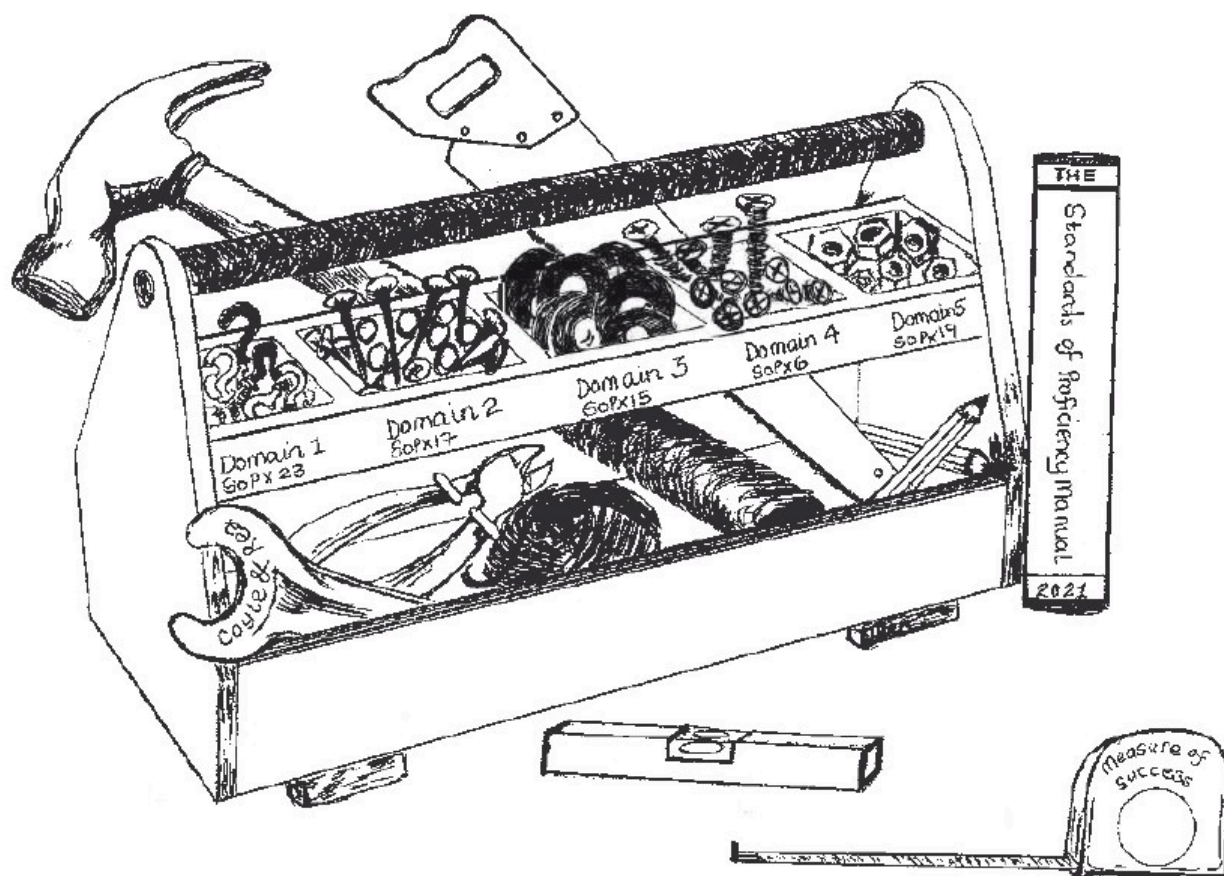
Consider a time when your personal values and/or life experience impacted on your professional practice. Describe how you managed this impact.

Understanding and Recognising Personal Values and Life Experience

Our personal values shape the way we negotiate our pathways through life. They provide a contextualised framework interwoven with our unique understandings, viewpoints, morals and beliefs. Our life experience and personal values influence the choices we make in our life journey, how we relate to, and construct our relationships with others and how we view, comprehend and make decisions. Once we understand the threshold concept that our personal values can consciously and subconsciously powerfully influence and impact each of our relational experiences, then we can explicitly recognise how our personal values and beliefs affect our daily decisions and behaviour, in everyday life, work, education and professional practice (Cousin 2006).

By understanding and recognising our personal values and beliefs, and knowing the impact of our personal values and life experience, we can prepare and plan to manage the impact when we encounter values and/or beliefs that are different from or jar with ours in our professional practice as social care practitioners. Attributed to the philosopher Socrates is the saying, 'To know yourself is the beginning of all wisdom', and what we know about ourselves, how we know it and how, as a result of knowing, we can instinctively 'nod to this acknowledgement of knowing oneself' in our everyday personal and professional relationships is the foundation of effective social care practice. Fenton highlights the paramountcy of self-awareness in social care work, stating 'Our epistemological position (typologies of knowledge-what we know and how we know it) is a valuable insight for each practitioner to be aware of as it is we ourselves that are our most valuable tool in working with young people' (2019: 42). Lyons, in her earlier work on self-development in the social care context, notes that 'Central to the student's ability to develop as a competent practitioner, is their knowledge of self, and how their upbringing, experiences, values and beliefs affect their ability to work with vulnerable people' (2007: 1). By developing an awareness of self, one gains a heightened intuitiveness of the internal and external working versions of self. This personal self-development lends itself to internalising how our complex selves can impact the authenticity, quality and effectiveness of the relationality between us as the social care worker and the people we support; the relational space between the carer and the person being cared for.

SCWRB – Standards of Proficiency Toolbox (Illustration by Rea 2021).



SCWRB – Standards of Proficiency Toolbox (Illustration by Rea, 2021), visually representing professional competencies as tools within a toolbox, symbolising the skills, ethical foundations, and measures of success necessary for proficiency in social care practice.

With regard to SCWRB's standards of proficiency, it may be helpful to visualise the Standards of Proficiency (SOPs) as being represented by a 'toolbox of social care skills and knowledge' with each of the proficiencies being a tool which students can aim to acquire, practise and develop on their academic and practice placement journey. Subsequently, graduates are required to possess the complete toolbox of social care skills and knowledge to gain access entry on the social care register. Any skilled craftsman will attest to the fact that using the correct tool/s (one which is fit for purpose) makes all the difference to the end result. Regularly caring for and maintaining the tools of your trade is essential, as is embracing new tools, techniques and training with which to elevate one's skill level.

One of the tools required of graduates under Domain 4 Professional Development is to understand and recognise the impact of their personal values and life experience on their professional practice and to be able to manage this

impact. Our values, attitudes and life experiences provide a template for how we develop and interpret relationships with others as we navigate through life.

Values: Our personal values are the degree of importance we attribute to certain beliefs, which motivates us, directs us in our ethical behaviour and guides the way we live our life. As individuals we may have shared and different values, e.g., being kind, advocating for others, being honest and valuing family and community. External influences, such as generational, cultural and/or religious factors, may impact on how we prioritise these values.

‘Values are attitudes or feelings about the worth of people, objects or activities. Individual values can be conflictual, and are contained within a value system, the adopted set of values influenced by culture, family, religion and society’ (Lyons 2007: 14).

Attitudes: In practice, the term ‘attitude’ is often used as an umbrella expression covering such concepts as preferences, feelings, emotions, beliefs, expectations, judgements, appraisals, values, principles, opinions, and intentions (Bagozzi 1994a; 1994b, cited in Jain 2012: 2). Our attitudes are constructed psychologically in relation to our values and beliefs; how we think about, evaluate and feel about things, people, places, experiences. According to Jung (1971), attitude is a ‘readiness of the psyche to act or react in a certain way’. Our attitudes directly influence our behaviour and can change as the result of our experiences.

Our life experiences: Our life experiences shape our identity and impact on how we live our lives. What we experienced and how we remember past experiences, what learning, if any, arose from those experiences, and how experiences can trigger emotions have the potential to govern our future interactions across the life course. Developing self-awareness of one’s own identity entails reflecting on the knowledge of one’s cultural background and heritage, including but not limited to one’s race, gender, sexual orientation, socioeconomic status, ethnicity, biases and prejudices.

Race: Ireland, once a homogenous nation, is now a multicultural society with people of many different nationalities making their home here. In social care, it is important to familiarise oneself with cultural competence and the cultural competence self-assessment questionnaire (Mason 1993). ‘The Census 2016 Profile 7 Migration and Diversity report shows that the 535,475 non-Irish nationals living in Ireland in April 2016 came from 200 different nations. Polish nationals were the largest group with 122,515 persons followed by 103,113 UK nationals and 36,552 Lithuanians. Just twelve nations each with over 10,000 residents – America, Brazil, France, Germany, India, Italy, Latvia, Lithuania, Poland, Romania, Spain and the UK – accounted for 73.6% of the total non-Irish national population’ (CSO: online).

Gender: Globally throughout history certain groups in society have been discriminated against on religious, legislative, political and social policy grounds, which in turn have been used to reinforce structural inequalities. Notably in Ireland, with its unique historical and cultural intertwining of State and Church patriarchal governance and control, women have been discriminated against. In their book *Producing Knowledge, Reproducing Gender*, Corcoran and Cullen identify the broader historical factors which determined gender inequality in Ireland, highlighting the revelations that have surfaced in the past few decades:

'In contemporary Ireland gender equality and claims for women's interests have featured in a series of public issues that have exercised the media, political elites, and public opinion. These include, waves of revelations about the fate of unwed mothers and babies subjected to state and church control; women's rights and access to reproductive health care; sexual harassment and assault specifically within the cultural and creative industries; and the legal system's approach to rape allegations' (2020: xvii).

Sexual orientation: The impact of shared values is powerful. For example, the Criminal Law (Sexual Offences) Act passed through the Oireachtas on 24 June 1993, decriminalising homosexuality and leading the way for a more open and inclusive society. The people of Ireland have pushed for greater change and acceptance in society for LGBTQIA (lesbian, gay, bisexual, trans, queer/questioning, intersex, asexual) people, leading to the 2015 referendum on same-sex marriage rights, which passed into law in November of the same year. The popular vote enabled Ireland to become the first country in the world to extend marriage equality to same-sex couples by popular vote.

Socioeconomic status: Socioeconomic factors such as occupation, education, income and housing affect the way we live our lives. Unemployment, ill health, lack of adequate education and housing are strong indicators of health and wellbeing in later life (Bronfenbrenner 1979). According to the *Healthy Ireland: Framework for Improved Health and Wellbeing 2013-2025*:

'Health and wellbeing are affected by all aspects of a person's life; economic status, education, housing, the physical environment in which people live and work. Health and wellbeing are also affected by policy decisions taken by Government, the individual choices people make about how they live, and the participation of people in their communities.' (Government of Ireland n.d.)

Ethnicity: For decades in Ireland research has evidenced active political and societal discrimination against Travellers (Mac Laughlin 1999). Every aspect of Travellers being othered in Irish society, from accommodation to education, has been well documented. Various attempts to assimilate the Traveller minority

illustrated resistance to accept Travellers as culturally distinct with their own ethnic identity. One of the major changes in Irish history was in 2017 when the Irish government recognised Travellers' ethnic identity.

'Our Traveller community is an integral part of our society for over a millennium, with their own distinct identity – a people within our people ... As Taoiseach I wish to now formally recognise Travellers as a distinct ethnic group within the Irish nation. It is a historic day for our Travellers and a proud day for Ireland.' (An Taoiseach Enda Kenny, 1 March 2017, Pavee Point n.d.)

This recognition brought with it the call for organisations, large and small, to address their values systems. The beginnings of a ripple effect is evident. In education alone, the first national access plan (Achieving Equity of Access to Higher Education in Ireland 2005-2007) identified Travellers as a specific group to be prioritised and included in successive plans. A National Action Plan for increasing Traveller participation in higher education was launched in 2019. Despite legislative and policy developments in recent years, many Travellers still experience racism, health inequality, marginalisation and discrimination based on the values and beliefs of a few, all of which impacts on opportunities to progress at the same level as their settled counterparts (Omidi 2019; McGinnity et al. 2017). Reflecting on the knowledge of one's cultural background, heritage and intersectionalities helps us to gain an understanding of how these intersections of self give rise to one's attitudes and values, and consequently make up our unique, multifaceted, complex identity of self. Once there is recognition and understanding of self, we can begin to process, understand and manage our bias.

Bias and prejudices: Bias is a prejudicial unfair inclination against a certain person, belief or group. In Wahler's study 'Challenging social work students' bias', she notes that:

'All students have individual bias, that can affect their judgment and ability to utilise professional values when interacting with marginalised groups in social work practice. While traditional cultural diversity courses often address racial, ethnic or sexual minorities, many students are biased against other groups that may not be included' (2012: 1058).

As a social care worker, it is vital to reflect and consider one's bias and prejudices. You may be working with certain groups in society (apart from racial, ethnic or sexual minorities) such as substance misusers, alcoholics and addicts; domestic violence victims; people with mental health challenges such as schizophrenia, bipolar and borderline personality disorder. Johari's window, a graphic model which is used to help people to understand their own self-

awareness, and their relationships with their self and with others, would be helpful here in realising what is known and unknown to self and what is known and unknown about self to others (Luft & Ingham 1955).

How do we know we are biased? Wahler's (2012) study proposed a four-step teaching methodology to help students self-identify and challenge their own biases and prejudices:

- Consciousness-raising
- Identification of the target group
- Education and exposure of the targeted group
- Self-reflection.

Classroom groupwork and individual exercises may be undertaken in order to raise consciousness of the group or groups against whom the students have the strongest bias. In commencing consciousness-raising of a group, students are asked to identify a group or groups in society that they are uncomfortable or frightened of working with. Once the groups are identified, students then participate in writing exercises on the reasons why the particular groups were chosen. Through class discussion and debates, stereotypes and assumptions about the group are explored, and, hopefully, as in the findings from Wahler's study, challenged. As part of the first step of consciousness-raising, students are also asked to prepare a 'brief, out of class self-reflective assignment to explore their family of origin, and peer groups values, beliefs and stereotypes regarding the targeted group and note any differences or similarities between their social circle idea of the group and their own' (2012: 1063-4).

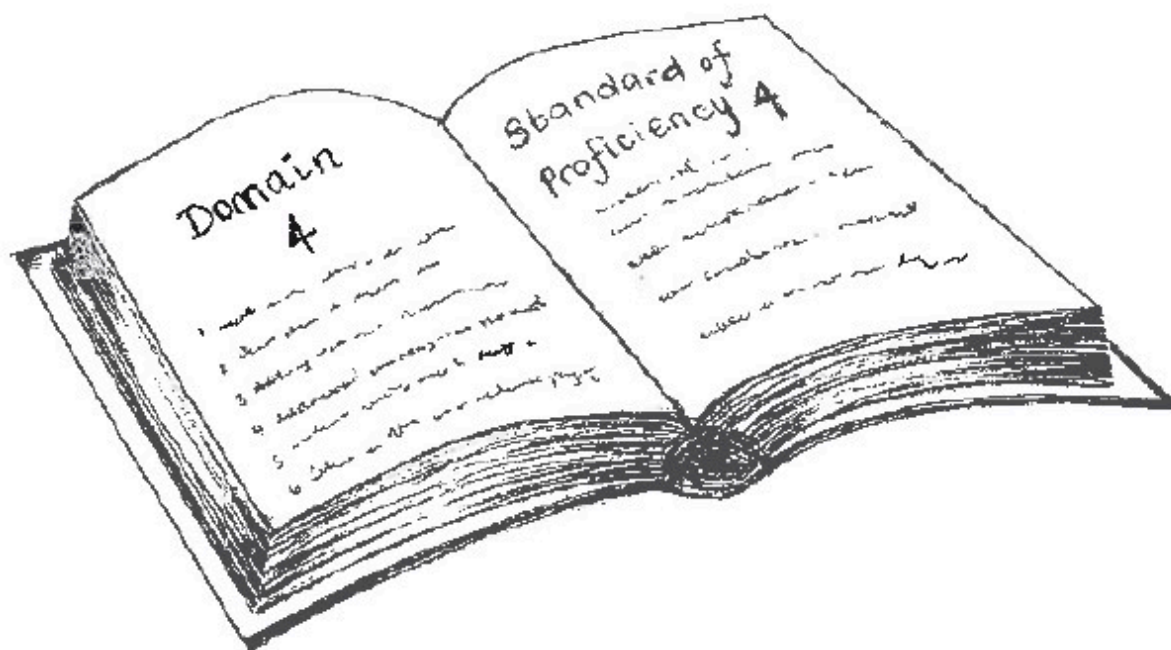
This exercise allows the student to reflect on the different influences which may affect their own bias. Researching, gathering, disseminating, sharing and presenting information about the targeted group in relation to oppression, discrimination, stigmatisation and social injustices provides an opportunity for other students to see and understand the impact of bio-psychosocial factors and determinants. One way in which this information may also be captured is in an interview with a social care worker who is already working with the targeted group, to gather their opinions about societal stigmatisations towards the group. (Wahler offers detailed questions for this interview (2012: 1066).) Self-reflection exercises and written work are vital throughout the different steps of challenging your own bias and prejudice process. Writing in a reflective diary or journal is conducive to processing, negotiating and making sense of your individual thoughts and feelings. According to Wahler (2012:1067), 'Previous studies have suggested that exposure to and engagement with different types of individuals

can reduce bias and prejudice (Comerford 2003; Swank & Raiz 2007; Eack & Newell 2008; Chonody *et al.* 2009)'.

Meeting, talking with, visiting and interacting with members of the targeted group can help the students see, hear, gather information and learn from another perspective. Space and time are then made for class reflections on changes that may have occurred as a result of, e.g., hearing members of the targeted group talk; or a realisation of one's own familial influence; or gathering evidential research into the relationship between oppression and the targeted group. When we understand our own bias and prejudice, we can know ourselves, we have the ability to acknowledge the potential for bias within us. As findings from Wahler's study conclude, 'Once students are aware of bias, understand issues affecting particular groups more fully, recognise effects of injustice and oppression and experience stories or relationships with people in the targeted group, beliefs can change' (2012: 1068-9).

The ability to recognise the effects of oppression, injustice and bias is a developmental process in our academic and life journey. Consistent self-reflection and self-reflexivity enable us to be honest with oneself in acknowledging personal bias. According to Bolton, 'being reflexive is finding strategies to question our own attitudes, thought processes, values, assumptions, prejudice and habitual actions, to strive to understand our complex roles in relation to others' (2009: 13).

It is also important not to be too hard on oneself if a realisation through reflection means that a personal bias must be acknowledged. Understanding the impact of socialisation, values, religious, cultural and other external influences will help us in this regard. In the social care context, becoming cognisant of how attitudes and feelings may impact on relationships with children, families and people who are supported gives us the capacity to recognise our own bias. Learning from our lived experiences identifies that personal values are fluid and can be developed and modified throughout the life course. In professional practice as a social care worker, a key skill is evaluating all intrinsic factors which have the potential to affect an outcome and then having the confidence that you have made the best possible decision.



Domain 4 – Standard of Proficiency 4 (Illustration by Rea, 2021), representing the structured knowledge and formal guidelines essential for professional competency and practice.

Case Study 1

Kathy had commenced a 10-week work placement in a family resource centre in Galway and in her first week she was scheduled to work with a family recently arrived in Ireland. The family, originally from Syria, had moved from an emergency reception and orientation centre into their new home in Galway six weeks earlier. They are just one of many refugee families who arrived in Ireland from Syria via a refugee camp in Lebanon.

Although Ireland is no longer seen as a monoculture, most foreign nationals, like many new immigrants in other countries, have tended to live in more densely populated towns. Kathy is 19 and grew up in the far west of Connemara with Irish as her first language. She was very anxious at the prospect of working with an ethnic minority family as she had very little experience of cultures other than her own. This would be the first time that Kathy was to work with refugees; it was in fact the first time Kathy would have worked with people other than Irish. Kathy was also very aware of the lack of community engagement relating to a direct provision centre being built for asylum seekers locally and wondered how she would reconcile her own personal values, fears and biases. She was also unsure how the family would settle into the local community.

On the first day the Syrian family arrived into the resource centre, they came with their two daughters aged six and five years. Kathy was surprised at the level of English the children had, having assumed that this would be a barrier. Kathy had not sought clarification from her supervisor as to how the staff communicated with the family to organise the visit. Arrangements were initially

made via an interpreter; however, on the day of the visit the parents arrived with the children only, and conversation with the parents was significantly limited as a result. Kathy thought the father did not want to engage during the visit as he often looked away. Kathy enjoyed her time with the girls – when asked what they liked about Ireland, both replied ‘music’.

The next week when the family arrived, Kathy had brought something along with her to share with the girls, hoping to engage them more fully and build trust. Kathy was an accomplished fiddle player and when everyone was settled, she brought out the instrument and played ‘Galway Girl’ for the children. While she was very happy the children enjoyed her playing, Kathy was overwhelmed by their father’s response. Gesturing to be given the fiddle, Kathy reluctantly obliged, the father took it gently, tucked it under his chin, raised the bow and played ‘The Fields of Athenry’. And there, in a few bars of music, a connection was forged – in some ways, they did speak the same language.

Kathy learned a lot about herself and her assumptions and how her lack of life experience had influenced the decisions she was making. What Kathy had judged as rude or dismissive actions from the father during the first visit was explained by the interpreter who was present at the second visit as being his way to hide his embarrassment that he could not communicate in English like his children.

Kathy’s supervisor suggested that she ask questions in advance of the work she is included in during placement, so that she can research the culture and the context of this family’s arrival in Ireland. The manager praised Kathy for her initiative with the fiddle; however, she advised Kathy to investigate and reflect on where the family came from, how they were fleeing from their homeland because of civil war and might be traumatised.

When Kathy reflected on working with this Syrian family, she realised that, as a result of her lived experience there had been a shift in her perspective and a recognition that personal values are not fixed but are fluid and have the capacity to expand and evolve with exposure to new experiences. Being aware of one’s biases enables oneself to manage their impact in a given situation. Each life experience has the propensity to develop our self-awareness to a higher level, which in turn builds on our ability to view each new situation through a holistic, non-judgemental, strengths-based social justice and advocacy lens.

TASK 2

Reflect on a time when your belief system had the potential to impact negatively on your work or personal life. What learning came from this?

Impact of Personal Values and Life Experience on Professional Practice



Caroline Coyle

Social studies lecturer in AIT. Focusing on the therapeutic use of drama in the social care context.

Image Rea, 2021



Imelda Rea

Social studies lecturer, Community Connector (MEND) and Student Support worker in AIT.

Image Rea, 2021

Hand-drawn portraits of Caroline Coyle and Imelda Rea (Illustration by Rea, 2021), showcasing their roles as Social Studies lecturers in AIT (now TUS), with expertise in therapeutic drama in social care and community support work.

Below are our personal experiences of how personal values and life experience have enhanced our professional practice.

From chapter author Caroline Coyle: In my experience of working in residential care, having knowledge of oneself is central to the work of a social care worker. Being grounded in oneself can be sensed by the young person in care. Having a strong internal locus of control, self-awareness and self-reflectiveness enables the young person to acknowledge you as a safe place to go to. For the young person, knowing that you will act as a buffer for their heightened emotions provides an opportunity for the young person's needs to be identified, and a relational space to empower the young person to understand their exposed needs. A life facilitated in a non-traditional care setting is for many an extremely difficult and trying time in their emotional, social and intellectual journey. How their own values and belief systems are developed at this point can be bolstered with the opportunity to link with positive role models to expand and develop their world perspective. An important time indeed, which requires those charged with caring for children and young people to be mindful of their own attitudes to and level of awareness of those who share their world.

My personal philosophy when working in a social care context is to utilise creative methods such as poetry, writing, storytelling, drama, dance and art for various physical and psychological therapeutic benefits, e.g., to promote

inclusion, forge pathways into the community, to provide a liminal space for the self to develop through interrelationships with others.

I have been using poetry, poetic inquiry and collaborative communal poem-making in my relational practice for many years, and these innate personal values have automatically transferred to my teaching philosophy. As a social studies lecturer focusing on the therapeutic use of drama in social care, I use the creative methods of arts-based media for collaborative participatory groupwork between the students and people we support in the community to facilitate individual critical reflection and learning on a deeper level.

From chapter author Imelda Rea: Core personal values – the things that are most important to us, the characteristics and behaviours that encourage us and guide our decisions – may not be fully our own true values after all. Discovering our values and identifying if these values run parallel to our work practice requirements may involve, as suggested below, analysis of self. We should not disregard or devalue current personal values automatically, however; we should take the time to understand what they are, how they developed within us over time and together with personal life experiences, so that we as practitioners can use the best of what we are to positively impact on others.

In my experience of working in residential care, it was essential to review personal values and learn how to manage them. Thinking about what exactly they were/are, to dissect the influences over one's lifetime and consider how this can work in a positive or negative way in professional practice. Not understanding or recognising that our personal values and life experiences impacts our decisions could be the barrier to truly engaging with people we support. In the early 1980s in the UK, my introduction to working in residential care was a baptism of fire and is worlds apart from the current structure of child-centred care. The number of children in some residential homes were, at times, too high for the number of staff. Even without a formal social care education, I was prompted to review and manage the impact of my personal values. Upon reflection, many of the opinions I thought were my own were simply the absorbed opinions of others, with little analysis of those opinions or of how acting on them would impact on a supported child or young person.

It is worth noting that hard-won connections can be quickly lost from a lack of self-awareness; it is therefore essential to identify the roots of the 'personal' values we carry within us and consider, if they are one's own, in this moment in time, fair and just. We may also have to re-evaluate the language we use as our personal values may not be reflected when we use outdated terminology.

Imelda's professional practice is informed now by her lived experiences, her further developed personal values and her educational journey to date. Caroline's

professional practice is informed by her lived experience as a social care worker working with young people in residential care; her personal values of inclusion, advocacy and social justice; and her use of creative methods as a means of participatory engagement and self-reflective tools of inquiry.

Graduating as a social care worker is important to ourselves, our family and our employers. However, the right values, behaviours and attitudes to work effectively with people who need care and support is vital and should be consistently demonstrated in our day-to-day care of others to show the value we place on all we work with and for. We have both travelled extensively, living and working outside Ireland for many years, and in doing so have gained experience of diverse communities. It is often not until we move outside our 'comfort zone' that we really understand what it can feel like to be different or in a minority. Our beliefs and values may be in sharp contrast to those around us and may be challenged by others as a result.

It is important that social care workers have the ability to be open-minded, willing to examine all viewpoints and, if needed, to alter their perspective towards others. A productive and comfortable place to examine this area of self can be in a structured group session. The perspectives of other individuals, shared within a group setting, can offer a wealth of different viewpoints, and generate self-reflection.

Appropriately Managing the Impact of Personal Values and Life Experience

While understanding and taking ownership of the influences of our values and life experiences on one's practice, the student must be cognisant of implementing strategies to manage the impact of these influences:

- Be open to the concept that your perspective can change.
- Actively train to increase self-awareness ('Sharpen the Saw').
- Make a conscious decision to be reflective. You may find that keeping a reflective diary or journal to 'write out' your feelings will help.
- Make yourself aware of how your personal values, attitudes and life experiences have the potential to influence your decisions and behaviours.
- Acknowledge that cultural, religious and gendered bias exists and may be inherited through a country's collective consciousness and/or a colonial psyche.

- Reflect on your cultural background, heritage, familial, cultural and/or religious influences.
- Familiarise yourself with the evidential research and information relating to the various groups you may be working with in social care.
- Make note of the groups in history which have been specifically discriminated against and research these groups with regard to oppression and social injustice.
- Utilise Bronfenbrenner's bioecological model to understand the external influences of ecological systems on children's development.
- Complete some of the self-reflective exercises on bias.
- Acknowledge a bias which becomes apparent. In the context of a situation which challenges you, breathe, recognise the bias, acknowledge it, and move on.
- Aim to complete a placement which you know will challenge you, your biases and your personal values.
- Engage in continuing professional development (CPD). Through CPD, theoretical and experiential learning, self-awareness is developed on an ongoing process across the life continuum.
- Knowledge of cultural awareness and implementing cultural competency in one's professional practice is ethically and legally imperative in modern Ireland.

Conclusion

Throughout students' academic journey, emphasis is placed on promoting the practice of self-awareness through reflection, enabling the student to understand and recognise the impact of personal values and life experience on professional practice.

Acquiring a critical understanding of the key threshold concepts of theoretical perspectives in social care empowers students to apply an effective relatability of theory to practice in the practicum; to deal with the everyday challenges which may arise; and to appropriately manage the impact of their personal values, biases and life experience in the authentic experiential learning space.



Tips for Practice Educators

In order to achieve this proficiency the student will need to understand and recognise the impact that their own personal values and life experience may have in any given scenario, case study or real-life situation.

The student will need to manage this impact on self and others, negotiating differences or challenges along everyday pathways in the social care context.

Invite the student to consider the sociological impact of how their own cultural, socioeconomic, religious and moral background (socialisation) has impacted on making them who they are today and who they aspire to be in the future.

Raise for discussion the concept of the fluidity of personal values and consider the changing nature of the impact of one's own lived experience.

Learning opportunities can be provided for students in class-based placement preparation, utilising case studies for interpretation and recognition of personal values and biases.

Examples of case studies based on social care issues may include the following:

LGBTQIA	Ethnic minorities
Travellers	Community development
Older people	Cyberbullying, social media
Social isolation	Residential and alternative care, foster care
Disability	Youth and youth work
Asylum seekers	Intergenerational solidarity
Physical, sexual or emotional abuse or neglect of children	

Invite students to reflect on how they would respond to the case study as a social care worker and, from their responses, to identify their personal values that impacted their decision. Once these personal values are recognised, the student then can begin to identify strategies to manage the impact of their personal values and life experiences.

Prior to entering student placement or new social care work environments, students should inform themselves of the organisational values and how these values are demonstrated in the culture of the organisation. Understanding and being aware of how our thoughts, attitudes and behaviours may impact those we are working within the social care context is vital. Being able to identify, recognise and manage the impact of one's own life experience and values is indicative of a reflexive and effective practitioner.

Small-group discussions in a safe space (with guidance on appropriate self-disclosure and adherence to confidentiality) enable students to focus on self-reflection and becoming self-aware and reflexive. Group sessions provoking reflection must allow enough time for students to draw together their responses, share these with the group and be open to peer learning.

One must be cognisant that interactions of this nature, whether facilitated remotely or face-to-

face, have the potential to draw unresolved issues to the fore. Student support services within the institution, e.g. counselling, should be identified, with encouragement to avail of these services if required, to promote student wellbeing. Understanding oneself and what motivates self is an enabler to care for others.

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Chapter 60 – Adrian McKenna (D4SOP5)

Domain 4 Standard of Proficiency 5

Understand the importance of and be able to seek professional development, supervision, feedback, and peer review opportunities in order to continuously improve practice.

KEY TERMS
Supervision
Feedback
Learning cycle
Peer review opportunities
Personal values

Social care is ... a profession that allows us to use a personal connection to maintain trusting, caring and supportive relationships to help the vulnerable individuals that we work with grow, develop and be the very best version of themselves that they want or choose to be.

TASK 1

Read Chapter 57 and write your own definition of professional development. List all the activities I completed as part of my continuing professional development.

Supervision

This chapter focuses on three main areas of professional development: supervision, feedback and peer review opportunities. To help you develop your practice, supervision is the tool that is at the core of what we do in social care. Having had the opportunity in the past to work with really experienced supervisors has certainly added to my professional practice. The abiding thing

for me is when supervisors make you feel very safe, allowing you to express yourself honestly, which I believe is one of the first parts of the social care worker development process. If you are not honest with yourself, you cannot be honest with someone else and if you are not honest with someone else, it is not possible for supervisors to support you on your professional journey. Engaging in and taking responsibility for professional development in social care normally starts with the supervision process. The hope would be that you will have a well-trained, experienced social care professional as your supervisor, and part of your supervision would be your developmental process. The Tony Morrison model of supervision identified personal development as one of the four tenets of supervision.

The objectives and functions of supervision are described by Morrison as:

- competent accountable performance (managerial function)
 - CPD (developmental or formative function)
 - personal support (supportive or restorative function)
 - engaging the individual with the organisation (mediation function)
- (Morrison 2005).

TASK 2

Register at www.hseland.ie and complete the PDP e-learning module.

This process requires you and your supervisor to collaboratively look at a personal development plan. In the first instance you look at where your development is currently; you do this by constructing a historical narrative around your education, experience and desires so that you can then look forward and identify the deficits in your practice, knowledge, skills and development. It can be a simple, straightforward process and there is plenty of support available to help you do this. The HSE have an e-learning module of professional development planning which is certified and can be completed in under an hour.

Feedback

Supervision is very much about feedback. The supervisor takes what they see, what they feel and what has been said to them in relation to your performance

and feeds that back to you in a supportive, gentle and coaching way. An example of that from my career is summarised in the following case study.

Case Study 1

My supervisor said to me that he didn't feel that I was very aware of the effect I could have on a room when I entered it. I wasn't entirely sure what he meant by the comment and I asked him to explain it further. He then challenged me to explain what other people in a room might see when I enter. I gave a description of how I might appear to others, but I was very much off the mark. My supervisor explained that as a very big man, standing well over six foot, with earrings, tattoos, beard, bald head, the whole works, can appear quite intimidating. He continued: I didn't actually need to say anything when I entered a room because my physical presentation was being interpreted as intimidating. This comment resonated with me, especially from the time I worked in detention services and residential homeless services for young teenage boys. Based on their experience of the world, someone who looked like me was viewed as a natural threat, and therefore when I entered a room I could change the vibe of that room very quickly by just being there.

TASK 3

1. How would you feel if you received this feedback in supervision? Discuss
2. Have you ever received feedback from a supervisor that enabled you to 'see' yourself from a different vantage point?
3. Describe how your own physical presence may be perceived by the different people we work with in social care.

This is how great supervision really helped me to understand that when I enter a space like that, I need to use my vocal, visual and caring skills very quickly to help calm that room space and change the misinterpretation of my physical presence. In my own practice as a supervisor I look to use the self in concrete examples in order to support learning for my supervisees. I will happily use positive and not-so-positive examples of my practice down the years to invite those I supervise to engage in their own narrative.

I supervised a social care worker in homeless residential service who was having difficulty asserting his leadership in a team setting. When we delved into the issue, they were struggling with the possibility of upsetting colleagues or being seen as not backing up a colleague. We looked at past examples of the times when I had peer reviewed his work skills and practice and how he felt afterwards. He was fixated on the 'challenge' aspect of communicating feedback

to colleagues, viewing the process as entirely negative. When we explored this further, his internal narrative was focused on the feelings of 'you have failed so now you get punished'. When I asked the supervisee to compare our feedback session with giving feedback to colleagues, he could see that I was doing the same thing with him, giving feedback, but using a learning, developmental process and analysing the experiences through the stages of experiencing, thinking, reflecting and acting.

Learning Cycle

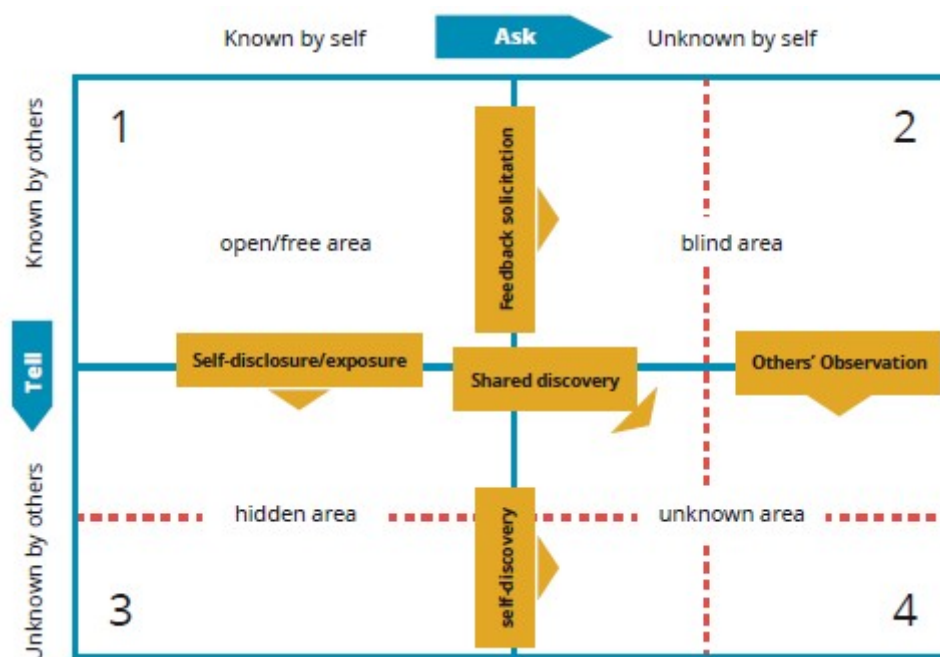
I like to remind those I supervise of the value of Kolb's learning cycle (Kolb 1984). Kolb showed us that the four stages in the 'cycle of learning' are the central principles of his learning theory. The 'immediate or concrete experiences' are the basis for 'observations and reflections'; the 'observations and reflections' are then distilled into 'abstract concepts' which presuppose an action that can be 'actively tested', creating new experiences, which are observed and reflected upon. When you combine that model of supportive supervision with the concepts of servant leadership you have a caring supportive model that holds people accountable, but in a way that helps them to thrive in the supervision process and not be afraid of it.

Servant leadership is very much what it says – it is leading by serving. It has been said that servant leaders put the needs of others before themselves, which is a distinctly social care process. These leaders quietly nurture and support followers as they shift authority to them, which fosters follower confidence and personal development (Northouse 2016). When the servant leader's goal is the shifting of authority and the strengthening of their peer(s), you can see how that would facilitate good, honest, robust feedback, leading to honest, supportive peer reviewing.

The peer review process is something that all social care workers should be comfortable with or at least open to. There are many models available, such as the 360-degree process, and these formal models can work if the team and the individual are open to the process. They are based on a series of questions that your peers have to answer honestly. Taking that feedback can be very, very challenging for you; but if you assume that if someone who is peer reviewing is being honest, well, then you have to look inside yourself and challenge yourself.

Peer Review Using the Johari Window

A particularly good tool to use when we are involved in this process is the Johari window (Chapman 2003). it is one of the few tools out there that has an emphasis on 'soft skills' such as behaviour, empathy, co-operation, inter-group development and interpersonal development. It is a useful model because of its simplicity and because it can be applied in a variety of situations and environments.



This Johari Window Model diagram is included by kind permission of the author, Alan Chapman, illustrating the process of self-awareness, feedback, and interpersonal communication through self-disclosure and discovery

The Johari model has four quadrants. The first quadrant is your 'open area' – what we know about ourselves and are willing to share. This is where the trust in the working relationship is built, by disclosing to and learning about each other. As well as helping the individual, this strengthens a team. Then we have our 'blind area' – this is where someone in the group becomes aware of an aspect of us that we don't recognise or refuse to see. With the help of honest feedback and supportive supervision we may be able to change some of these aspects. The third quadrant is the 'hidden area' – where we may actively try to suppress or hide aspects of ourselves from others. This is particularly challenging when you are exposing yourself to high levels of openness and honesty. Finally, the fourth

and most challenging quadrant is the 'unknown area' – this is unknown to you and unknown to your colleagues. This quadrant can never become exposed if you do not engage honestly with others. The general premise is that over time the balance between the four quadrants can change. For example, if you decide to be more open with a colleague and tell them something you had previously kept hidden, this increases your open area and decreases your hidden area. It is also possible to increase the open area by seeking honest feedback from peers; this in turn can decrease your blind area. If the culture of an organisation allows for this depth of analysis in the supervision process, you will be working in an incredibly supportive caring team.

Professional development and a commitment to improving and developing your practice requires you to continuously challenge your sense of self. If we do not understand who we are, where we are, what triggers us, what keeps us happy, what makes us sad, what frightens us, what angers us, how we fit in a team; if we do not work on continuing professional development; if we do not look for continuous feedback in supervision – well, then we cannot continually improve our practice. In this case, what we are talking about is us having the ability to critically analyse our professional practice, and one way to do that is to develop a very strong working relationship within the supervision process. As social care professionals, we need to be mindful of the impact of our own personal values and life experience on the individuals we work with and for. Although one would believe that this in itself is a simple thing to do, it is by the very nature of humankind complex and in need of some consideration.

Personal Values

Personal values are the things that are important to us, the characteristics and behaviours that motivate us and guide our decisions. As an example, maybe you value honesty. You believe in being honest wherever possible and you think it is important to say what you really think. When you do not speak your mind, you probably feel disappointed in yourself. It has been suggested that it is from our early childhood experiences that we begin to form the core beliefs and values that influence the way we judge ourselves, others and the world at large (Beck 1995). In Ireland, and indeed worldwide today, anybody who is not a part of the hegemonic culture may find themselves being the victims of oppression and marginalisation. All sub-groups in society, whether they are ethnically diverse, religiously different, identify a different orientation or sexuality or are measured

by economic strata, can attest to that marginalisation and oppression. As social care workers we only have to look at the public discourse surrounding the marriage referendum, the Eighth Amendment referendum and the continuing discourse in relation to the Traveller community and those seeking asylum in Ireland. With that being said, it does not take a huge leap of faith to assume that we as social care professionals may share those prejudices too. If we are influenced by our personal values that are formed by these prejudices rather than a professional value system, it could be potentially challenging for us to understand, work with and take part in an ethical decision-making process with any marginalised individuals, groups and communities. Moreover, we could contribute to social care becoming an element of oppression in a modern Ireland.



Tips for Practice Educators

Complete a Johari window task within the supervision setting. Ask the student to look at themselves using the four quadrants, and then you, as supervisor, do the same.

Look at a piece of work or a work-based scenario and ask the student to look at the scenario from a Kolb learning cycle perspective.

Look at understanding servant leadership and how it might work in a social care setting: <https://www.greenleaf.org/what-is-servant-leadership/>

What does supervision mean to you, the practice supervisor, and the student? Do you see the value in the process? See: <https://www.iriss.org.uk/resources/insights/achieving-effective-supervision>

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Chapter 61 – Francis Gahan (D4SOP6)

Domain 4 Standard of Proficiency 6

Understand the importance of participation in performance management activities for effective service delivery.

KEY TERMS
Effective
service
delivery
Performan
ce
management
Activities

Social care is ... a profession that allows you to become the change that you want to see in the world. Those who become social care workers will often find their own happiness and fulfilment in caring for and supporting others.

TASK 1

How can performance management activities influence the standard of support that social care workers provide for service users?

Introduction

Although performance management is a relatively new concept in the provision of social care in the Republic of Ireland, there is no doubting the benefits of such a process if carried out in the correct spirit and manner (Carbery 2013). Performance management is increasingly becoming central to unlocking the success of a social care organisation and in ensuring that the social care worker

is best placed to provide effective support to those they care for. While descriptions of performance management derived from other sectors such as industry or economics might seem impersonal or unrelated to 'caring' work, there is value in applying this concept to social care practice, if the focus and intent of one's work is to promote the wellbeing, empowerment and autonomy of those they support. It is well understood that such outcomes are best achieved through the medium of the relationship that is built and maintained between service user and social care worker. As such, performance management in social care work must focus on ensuring that the conduit through which the work is carried out (the relationship) is managed, maintained and positively reinforced. Logically, if the goal is to maintain fertile and fruitful relationships, the social care worker must ensure that they too are fit to support service users, willing to engage in self-care and supervisory support and eager to embrace the concept of performance management that will ultimately result in better outcomes for service users.

Performance Management

Armstrong (2014) describes performance management as the continuous process of developing the performance of human resources within an organisation. This, as Corbett (2016) suggests, requires the alignment of individual and team goals to the strategic aims of the organisation. Rostam (2020) also outlines the need for the continuous appraisal and development of individuals and teams within an organisation. He suggests that this must be carried out on a cyclical basis to allow for continuous communication, support leading to skills development and increased performance of staff members and organisational teams.

Performance management has evolved from an operational concern to one that plays a strategic role in the achievement and outcomes of an organisation. Thus 'social care' has adopted principles from performance management, with good reason. While the outcomes of manufacturing and commercial industries often differ greatly from the outcomes associated with social care work, there are many benefits to the adoption of the concept of performance management by the social care profession. However, it is essential that we take heed in applying such principles to 'caring work' to ensure that performance management is done in a manner that is both appropriate and beneficial to those we support, to social care workers themselves and to social care organisations. Performance

management in social care should be seen as a more fluid and organic concept than in other sectors because the nature of social care work itself is ever-varying and ever-varied. There are numerous service types supporting service users with a multiplicity of human need and each individual service user will inevitably have unique personalities, strengths, limitations and needs.

Performance management is a career-long engagement that social care workers and organisations should use to ensure the best possible care is provided for those they support. It occurs even before a social care worker is employed by a social care agency. Before they secure employment with an organisation, they will most likely be interviewed for the position. This can be seen as the first step in the performance management process. Interview panel members will need to be satisfied that the potential employee holds the appropriate skill and knowledge levels to work in the organisation. They will also ascertain the interviewee's level of desire to care for service users of the organisation and this will give some insight into the value systems and motivations of the individual.

While explicit performance indicators such as the level of training and experience of staff members needs to be managed to ensure that the skills and knowledge of a staff group are maximised, there are also implicit performance indicators that should be acknowledged and monitored through the performance management process. Implicit performance includes aspects of our practice with a service such as how we communicate and relate to others, how we feel and think about our work and what motivates us to care for others. The culture and norms of an organisation and the collective motivations of a team can affect these. These can in turn influence how individual social care workers consume knowledge and how social care workers work and think about the work they do. Therefore, it is a necessary part of performance management to ensure that the individual and team values and attitudes in an organisation are aligned with the core values and principles of social care work. This implies that those who manage the performance of social care workers must ensure that employees of a social care organisation practice in a non-judgemental, non-discriminatory and empowering manner.

Effective Service Delivery

Organised social care delivery and the outcomes associated with social care work are very different from those of manufacturing, economic and commercial

organisations, which are usually concerned with generating financial profit. In education, practice placement allows students to apply theory to the work of social care and to hone their skills in the work. Such an opportunity also helps students to appreciate the true values of the work and the principles underlying social care practice, and to understand the desired outcomes of such work, thus instilling the meaning of effective service delivery in the social care student.

One way to gain an understanding of the meaning of effective service delivery in social care is to examine definitions associated with the work. Lalor and Share (2013) have interrogated a variety of definitions and while they consider that social care practice cannot easily be tied to one single, comprehensive definition, they provide common strands or factors which are central to all aspects of the profession. These include 'shared life-spaces', 'support', 'protection' and 'advocacy'. Most notably, definitions of social care provide that the work is fundamentally based on a relationship that is built and maintained between service user and worker. Thus, the 'relational' aspects of the work must be considered essential to effective service provision.

Social care has traditionally been differentiated from other professions mainly by virtue of the centrality of the relational aspects of the work and the reliance on the relationship that is formed between the social care worker and service user(s) in achieving 'desired outcomes'. Relationships are therefore seen as the crux of the work and essential to the achievement of positive outcomes for service users. Social care is about human development, knowledge of 'the person' and trust in relationship-based practice as the catalyst for human growth and healing. Therefore, performance management in the social care sector should be intrinsically concerned with both the individual's and team's ability to hold the relational aspect of service provision at the heart of their practice and to support service users in meeting their own goals, which are ultimately central to organisational outcomes. Building and maintaining relationships requires specific approaches, attributes, skills and value systems. Performance management activities provide an opportunity for support and advice in sustaining these principles.

Such principles are often inherent in the mission statements and vision of social care organisations and apparent in the principles and policies that guide the work. Organisational guidelines also set out the desired outcomes of the work that social care workers engage in every day. Organisational goals are included in the continuous support of staff and are central to evaluating, managing and supporting the performance of a staff team. Therefore, organisational policies will be in place to promote best practice and to ensure that all staff and service users are treated fairly and with dignity. These might

include a dignity at work policy, supervision policy, complaints procedure policy and a staff appraisal policy.

Performance Management Activities in Social Care Practice

Social Care Ireland (2015) describes continuing professional development (CPD) as a process whereby social care workers continuously broaden their knowledge base, skills and expertise. By engaging in CPD activities social care workers ensure the maintenance of high standards of conduct and practice, which will ultimately lead to increased benefits for those who are supported and advocated for in the work. It is advisable that social care workers consult with and get feedback from their line managers and supervisors in deciding on CPD activities.

CORU provides that social care workers 'must make sure that [their] knowledge, skills and performance are of a high quality, up to date and relevant to their practice'. Registrants are 'required to maintain and develop professional competence by participating in continuing professional development' (CORU 2013: 13). CPD is central to ensuring that standards of practice are maintained and social care workers who register with CORU must engage in 30 hours of CPD in each year of practice. They must also maintain a CPD portfolio of development activities that they have engaged in as part of professional performance development.

Such activities can include active engagement with supervision and mentoring, participation with a professional body or learning from online sources (see CORU 2020). In a sense CPD is about monitoring and maintaining one's own standards of practice and while CORU has the authority to audit individual CPD portfolios, it is the responsibility of the social care worker to ensure that they engage in what might be coined 'self performance management' and to choose activities that will allow for their own continued development.

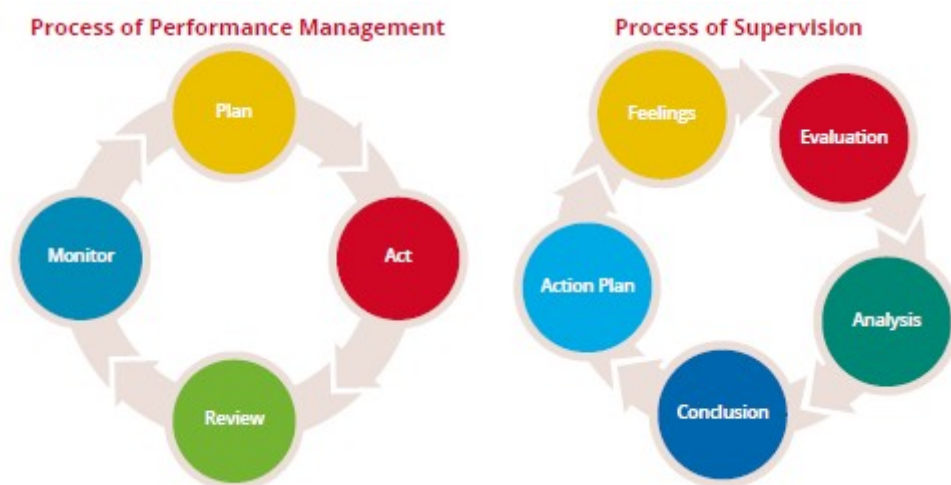
Supervision is another performance management activity that social care workers engage with during social care practice and social care educational programmes often provide in-depth theoretical training in the principles and practices of supervision in social care. Morrison asserts that 'the overall aim of supervision is to promote best practice for clients by maintaining existing good practice and continuously striving to improve it' (2003: 46). Furthermore, Hawkins and Shohet (2006) suggest that the importance of supervision in

practice cannot be overestimated as it serves to support workers who are often involved in the complex and emotionally involved relational work of social care. Such work often requires much personal and emotional involvement and supervision provides the opportunity for the worker to be supported in overcoming challenges in practice, to flourish and develop through guidance, counselling and direction, as described by Page and Wosket (1994). Kadushin and Hawkins (2003) consider that supervision is involved with the examination of one's effectiveness in practice and it requires the worker to evaluate issues such as professional strengths and limitations, personal effectiveness and even one's personality. Supervision has three main functions, according to Morrison (2003): support, accountability and education. The table shows some practice examples of the functions of supervision and potential responses to such examples.

Function	Example	Response Through Supervision
Support	A social care worker in a residential child care setting discusses an incident when a child they had been supporting became extremely upset and began crying uncontrollably. The social care worker found this situation distressing as he knew that the child's mother had recently died. The social care worker was unable to console the child at that moment. It also evoked memories of the loss of his own mother when he was a child. This added to the emotional response of the social care worker.	The supervisor provides a quiet space for the social care worker to talk about the incident. They both discuss the incident and the supervisor provides feedback on the positive aspects of the social care worker's actions during the incident. They discuss the emotional response of the social care worker to the incident and the impact that this has had on him. They may decide that counselling support is required for the social care worker to deal with any unresolved feelings associated with the death of his mother when he was a child. Support and advice is provided in relation to how the social care worker might manage a similar situation in future and support the child with their loss.
Accountability	A new infection control policy has been introduced in a day care service for older people due to an outbreak of a dangerous virus in the community. The supervisor is tasked with ensuring that all employees in the day service are adhering to the policy.	During supervision, the supervisor provides the social care worker with a copy of the infection control policy and discusses the practicalities of implementing such a policy. The supervisor enables the social care worker to ask questions and discuss any uncertainties about implementing the policy. They may review progress of this in following supervision sessions.

Function	Example	Response Through Supervision
Education	A supervisor observes a new employee interaction with an older man with Down Syndrome who is non-verbal. The supervisor notices that the older man is trying to communicate that he wishes to have his lunch at a local restaurant. The social care worker misinterprets the man's non-verbal communication and does not respond in a way that acknowledges the request of the service user.	In supervision the supervisor spends time discussing the needs of the service user and his preference to eat out at a local restaurant. The social care worker is educated on the non-verbal communication of the older man and what such communication might represent for him. The supervisor may ask the social care worker to study the behavioural support plan of the older man to gain further knowledge. The service user may also wish to be involved in providing additional training for the social care worker and the supervisor may organise and support this training. The social care worker is encouraged to ask questions and a supportive atmosphere is provided.

The Child and Family Support Agency, Tusla, contends that effective supervision practices should be at the core of organised support for children and families (Tusla/HSE 2013). It says that equal responsibility must be shared by the organisation, supervisor and supervisee to ensure proactive engagement with the process. Indeed, the need to ensure ongoing effectiveness and performance



Author created diagrams illustrating the Process of Performance Management and the Process of Supervision, highlighting cyclical frameworks for structured evaluation, reflection, and continuous improvement in professional practice.

Formal *staff appraisal* is also a mechanism by which social care organisations promote performance management. The Health Information and Quality Authority (HIQA) provide that ‘each individual staff member’s performance is formally appraised, at least once a year’ (HIQA 2018: 67). Appraisal is a more formal process than supervision. It is a systematic review of the performance of a social care worker over a period of time – usually a year. It involves setting new goals, reviewing previous goals and evaluating the job role (Morrison 2003). It is also necessary to consider aspects of an individual’s performance during appraisal processes that have been positive and to identify areas of practice that require improvement. This allows both the social care worker and the organisation to record and monitor performance and this should be carried out in line with organisational goals and with the needs of service users in mind. It is advisable that performance management activities and appraisals be undertaken with reference to SCWRB’s *Standards of Proficiency for Social Care Workers* (2017) and *Code of Professional Conduct and Ethics* (2019), ensuring that any aspects of a social care worker’s practice requiring additional attention, support or training are addressed.

The Importance of Performance Management in Social Care

It is possible that through life experience and employment in other sectors, some people have come to see the process of performance management as a tool for addressing poor standards of work or a mechanism of control for organisations and managers to keep workers ‘in line’. This might have occurred due to a lack of understanding or application by former managers of such a concept in previous work situations. This is not a helpful way of framing performance management in social care. While performance management systems have become increasingly common in many sectors of employment, they are now a constant feature of social care practice in the Republic of Ireland.

However, in human service work, performance management should be considered a continuous process of reflection on the culture, norms and beliefs of an organisation and not a process through which organisations can maintain dominance and control over their workforce. Moreover, Handy (1999) suggests, performance management should be a mechanism by which we can continually review the traditions, values and work practices of our place of work.

Possible Outcomes for Effective Performance Management

- Clarify job roles, responsibilities and expectations
- Enhance individual and group productivity
- Develop employee capability and effectiveness through feedback and mentoring
- Align behaviours and values to organisational ethos and mission
- Improve communication between staff and management
- Improve outcomes for service users
- Promote self-care

On achieving the minimum educational standard of a Level 7 degree from an approved education provider (SCWRB 2017), graduates will have met a minimum standard of education, knowledge and skills which will allow them to register with CORU and to work safely and effectively in practice. The profession also requires that registrants engage in the process of CPD to ensure that social care workers continue to build on their own standards of practice and on those of the profession itself. Furthermore, caring work can often be challenging due to demands associated with emotion, relationships and dependency, and this can have consequences for social care workers such as occupational stress and even burnout. The importance of performance management also comes into play in supporting staff members to identify occupational stress and to address any issues that may be causing such difficulties.

While social care is a profession that can yield significant personal and moral reward, it also requires that social care workers be cognisant of its challenges and engage in reflective practice and self-care. This is also where performance management and supervision can be effective, providing the opportunity for staff to reflect on their practice, and identify training and development activities which will encourage professional development and self-care. A supportive and understanding work environment and team is essential to this process. Furthermore, an organisational culture that is non-judgemental and supportive of the development and wellbeing of its human resources is also crucial in managing and improving the performance of staff.

As considered earlier, those who write about and indeed those who have experienced social care work agree that the 'relationship' is central to the caring task and to the successful outcomes of the social care organisation (Howard & Lyons 2014; McHugh & Meenan 2013; McCann James *et al.* 2009; Hanlon 2009). Therefore, performance management in social care work must place considerable emphasis on ensuring that the conditions within a social care

organisation allow for the growth and maintenance of effective relationships in supporting those in their care. Performance management activities allow for a space where a manager/supervisor can provide advice on how a social care worker might change or enhance their practice to develop or maintain their relationships with service users, other staff members and other professionals.

Education and training programmes in professional social care provide students with knowledge that will enable them to begin to understand the needs of those they will support in their career. This includes knowledge of principles of respect, empowerment, social justice, advocacy and non-discriminatory practice. Training and education also provides the opportunity for the development of practice skills and the application of the necessary attributes to the work through practice placement. These skills and attributes include communication and people skills, self-awareness, empathy, inter-agency collaboration and the ability to reflect on one's work for personal and professional development and for one's self-care. But there is a need to be ever aware throughout a person's career of one's performance in practice; one's strengths and limitations. This is necessary so that social care workers can ensure that they are as effective as possible in supporting others to achieve their goals or to overcome problems in their lives.

While social care work is increasingly adopting principles of performance management for effective service delivery, this needs to be carried out in a manner that continues to hold the needs of the service user at the heart of service delivery. Social care workers care for a diverse range of service users who may be experiencing disadvantage, vulnerability or marginalisation, including people with a disability, people who are homeless, older persons, people with substance dependency and families experiencing difficulty. Organisations and individuals who continue to embrace principles of performance management should continue to believe in the relationship as the key determinant of effective service delivery and adapt performance management activities to support this.

The type of work engaged in by social care workers is, by its nature, extremely varied and in turn it requires a varied and broad range of skills, attributes and a considerable degree of knowledge to deliver effective support. This can be both a rewarding and a challenging experience for those who choose social care as a career. The choice of an individual to opt for such a vocation must be respected, rewarded, and supported. Therefore, it is necessary that organisations and social care workers who are driven to support others experiencing vulnerability, dysfunction or distress in their lives appreciate the importance of participation in performance management activities for effective service delivery, self-care and

to help others meet their physical, emotional and social needs, achieve their goals and live fulfilled lives.



Tips for Practice Educators

Practice educators should provide information to students about the process of performance management in their organisation, the activities employed to manage performance of staff and the responsibilities of those involved. Such information might be in the form of a discussion or the provision of agency policy documentation and forms associated with recording and monitoring practice performance.

Practice educators can provide a discussion about the importance of performance management during supervision. It would be useful to carry out a 'mock' appraisal with the student during the latter stages of placement, using normal procedures and forms, and to support the student in identifying training and CPD opportunities to address their development needs at that point.

Practice educators should encourage the development of reflexivity and reflective practice in their students' work. This can be done by encouraging the use of a reflective journal, which the student can use in reflecting on their own work performance during supervision meetings. The student should be supported in developing their critical thinking skills when reflecting on the work of the organisation and on their strengths and limitations as a social care worker.

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DOMAIN 5 - PROFESSIONAL KNOWLEDGE AND SKILLS

Social care workers require a broad knowledge of human development, social justice, health and wellbeing, and evidence-informed practice. They apply theoretical frameworks and develop skills to support individuals, families, and communities. Relationship-building, advocacy, creative interventions, and critical reflection underpin effective social care, alongside the ability to adapt to diverse service user needs across various contexts.

Domain 5: List of Contributors

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

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

Sharon Claffey qualified as a social care worker in 2020 with a BA (Hons) degree from Institute of Technology Carlow. She has practice experience in childcare and recently in the homeless sector. She has experienced many different areas in this sector, for example family hubs, all-male hostels and residential care. She has also completed an internship in IT Carlow, where she worked in the placement office for ten months. She was an active volunteer throughout her time as a student and has volunteered with Le Chéile (Mentoring and Youth Justice Services) for four years to date.

Paul Creaven graduated from Limerick Institute of Technology in 2015 with a first class honours in Applied Social Studies (Social Care). Since then Paul has worked in services that support people diagnosed with acquired brain injuries, strokes, autism spectrum disorder, physical and sensory disabilities and mental health. As well as working in diverse service settings Paul has worked on projects in accessibility, has been a local co-ordinator of a national audit by the Commission on Accreditation of Rehabilitation Facilities (CARF), a certification co-ordinator with ETB and QQI frameworks in vocational and day services, and a fundraising co-ordinator; has supervised students on placements and provided presentations to businesses, schools and colleges on awareness of acquired

brain injuries, strokes and services. Paul is now a community service manager in Rehab Care in Galway, where he has been working since early 2019.

Niamh Delany has seventeen years' experience as a social care worker in services supporting people with intellectual and psychosocial disabilities. She holds a master's in International and Comparative Disability Law and Policy and is passionate about the implementation of the United Nations Convention on the Rights of Persons with Disabilities. Throughout her career Niamh has advocated for and empowered decision-making and choice using person-centred planning. She serves as Independent Chair of the Peamount Healthcare Equality and Human Rights Committee. Niamh offers quality improvement and regulatory support consultation to organisations providing services for people with disabilities. She is an active member of Social Care Ireland.

Helena Doody is a social care worker in education and Head of the Department of Humanities in Technological University Dublin, Tallaght Campus. Helena has over thirty years' experience working with marginalised groups and individuals. During this time, she has worked in the social care sector as social care worker, social care leader and co-ordinator of services. She has a passionate interest in advocacy, equality and issues regarding access to higher education, which is the topic of her current doctoral research. Her experiences to date have provided her with a multi-lens view of the systemic inequalities that exist in society from both the social care front line and academia. Helena is currently on the Board of Directors for Social Care Ireland.

Laura Doyle, who is a social care manager employed in a service for adults with intellectual disabilities, graduated with a BA (Hons) in Applied Social Studies in Social Care in 2012 from Waterford Institute of Technology and worked as a social care worker for a number of years supporting adults with disabilities. Laura currently supports a team of social care workers in the provision of high-quality services and supports in a day service setting. Laura is also a PhD student in Waterford Institute of Technology, undertaking a research project on 'Moving towards a human rights-based approach in disability services: An analysis of social care workers' skills and competencies, which explores how policy manifests into social care practice.

Francis Gahan qualified as a social care worker with a BA (Hons) in 2013. He has practice experience in disability service provision and residential childcare. He holds an MSc in Applied Social Research from Trinity College Dublin and is currently undertaking PhD research at Technological University Dublin. He also continues to work on the Applied Social Studies (Professional Social Care) programme at Carlow College, St Patrick's, where he attained his undergraduate degree.

Sarah Joyce currently works full time in frontline homeless services. She has extensive experience in numerous challenging environments from homeless services, education centres and direct provision centres to addiction services, dealing with people from a person-centred perspective. She holds a BA (Hons) in Social Care from Technological University Dublin.

Antonia Kenny is a social care worker currently teaching in Moate Business College in the School of Caring. Prior to this, Antonia worked in Rehabilitative Training and lectured across the Humanities Department in the Institute of Technology Carlow. Antonia has also worked in residential care and day service settings for people with disabilities and is a committee member of the Social Care Ireland Disability Special Interest Group. She completed her MA in Health Promotion in 2017 with the National University of Ireland, Galway, focusing her research on the barriers and facilitators to social inclusion for people with intellectual disabilities. This research was published in the Scottish Journal of Residential Child Care in 2018.

Gillian Larkin is a lecturer in Applied Social Care at Technological University Dublin, Tallaght Campus. She lectures across the programme in Professional Practice, Management and Supervision in Social Care, Leadership and Organisational Change in Social Care and Strategy and Governance in Social Care. Prior to becoming a lecturer, she worked in family support and residential care settings for fifteen years, and for the last ten years has worked on a voluntary basis coaching and mentoring people experiencing difficulties with addiction and mental health. She is currently completing a MA in Applied Psychology (Positive and Coaching Psychology).

Lindsay Malone is a social care worker in education and is the Deputy Head of Faculty of Lifelong Learning at Institute of Technology Carlow. She has spent the last number of years as an associate lecturer teaching across BA and MA programmes. Lindsay has held senior management roles across both the voluntary and community sector and the private sector. She is currently undertaking a PhD in Education and Social Justice at Lancaster University. Lindsay was previously a director with the Gaisce National Council and is a fellow and mentor with the Irish Institute of Training and Development (IITD).

Victoria McDonagh is a social care worker with over twelve years experience in both Ireland and Australia. She is currently a lecturer in Social Care and Early Childhood Studies in Waterford Institute of Technology. Victoria has worked with a wide range of service users in the areas of family support, mental health, dementia care, chronic illness and disability. She has also worked in management, leading social care teams and programmes. Following her degree in Social Care, Victoria has completed postgraduate study in Family Therapy

and a master's in Child, Youth and Family Studies. Victoria is passionate about empowering service users to reach their full ability as well as providing person-centred support. She is also active in research in social care and early childhood.

David Power has an MA in Management, a BA (Hons) in Social Care, a BA in Applied Social Studies, a National Certificate in Vocational Rehabilitation, a diploma in Education and Community and a diploma in Employment Law. He was President of the Irish Association of Social Care Workers (IASCW) and one of the founding members of Social Care Ireland Executive. He has represented the profession on the Health and Social Care Professionals Council for eight years. He has over 34 years experience in the provision of services to the most vulnerable people in our communities (including with the Children Detention Schools, the Crisis Interventions Service, Community Care HSE) and is now the Director of the voluntary agency Smyly Trust Service.

Noelle Reilly is a social care worker currently working as social care placement co-ordinator and associate lecturer in Institute of Technology Carlow. Noelle has extensive experience as a social care worker in Ireland and has worked in residential care and in the disability sector. Noelle is currently a member of Social Care Ireland and is an active member of the Irish Association of Social Care Workers and a member of the Social Care Workers Registration Board.

Juliane Reinheimer is an experienced social care worker and has worked with people with intellectual disabilities in St Michael's House since 2003. She spent several years in Germany, in Castletown Bearhaven psychiatric hospital, has worked in Co-Action and has volunteered in the Darndale Life Centre. As well as a social care degree from the Open Training College, Juliane completed a diploma in Public Relations at Griffith College and has an LLM in International and Comparative Disability Law and Policy from the National University of Ireland Galway.

Padraig Ruane is a social care worker currently working with the National Advocacy Service as a disability advocate. Padraig graduated from Dublin Institute of Technology in 2009 with a degree in Social Care. He has experience in disability services, individualised services and for the past six years has been working in the area of advocacy.

Christina Sieber is a social care educator currently working as the Professional Practice Co-ordinator for Social Care with Institute of Technology Carlow, Wexford Campus. Christina completed a master's in Social Care at Cork Institute of Technology in 2005 and a master's in Teaching and Learning in the Institute of Technology Carlow in 2018. Christina worked in the field of social care for nineteen years in mainstream residential care before taking up her current post with IT Carlow. She has been an associate lecturer with IT Carlow's Life Long

Learning department on the Social Care course since 2015 and has supervised many students completing their dissertations at both degree and master's levels. Christina's main interests are in the area of reflective practice and the correlation between reflective practice and critical thinking.

Chapter 62 – Sarah Joyce (D5SOP1)

Domain 5 Standard of Proficiency 1

Know, understand and apply the key concepts of the domains of knowledge which are relevant to the profession.

KEY TERMS

Relevance
to Profession

Domain 1: Professional
Autonomy and
Accountability

Domain 2:
Communication,
Collaborative Practice
and Teamwork

Domain 3: Safety and
Quality

Domain 4: Professional
Development

Domain 5:
Knowledge and Skill

**Social care is ... understanding what people
meant when they said 'find a job you love and
you will never work a day in your life'**

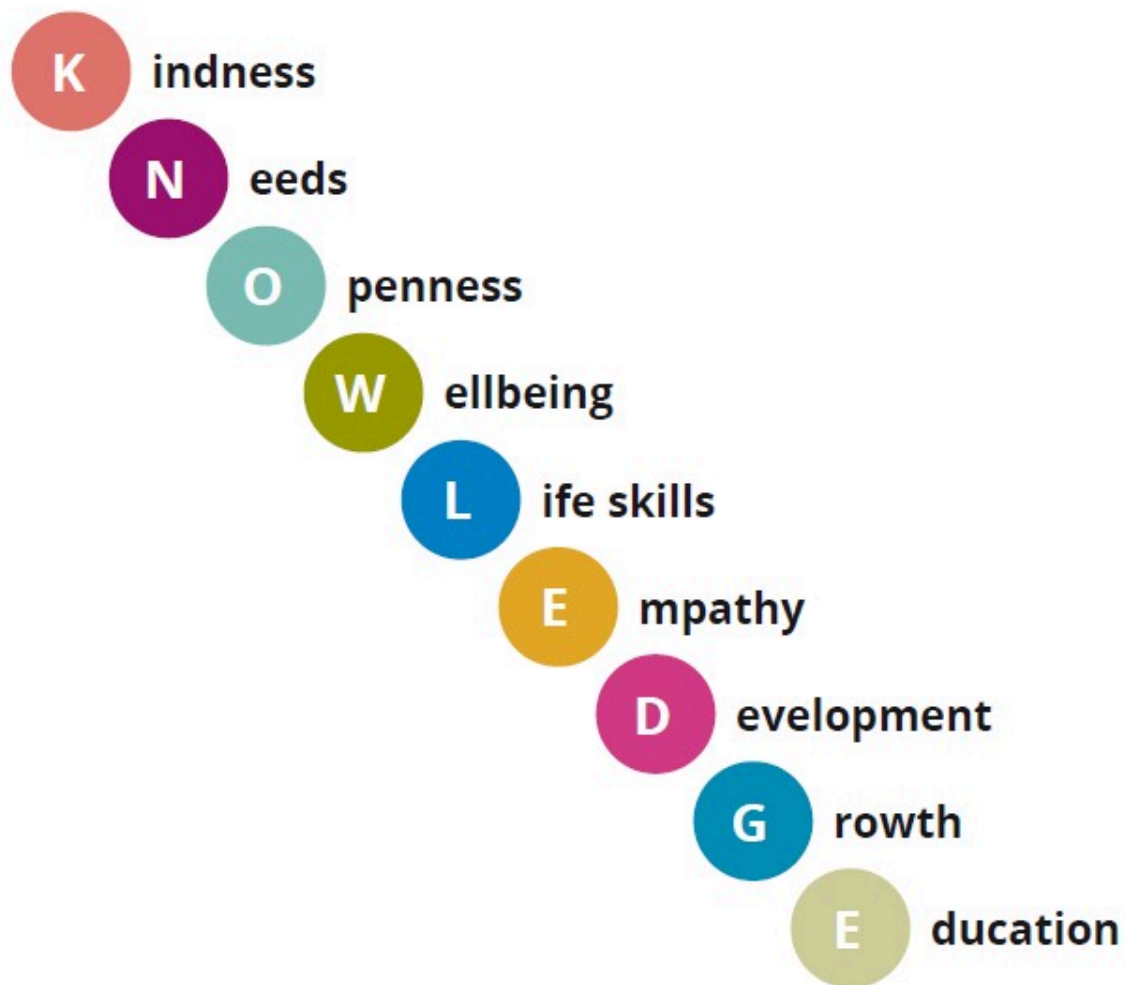
Relevance to Profession

This proficiency recognises that all the domains work in tandem with each other and therefore our knowledge/skill set as practitioners must encompass all domains. This is achieved, first, by understanding each domain and its related proficiencies and, second, being able to relate the relevant skills/knowledge to those proficiencies in a professional setting. While each domain has an allocated number of proficiencies it also has a key concept running through it. For example, in domain 5 the key concept is the knowledge and skills within the

social care profession. For the purpose of this chapter I will be relating my points back to working within the homeless sector.

Knowledge in the social care sector is a vast area. It can refer to academic knowledge gained through studies, for example using case studies to learn about unique behaviours. Knowledge can relate to life experience gained outside a lecture hall, for example visiting a client in their home and being able to turn the power back on after a switch has tripped. Social care involves using life skills and knowledge to work with people in order to enhance their lives and support them.

The five domains of the CORU proficiencies are individually unique, yet all are equally relevant to the core of the social care sector. The domains encompass everything that falls under the umbrella of social care. As such, it is vital that all social care workers have a clear understanding of each domain and its relevance to their chosen profession. In college, students learn the knowledge related to social care; on placement they see how this knowledge impacts on practice. The knowledge we have as social care practitioners is what underpins our practice – we make informed decisions based on our knowledge of the sector. It is vital to note that we are always learning and gaining additional knowledge; this is what allows for continuous professional development and development within the sector.



Author created diagram illustrating the acronym KNOWLEDGE, representing key values such as Kindness, Needs, Openness, Wellbeing, Life skills, Empathy, Development, Growth, and Education as essential components of learning and personal growth.

Domain 1: Professional Autonomy and Accountability

Social care focuses on working with people who are often on the fringes of society. Often the client base includes some of society's most marginalised and vulnerable people. As a result, it is imperative that we as social care practitioners build strong, meaningful relationships with the clients in our care. Positive, meaningful relationships are the very essence of social care. This is what brought a job that was once viewed as a vocation to a professionalised standard. There is always going to be a need for care within society. However, with that care comes responsibility and the requirement to be accountable for one's actions, both personally and professionally. Practitioners must understand their organisation's

policies and procedures, and know how to address poor practice (Lalor & Share 2009).

It is important to be able to differentiate between the knowledge we gather as practitioners and the knowledge we share as practitioners. For example, when writing a report, it is imperative that the report is clear, factual, and relevant. 'Would it stand up in court?' This is an honest question all social care practitioners must ask themselves. 'Would you be comfortable reading out what you wrote in front of the person in a courtroom? That is the level of factual report-writing required from social care workers.

The need for autonomy and accountability within social care stemmed from past failings in the sector: the clerical sexual abuse scandals; failings in the disability sector; failings in childcare; and the current homeless crisis. When there is no one to hold accountable it can be detrimental to the victims (Jones & Carston 2016). This is why we must strive for professional autonomy and accountability and ensure that the highest standards are fostered throughout the social care sector.

Domain 2: Communication, Collaborative Practice and Teamwork

The key concept of teamwork is to achieve tasks that an individual could not. A team encompasses the skill set of all members and results in combined productivity. Within social care, work is often carried out by multidisciplinary teams and it is crucial that there is effective teamwork as each member plays a vital role (Reeves *et al.* 2011). An example of clear communication within a team is the shift planning meetings often carried out in residential services. When the new shift comes in, there is generally an oral handover followed by a shift planning meeting. The meeting sets out clearly defined goals for the coming shift. It also offers role definition to all incoming staff so they are clear on what they are required to do. This allows for clear communication of what is needed from the staff team.

Social care can be a challenging sector and often one person simply cannot meet all the needs that service users present with. Interagency collaborative practice fills that gap, for example homeless organisations working with medical teams to deliver high-quality care to residents in their hostels. The Safetynet service in Dublin City is a medical charity that delivers care to those marginalised in society and without access to healthcare, including homeless people, drug

users and migrants. It also facilitates a network of health services working with homeless people to ensure a co-ordinated approach and promote best practice. It works in conjunction with homeless organisations to achieve this. In-reach services are provided across hostels in Dublin, and the Safetynet bus provides outreach services in Dublin City in the evenings. A full list of its services can be found on its website www.primarycaresafetynet.ie.

Follow this link to read an example of how Safetynet supported a person and her partner to exit homelessness: <https://www.irishtimes.com/news/social-affairs/stigma-of-homelessness-they-couldn-t-hide-the-disgust-on-their-faces-1.3646825>

TASK 1

Q. How can social care practitioners educate others in order to remove the stigma attached to homelessness?

Divide the class into groups. Can each group come up with four other agencies (either real or imagined) that would provide beneficial in-reach/ outreach to homeless services? Use the headings Mental Health; Physical Health; Addiction; and Emotional Wellbeing.

Domain 3: Safety and Quality

The social care sector encompasses a widely diverse cohort of service users, including people with disabilities, older people, children and families, people experiencing homelessness, people in addiction, and people experiencing mental health difficulties. The common theme is that all of them need help and support from social care workers. It is imperative that this help and support is provided in a safe environment. If it is not, it could lead to additional difficulties being introduced into the lives of people in an already challenging situation.

The Irish Association of Social Care Educators define social care as 'a profession committed to the planning and delivery of quality care and other support services for individuals and groups with identified needs' (Lalor & Share 2013: 21).

Case Study 1

'Maeve' is a social care practitioner working in a low-threshold day service in a homeless organisation. Low-threshold refers to minimal conditions being placed on clients and meeting clients where they are at. It works in conjunction with a harm-reduction approach when dealing with people using drugs. When working with low-threshold clients, practitioners are often 'responding to a variety of complex needs namely chaotic drug use and associated risky behaviours; homelessness; complex physical and mental health issues and previous challenging backgrounds and emotions' (Morton & O'Reilly 2016: 16). As part of her training, Maeve has completed harm-reduction training in order to be able to use these techniques when working with clients. She has also completed Naloxone training. Naloxone is a prescription medication used to reverse the effects of opioid drugs. It can be injected or used in nasal form. In the day service, there are strict procedures to follow when dealing with an overdose. These procedures are designed to ensure the safety of the person who is experiencing the overdose, the other service users present, the staff, and any external emergency personnel. One of Maeve's key clients is 'Mick'. Mick has a heroin addiction and regularly presents to the service affected by heroin. Maeve has been working with Mick for over a year and has built a positive working relationship with him. Mick likes working with Maeve and trusts her judgement. They are currently waiting for a detox bed to become available for Mick.

One day Mick presents to the service heavily affected by heroin; he is not responding to Maeve. Maeve directs Mick to the couch in the communal area and gets him to sit down. Staff remove the other clients from the area to allow privacy. Maeve checks Mick's breathing (number of breaths per minute). Mick's breathing is low and the emergency services are called. Maeve puts on gloves and administers Naloxone while on the phone to the emergency services as they talk through the procedure with her. The needle is then placed in a sharps bin and secured. Maeve directs staff to the front of the service to look for the emergency services and direct them to the entrance. As Mick begins to come round, Maeve calmly explains where he is and what has happened. The ambulance personnel arrive and staff lead them to Mick. Maeve has printed off a sheet with Mick's medical information, including what medication he is on, and any medical conditions he has, for the ambulance personnel. Mick leaves with the ambulance personnel to go to the hospital, where he will be fully assessed. Maeve debriefs with staff after the incident.

TASK 2

In pairs, discuss how Maeve ensured that safety standards were followed when Mick was experiencing an overdose. How did Maeve provide quality care to Mick throughout his overdose experience?

Domain 4: Professional Development

Social care is an ever-evolving sector and as a result it is essential that social care workers avail of ongoing continuous professional development (CPD). CORU defines CPD as 'The means by which health and social care professionals

maintain and improve their knowledge, skills and competence, and develop the professional qualities required throughout their professional life' (CORU 2013: 11). This definition highlights the importance of CPD in the social care sector.

One effective tool for professional development is supervision. Supervision is a safe area for social care practitioners to discuss any issues or difficulties they are facing and receive the support they need. Research has shown that quality supervision results in 'job satisfaction, commitment to the organisation and retention' (Carpenter *et al.* 2017: 1). CPD, combined with effective supervision, can help social care workers through any difficulties they may face in their role. A study carried out by Social Care Ireland into workplace violence in 2016 made a number of key recommendations for future practice, including providing regular professional supervision in a suitable setting, and recommendations for social care workers to engage in CPD. The importance of regular training was also highlighted (SCI 2020).

Domain 5: Knowledge and Skill

The professionalisation of the social care sector stemmed from a need to ensure that all social care workers have the highest standard of knowledge and skills required to work in a professionalised environment. This knowledge and skill set is acquired throughout the degree, primarily in a classroom setting; it is then put into practice during placement and refined in the workplace after college. Knowledge is the ability to understand a concept; a skill is the ability to use that knowledge by applying it to a concept (Given *et al.* 2008).

Case Study 2

'Michael' is a third-year social care student on placement in a homeless service. As part of his studies he has undertaken modules on both mental health and suicide. Michael feels he has a wide span of knowledge on both topics. His placement offers him the opportunity to complete applied suicide intervention skills training (ASIST). Michael accepts the offer of the two-day training course. The ASIST training teaches suicide first aid skills to practitioners; it also trains participants to reduce the immediate risk of a suicide and increase the support for a person at risk. It helps them seek a shared understanding of reasons for living. The workshop provides opportunities to learn what a person at risk may need from others in order to keep safe and get more help (HSE 2020). After completing the training course Michael has the skill set and the knowledge to help someone

presenting with suicidal thoughts and/or behaviours. He feels confident that he would know how to reduce the immediate risk to the person to keep them safe in that moment.

TASK 3

Can groups display an understanding of each domain using only pictures?

While skills and knowledge can be attained, the personal factor is far more innate to the social care worker. The importance of building and maintaining relationships within the social care sector is at the very core of the profession. This is what brings the skills and knowledge to life. It is the realisation that a person not only has the ability to help and support, but also the willingness and kindness that is imperative when dealing with vulnerable and marginalised people.



Tips for Practice Educators

Use the online Kahoot game (an online tool that allows lecturers to set quizzes for students: <https://kahoot.com>) to set a quiz for the class based on the key concepts of each domain.

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Chapter 63 – Juliane Reinheimer (D5SOP2)

Domain 5 Standard of Proficiency 2

Understand and be able to apply principles of social justice in one's work including being able to challenge negative discrimination and unjust policies and practices; demonstrate an understanding of cultural competence; and work towards social inclusion.

KEY TERMS

Social justice
Negative
discrimination
Unjust
policies
Cultural
competence
Participatio
n

Social care is ... when the social care worker uses passion, empathy, activism and resilience to fight for social justice for the people they support.

The focus of this proficiency is on understanding and applying a social justice approach to social care practice. Social care workers work in disadvantaged and marginalised communities within society, who include people with disabilities, older people, people from the Traveller community, children, women and young people. For these marginalised groups, achieving social justice will be a continuous, ongoing struggle because they face barriers such as outdated laws and societal attitudes. The realisation of the Assisted Decision Making (Capacity) Act (DoH 2015) in Ireland demonstrates this very well. Arguably, change is slow; however, with awareness and knowledge, social care workers can promote a more socially just experience for the people in our care. This chapter applies the proficiency to social care services for people with intellectual disabilities, but the information presented here is relevant to all social care settings.

Introducing Social Justice

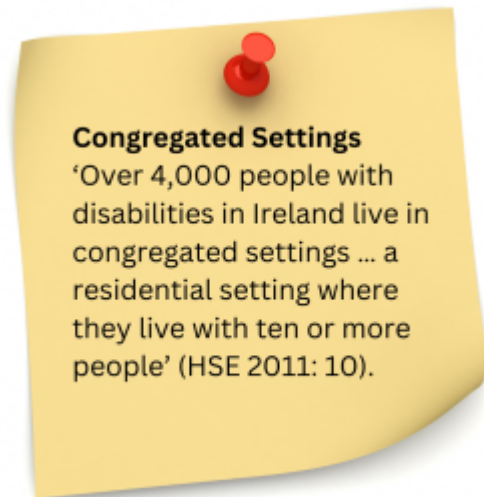
Social justice can be understood through the four principles of **access**, **equality**, **rights** and **participation** (Adams & Bell 2016), which are explained in the following table.

Access	This reflects the hierarchy in society, where some groups have resources, status and
Equality	As well as being fair to everyone, equality is a ' <i>commitment to social justice</i> ' which ' <i>capacity of people to transform their world</i> ' (Adams & Bell 2016: 42).
Rights	Our basic human rights include access to food, safety, a home, a living wage; and in a <i>and against different forms of violence, including hate crimes, violence against women</i>
Participation	<i>'Our vision for social justice is a world in which the distribution of resources is equitable and psychologically safe and secure, recognized, and treated with respect. We envision full capacities) and interdependent (capable of interacting democratically with others to participate fully in a life of choice and access.</i>

Social justice is the practice of active empowerment, enabling everybody to exercise their human rights. In broad terms, social justice magnifies and explores the relationship between the individual and society by questioning if this relationship is fair and just. Additionally, social justice acknowledges the fact that external influences can have an impact on our health and wellbeing, access and ability to exercise our rights in society.

TASK 1

Think of one service user group and give examples of how the four principles of access, equality, rights and participation of social justice may be relevant to their lived experience.



The place where a person lives can also contribute to the social injustices they experience, and one example is residential care settings for adults with mental health issues and/or intellectual disabilities. Irish journalist Mary Raftery exposed our past failings in a two-part RTÉ documentary series entitled *Behind the Walls* (Raftery 2011). This programme highlighted the many abuses that took place in mostly Church-run mental health institutions in Ireland during the 1940s, 1950s and 1960s. Large

institutional services were abolished and people with an intellectual disability were moved to smaller congregated settings.

According to Parker and Clements (2012: 24), 'an institution is not defined merely by its size' and the fear with all small congregated living community-based spaces is that they can function as 'mini-institutions' if residents have no choices or control over their lives (Fox 2013). There are practices currently in place in residential services for people with an intellectual disability to help with the transition from a larger institution to their community-based home. This is part of the New Directions policy and the National Disability Strategy to promote 'large scale national change', inspired by the principles of social justice (HSE 2009: 26). However, resources are needed to support organisations to become more community-based with services and buildings that are more open and inclusive, to help service users access community services and facilities. The situation is not perfect and service users may have to live with people not of their choosing, or have their placement changed due to ongoing funding issues or a lack of suitable accommodation. It is professionally challenging to provide hope to service users who have been moved, or who cannot exercise their choice of living companion or accommodation.

TASK 2

Please watch *Behind the Walls*, Parts One and Two, available on YouTube:

<https://www.youtube.com/watch?v=9SkBvTUXN2U> and <https://www.youtube.com/watch?v=WXtdqlyqIHA>.

Negative Discrimination

Negative discrimination is experienced when a group or an individual is treated poorly or is oppressed by another person or group. In Irish law there are nine recognised grounds of discrimination: gender, civil status, family status, sexual orientation, religion, age (except if a person is under 16), disability, race and membership of the Traveller community (O'Duffy 2018). It is worth mentioning that discrimination can occur on more than one ground, they can overlap, and this is known as 'intersectional' discrimination. This is the case when various characteristics 'intersect' and amplify the experience of discrimination. For example, a woman might be discriminated against not only for her gender, but also because she is a member of the Traveller community, because she is a single mother and/or because she has a hearing impairment. O'Duffy (2018: 11) asserts that discrimination can also be direct or indirect. Direct discrimination relates to experiences 'when a person is treated less favourably because of who they are' and indirect discrimination occurs when a rule (this could be a policy, for example), which might be seen as fair, puts a person at a disadvantage on any of the above listed grounds, based on its impact or consequence.

Unjust Policies

An unjust policy could be an unfair rule which might be directly or indirectly discriminatory. Public policy affects us all profoundly and pervasively and can influence every aspect of our lives. A public policy is a rule that guides the way services are distributed or interact with individuals. Public policies are usually determined by governments in consultation with stakeholders and have a direct impact on the way services and supports are provided. Each area of social care work is impacted by policy at various levels and to a greater or lesser extent. As social care workers, it is important to be aware of unjust policies. An 'unjust policy' could be, for example, a policy in a community house that the residents are not allowed to have friends over, or that people with intellectual disabilities are not allowed to get married or enter sexual relationships. It is important to note that this is a complex issue and although some policies may appear unjust, they may be written with safety in mind. With an awareness of amending unjust policies and reducing risk-averse practices, services are moving towards positive risk management.

TASK 3

Review Inclusion Ireland's website (<https://inclusionireland.ie>) and discuss the recent positive developments that reflect a move towards social justice practice.

Cultural Competence

Rhonda Livingstone highlights that cultural competence is based on our motivation and action to create understanding between people, and to be respectful of different cultural perspectives (DEEWR 2010). Relationship building is fundamental to cultural competence. This is based on providing strong foundations of understanding about each other's expectations and attitudes, values and beliefs. Underlying cultural competence are the principles of trust, respect for diversity, equity, fairness and social justice. *'Culture is the fundamental building block of identity and the development of a strong cultural identity is essential to an individual's healthy sense of who they are and where they belong'* (DEEWR 2010: 21).

Social Inclusion through Person-centred Planning

Social inclusion is a universal human right. The aim of inclusion is to embrace all people irrespective of race, gender, disability, medical or other need. It is about giving equal access and opportunities and getting rid of discrimination and intolerance (removal of barriers). It affects all aspects of public life. Social inclusion is visible through the process of individual planning and designing the service to meet the needs of each service user, irrespective of race, gender or disability. In my professional experience, individual planning is now replaced with 'person-centred planning'. To ensure this does not become a 'box-ticking exercise' it is important that adequate time is provided to meet with service users, work with them in a meaningful way and explore their true needs and wishes, along with identifying their support circle. Service users may feel ambivalent towards this process, especially if the experience feels more like an 'assessment'. It is essential to develop a relationship with the service user before engaging in person-centred planning to encourage information sharing that is

not perceived as too personal and invasive and is respectful of the individual's right to privacy and choice. It is also important to be aware of the culture within the service, and the physical environment, to ensure that every service user feels included.

As stated by McConkey and Ryan (2001), staff have significant power and influence when it comes to the lives of people with intellectual disabilities in residential services. It is important to note that this influence occurs both consciously and unconsciously through daily interactions. Organisational policies, the political landscape, domestic jurisprudence, the attitudes, values and beliefs of close family members, societal norms and ethics also play influential roles.

Participation

Participation is a principle of social justice, where service users are given the opportunity to participate in decisions that affect their life. Working as a social care worker with service users day to day, there are many opportunities to support participation. The promotion of meaningful participation of the people we work with is a human right and embedded in international rights law. In some situations, however, participation in social care practice can include the process of making decisions on what is deemed to be in the 'best interest' of service users. The Assisted Decision Making (Capacity) Act 2015 outlines that all necessary steps need to be taken to support a person's participation in the decisions that affect their life. A person is deemed as having capacity, unless *'he or she is unable – (a) to understand the information relevant to the decision, (b) to retain that information long enough to make a voluntary choice, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his or her decision (whether by talking, writing, using sign language, assistive technology, or any other means) or, if the implementation of the decision requires the act of a third party, to communicate by any means with that third party'* (DoH 2015: 17). It is also important to note that just because a person is deemed not to have the capacity to make one decision, it does not mean that they will not have the capacity to make further decisions. According to the 2015 Act, in all cases the person is first deemed to have capacity.

TASK 4

Reflect on past team meetings and think about the different approaches and attitudes that were voiced by fellow team members with regards to supporting service users.

Think about what you read about social justice.

Reflect on the outcomes of the meeting. Were they based on the service users' will and preference? Was capacity considered for every decision? Why is this discussion crucial in relation to social justice? Have a critical discussion.

Case Study 1

Ronnie is a 32-year-old man who lives in a residential community house with five other people with disabilities. He and his key worker are reviewing the yearly goals of his person-centred plan. Ronnie had in his plan that he wanted to give his room a makeover, and his key worker went out of her way to collect catalogues and measure his room to make sure everything fits. However, Ronnie decided that he would like a red wall with lots of Manchester United posters and he wants to keep everything else the way it is. The key worker is trying to persuade Ronnie to take the opportunity to get all the walls painted and bring in new furniture. Paul is adamant that he only wants the red wall with the posters.

Discuss this case and give a rationale for your opinion.

Social care workers need to be aware of rights, in order to support individuals to participate fully, based on their will and preference, in society. It is a balance between supporting people to live to their full potential, while being respectful to a person's will and preference. This can be challenging, as sometimes service users do not want to make the decision to act in the way that we deem is in their best interest.

Participation in Practice: Politics and Sexual Relationships

Political participation gives people a chance to develop networks with other people who might experience similar challenges in society. It is the basis of any movement. It empowers disadvantaged groups and creates opportunities to combine skills and talents. Social care workers play an important role here.

Often the service user needs the confidence, information, encouragement and an easing of the way to get there. Role modelling, adjusting the environment, travel training, practising speaking in public (for instance at house meetings), are some examples of how social care workers put supports in place for service users to acquire social justice.

Political participation of people with an intellectual disability appears still a challenge to achieve, although this topic has been discussed more in recent years. Political participation is slowly getting more attention within the disability landscape, but there are still many intellectually disabled people, particularly in congregated settings, who are deprived of exercising their right to vote. This demonstrates that social justice is not achieved and we as social care workers can have a significant role to play to change this. Making sure service users are registered to vote is the first step. More and more organisations have good resources to help service users to make an informed choice, for example practising, using made-up ballot papers, how to fill out voting slips correctly; making sure service users do not accidentally spoil their vote. Voting is in many countries interlinked with the condition of legal capacity which recognises people making their own decisions. For example, in Germany, people with intellectual disabilities are not allowed to vote, despite that country's ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). Therefore Germany is not compliant with Articles 12 or 29 of the UNCRPD. The right to political participation is enshrined in the Convention's Article 29, 'Participation in political and public life'.

Participating in a full life includes equal enjoyment of sexual relationships between intellectually disabled people in congregated settings. This is a subject which has been seen as 'the pink elephant in the room', evident from the lack of policy and legislation to support people with disabilities. In my practice I have experienced organisations trying to address this issue by developing policies which acknowledge the equal rights, sexual needs and desires of people with an intellectual disability. While people are still living in congregated settings in Ireland, opportunities for privacy can be challenging. When we look at jurisprudence in Ireland one needs to point out the Criminal Law (Sexual Offences) Act (DoJ 2017), with its disability-specific offence approach. Section 21 describes the different situations deemed unlawful when a person has sexual intercourse with a 'protected person' or someone who lacks the capacity to give consent to the sexual act. People are deemed to lack capacity if *'by reason of a mental or intellectual disability or a mental illness, incapable of (a) understanding the nature, or the reasonably foreseeable consequences, of that act, (b) evaluating relevant information for the purposes of deciding*

whether or not to engage in that act, or (c) communicating his or her consent to that act by speech, sign language or otherwise' (DOJ 2017: 17-18). It is important for social care workers to be aware of the legislation and to remember the Assisted Decision Making Capacity Act (DoH 2015) which means that all persons are deemed to have capacity first.

Please discuss the following case example in class:

Case Study 2

Anna is 46 and is going out with Patrick (32). Anna and Patrick both use a day service and they have known each other for a long time. The day service used to be a workshop, but it is not any more. Anna and Patrick enjoy holding hands and kissing. They both tell each other that they would like to have sex. Anna lives with her sister and Patrick with his parents. Patrick is not allowed to visit Anna. Anna has been invited to Patrick's house for dinner twice. But Anna does not go to visit him any more, because her sister does not want Anna to be with Patrick. Anna and Patrick say that they are engaged. Once Anna was out with her key worker and stopped at a jewellery shop because she wanted to have a look at the engagement rings. The jeweller said that she must grow up for that and smiled at the care worker, who answered, 'She is forty-six'. Anna left but did not really understand why the jeweller said she would have to grow up. Anna and Patrick have been together for the last ten years.

TASK 5

Discuss this case study, keeping in mind the four principles of social justice and the relevant legislations. If you were Anna's key worker, what would you do to support her to live a full life?



Knowledge about one's rights, for example an understanding of the UNCRPD, and making this information accessible is vital. There are many organisations (Inclusion Ireland, NDA, Mencap, IDA) who have accessible resources for service users and social care workers to tap into. These documents are available as 'easy read materials' and can advise service users, for example, on how, where and to whom to complain if there are violations

of any rights. It is worth mentioning that social care workers need to support service users to become self-advocates, so they can step back and give people the chance to develop and use their own voice.

Role of the Social Care Worker

The social care worker plays a vital role in the lives of many marginalised groups. In other words, they become an 'advocate' for social justice. The aim is to try to support people to access and participate in a fair and equal way in the day-to-day life in 'mainstream' society, just as others can. Social justice underpins a social care worker's practice on many levels. For example: to have access to health care, to be able to make informed decisions, to discover choices and alternatives, and to try new things out or to support change. The social care worker can also support relationships service users have with partners, families and friends, can enhance a person's access to education or recreational activities, support people to look after their finances, and be aware of and provide opportunities to integrate cultural diversity within the setting. Social care workers also facilitate the exercise of rights, for example by supporting people to get the right information, to speak up for themselves and to participate in the political landscape, depending on the individual's wishes. We need to continue to engage with service users to ensure their voice is included in all matters related to social justice.



Possible tasks to complete on placement under the guidance and direction of the placement supervisor:

- With service users, visit the local Citizens Advice Bureau, meet the person who is responsible for advising people with disabilities, get a contact number, say hello.
- Network with NGOs – find out what organisations are in your community and organise a visit.
- Encourage service users to become involved in local advocacy groups or community organisations.
- Promote opportunities for service users to meet peers from other services, advocacy groups, for example.

Student social care workers will find it very beneficial to keep up to date with what is going on within the organisation, external organisations, self-advocacy groups, NGOs, government initiatives and university projects. What is on offer? Where could the service users piggyback on existing projects?

Introduce the student to social stories, timetables, travel plans, picture keyrings, memory markers, visual diaries, which are a great support to many.

Look at extra training, e.g., computer skills, phone skills, internet safety, upskilling, QQI courses, appearance, speaking in public, how do I present myself, how do I want to present myself, makeovers, learning how to hold and participate in a meeting, note taking, what information to keep, how to get to decision makers, knowing my TDs, knowing how the government works.

Assist the student in supporting service users to use technology, explore different apps which can help people to write a letter or to take notes, or learn how to use social media and about the dangers involved in using the internet.

Find out what courses are offered in the local colleges. Are they interesting, suitable, inclusive, accessible?

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Chapter 64 – Laura Doyle (D5SOP2)

Domain 5 Standard of Proficiency 2

Understand and apply a human rights-based approach (HRBA) to one's work including the promotion of the service user's participation in their own care; ensure clear accountability; apply principles of non-discrimination; support other staff members to empower service users to realise their rights; be aware of the legality of actions within a service including the need to comply with any relevant legislative requirements including adhering to human rights obligations

KEY TERMS

Human rights-
based approach
FREDA principles
Participation
Non-discriminati
on

Social care is ... supporting people to realise and work towards their desirable future by establishing strong interpersonal relationships and using a human rights-based approach.

Introduction

In Chapter 3 I introduced the concept of the human rights-based approach (HRBA) in social care in the context of examining of how social care workers act in the best interests of service users with due regard to their will and preference. This chapter examines how practitioners can apply a rights-based approach in their own practice, while upholding the principles of non-discrimination across all aspects of their work. We will also look at how social care workers can increase and promote participation of service users and also examine the topic of accountability. Opportunity will be provided throughout for the reader to reflect on how they can support this proficiency in practice.

Human Rights

Human rights, as stated in the Universal Declaration of Human Rights (1948), are the universally agreed basic rights and freedoms that should be available to all people simply based on their humanity. We are all born with human rights regardless of nationality, gender, religion or any other status. According to Harris and White (2018), human rights are absolute, qualified or limited.

- **Absolute rights** cannot be restricted in any circumstance; they include rights such as the right to life or the right to be free from torture.
- **Qualified rights** can be infringed upon provided there is justification, e.g., the right to freedom of expression, the right to privacy.
- **Limited rights** can be restricted, or limited, by specific circumstances such as the right to liberty, which can be restricted when a crime has been committed and a person is imprisoned. (Harris & White 2018; Council of Europe 1950).

There are various international and national human rights instruments. The table lists some of the main human rights instruments that relate to social care:

International Human Rights Instruments	Irish Specific Legal Framework
Universal Declaration of Human Rights 1948 (not a legally binding instrument but a declaration of agreed-upon values and standards) European Convention on Human Rights 1950 International Convention on the Elimination of All Forms of Racial Discrimination 1965 International Covenant on Civil and Political Rights 1966 International Covenant on Economic, Social and Cultural Rights 1966 Convention on the Elimination of All Forms of Discrimination Against Women 1979 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984 Convention on the Rights of the Child 1989 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990 International Convention for the Protection of All Persons from Enforced Disappearance 1990 UN Principles for Older Persons 1991 (nota legally binding instrument, but agreed-upon principles which should be incorporated by local governments in frameworks and programmes) Convention on the Rights of Persons with Disabilities 2006 Charter of the Fundamental Rights of the European Union 2012	Bunreacht na hÉireann (Irish Constitution) 1937 Employment Equality Acts 1998-2015 Equal Status Acts 2000-2015 Mental Health Act 2001 European Convention on Human Rights Act 2003 Disability Act 2005 Health and Social Care Professionals Act 2005 Citizens Information Act 2007 Health Act 2007; and Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013. Irish Human Rights and Equality Commission Act 2014 Assisted Decision-Making (Capacity) Act 2015

Human Rights-Based Approach

Garcia Iriarte (2016) describes a human rights-based approach, in the context of examining different disability models, as the way that society provides for equal opportunities for all members to realise their rights regardless of difference. Difference in this context is seen as an inherent part of the human condition. Dukelow and Considine (2017) view a rights-based approach as an approach ‘which advocates a guaranteed level of social provision as a matter of right and entitlement’ (Dukelow & Considine 2017: 323).

Curtice and Exworthy (2010) define a human rights-based approach to care as a 'bottom-up' approach whereby the clinical processes, organisational practices and culture of a service support and protect the human rights of people who use social care services. HIQA (2019a) describes a human rights-based approach as an approach that promotes, supports and protects the inherent rights of people using social care services and supports, and guarantees support as a matter of right.

The FREDA Principles



The FREDA principles, HIQA (2019a) included with permission.

According to Curtice and Exworthy (2010) a human rights-based approach can be supported by adhering to the core principles of fairness, respect, equality, dignity and autonomy, or the easy to remember acronym FREDA. HIQA introduced the FREDA principles to Irish health and social care services in 2019 in its document *Guidance on a Human Rights-Based Approach to Care and Support in Health and Social Care Services*. The FREDA principles were first introduced by Curtice and Exworthy (2010) and have already been used in the English health and social care services (HIQA 2019b). A breakdown of each principle is outlined below.

Fairness	The principle of fairness means that due consideration is given to the person's will and preference in relation to a decision to be made about their care or support. The person is at the centre of the decision-making process; their opinions and views are sought and weighed against any other important factors in relation to the decision being made.
Respect	Respect applies not only to the person but also to their value system. This principle upholds the objective, unbiased consideration and regard for the rights, values, beliefs and property of other people.
Equality	The principle of equality warrants that people are not treated differently or less favourably than other people based on any of the grounds of discrimination as set out in law. Equality also ensures that people are afforded equality of opportunity.
Dignity	The principle of dignity ensures that each person is treated as a human being, that they are treated with compassion, care, and in a way that supports their self-respect.
Autonomy	Autonomy is the principle of self-determination whereby a person makes decisions on how they live according to their own values, beliefs and preferences. It involves a person using a service being informed about all aspects of their care and support.



Figure 1. Source: Curtice and Exworthy (2010); HIQA (2019a) reprinted with permission.

The PANEL Principles

PANEL is another human rights-based approach, adopted by the Scottish Human Rights Commission in their National Action Plan for Human Rights. PANEL focuses on understanding the core underlying values and core principles of human rights instruments which, in this approach, are participation,

accountability, non-discrimination, empowerment and legality (Scottish Human Rights Commission, cited in Smith 2018):

Participation	The principle of participation means that the person should participate in all aspects of decision-making that affect them.
Accountability	Accountability requires that human rights standards in services are monitored to ensure clear accountability.
Non-discrimination	All forms of discrimination on any of the protected grounds enshrined in law are prohibited.
Empowerment	Empowerment, as a human rights principle means that people are supported to realise and exercise their human rights.
Legality	The principle of legality ensures that practices and supports are grounded in human rights instruments and laws.

Source: Scottish Government 2015

On further examination of the proficiency it becomes clear that this proficiency itself has been designed and based on the PANEL principles:

- The promotion of the service users' **participation** in their own care
- Ensure clear **accountability**
- Apply principles of **non-discrimination**
- Support other staff members to **empower** service users to realise their rights
- Be aware of the **legality** of actions within a service.

Supporting a Human Rights-Based Approach using the FREDA or PANEL Principles

A human rights-based approach in social care is the integration of principles and standards of international human rights instruments into social care policy and practice. A human rights-based approach empowers people to know and claim their rights (Smith 2018). When we discuss human rights in social care, many rights come into focus, including:

- The rights of the child
- The rights of people with disabilities

- The rights of older people
- The rights of women
- The rights of people with mental health conditions
- The rights of members of socially marginalised groups
- The rights of the social care worker.

Understanding and having extensive knowledge of all the different human rights instruments can be a daunting task; however, Curtice and Exworthy (2010) argue that understanding and implementing the FREDA principles negates the need for technical knowledge of various rights instruments as the FREDA principles capture the underlying concepts and principles which underpin human rights instruments. As social care workers, we have a duty to uphold the rights of people we support so we should be aware of and have knowledge of the different human rights instruments that apply to our role. The FREDA or PANEL principles will help the practitioner promote and adopt a human rights-based approach in their work without the need to spend an excessive amount of time on the legalistic interpretation and implementation of rights, instead focusing on the underlying values and principles. Implementing a human rights-based approach in social care can be achieved by following these principles and embedding them as part of our everyday practice and in our interactions with service users.

Case Study 1

A Human Rights-Based Approach in Practice

Margaret is a woman in her forties who lives at home with her elderly mother. Margaret has an intellectual disability and attends a day service centre where she receives support from her social care worker, Jane. On arriving at the centre on Monday, Margaret informs Jane that she won't be attending the centre on Wednesday as she has a doctor's appointment. Jane asks Margaret if she would like to let her know why she is attending the doctor. Margaret says that her mam wants her to have a smear test. Margaret informs Jane that she doesn't know what a smear test is or what it is for. Jane sits down with Margaret to explain what a smear test is and what it is used for. Margaret is initially shocked by this information and states that she does not want to have it done but is worried that if she doesn't she will upset her mam. Jane explains to Margaret that she does not have to have the smear test if she does not want to.

Worried that Margaret's views are not being sought or supported, Jane seeks further guidance from her line manager. Her line manager asks Jane to seek consent from Margaret to contact Margaret's mam for more information and to arrange a meeting to put a plan together on how Margaret will be supported using a human rights-based approach. After getting consent from Margaret, Jane contacts her mother, who informs Jane that there is a history of cervical cancer in

Margaret's family and that she booked her an appointment because she believes that early detection is key, as Margaret is at risk.

A summary of the key steps taken that followed a human rights-based approach:

- Margaret was informed at all stages of the decision-making process and her will and preference and her consent was continuously sought.
- With Margaret's consent Jane arranged to have a meeting with Margaret, herself and Margaret's mother to discuss Margaret's will and preference.
- Margaret was supported to communicate to her mother her decision not to attend the doctor's appointment for the smear test.
- Margaret's mam felt that because Margaret has an intellectual disability she is not able to make decisions for herself and should just go ahead with the smear test.
- Jane spent time explaining to Margaret's mam that although Margaret has an intellectual disability, she has the same right to make decisions on her own healthcare as anyone else.
- During the meeting, Margaret stated that she doesn't know much about cervical cancer and the smear test but would like to find out more and that maybe the test is something she could do in the future.
- Jane asked Margaret if she would like to put a plan in place to find out more about cervical cancer and the smear test in a way that she can understand. She agreed to this.
- Jane developed a plan for Margaret to be informed about cervical cancer and the smear test using accessible language that Margaret will understand, and given over a period of time that is conducive to Margaret's decision-making.
- Jane regularly sought guidance and support from her line manager to ensure accountability and also to ensure that she was upholding a human rights-based approach in line with her own obligations and duties as a social care worker. Jane documented all stages of her work that supported Margaret's human rights in line with her organisation's report-writing policy and procedures.
- Jane and Margaret regularly work together on her plan to find out more information on cervical cancer and the smear test so that Margaret can make an informed decision on her healthcare.

Promoting Participation

One of the key ways in which social care workers can embed a human rights-based approach in their practice is by ensuring that service users are involved and participate in all aspects of their care. Participation involves service users playing a fundamental role in influencing and shaping the services they use. According to Warren (2007), participation in social care can take place in many different forms, including:

- Individual care planning and reviews
- Service planning and development
- Staff recruitment and training

- Research.

In disability services in Ireland there is a fundamental philosophy that there is ‘nothing about me without me’, meaning that people need to be involved in all decisions and aspects of their care and support; their opinions and views need to be actively sought at all stages of any decision-making processes. For example, at an everyday practice level it could mean the involvement of the service user in choosing who they receive support from, or at a governance level by the service user being involved in the development of organisational policies and procedures. Decisions on services and supports for people should never occur without the involvement of the person, or persons, to whom decisions relate. Decisions on the care and support of a service user should only occur with participation and involvement of the service user at the centre of this process. This can occur and be supported by the social care worker individualising the decision-making process, for example designing any decision-making interventions around the person’s attention span and the amount of time they can focus on a particular issue, so that it is conducive to the person’s decision-making capacity. Some of the ways in which practitioners can support this is by having service users choose where meetings take place, for how long, and who will attend.

TASK 1

Place yourself in the position of a service user who is being supported by a social care worker. How would you like to be supported to participate in your own care?

Social care workers will need to utilise their problem-solving and negotiating skills where there are instances of resistance or conflict with the service user; it is in these moments that the relationship between the practitioner and service user is of utmost importance. As social care workers we need to continuously look for and identify opportunities to promote participation for service users in all aspects of their care. The illustration below, based on elements identified by Beresford (cited in Harris & White 2018), highlights some more ways in which social care workers can increase service user participation.



Figure 2. Author created diagram: Key elements to increase participation, Beresford, cited in Harris and White (2018)

Accountability in Social Care

Social care workers have several lines of accountability: to act within the law; to act according to codes of conduct as set out by regulatory bodies; organisational accountability to line managers and organisational policies and procedures; and accountability to service users. Social care workers are expected to adhere to these various lines of accountability.

Simply put, accountability means being answerable to questions relating to personal standards of professional practice. For social care workers, professional accountability ensures that we operate and adhere to practices and standards as set out by law in relation to our practice. To help ensure accountability, it is important that social care workers are aware of the various lines of accountability in relation to their practice and also various legal frameworks that underpin our

practice, some of which are outlined in Figure 1 above. The code of conduct for social care workers is legally outlined in the Social Care Workers Registration Board Code of Professional Conduct and Ethics Bye-Law 2019, which sets out the standards of ethics, conduct and performance expected of registered social care workers. To ensure accountability it is important that social care workers adhere to this code of professional conduct and ethics.

Principles of Non-discrimination

Discrimination means that one person is treated less favourably than another person in a comparable situation. The Equal Status Acts 2000-2018 prohibit discrimination in relation to access to and use of goods, services, accommodation and education, and set out nine grounds of discrimination: gender, civil status, family status, sexual orientation, disability, age, race, religion and membership of the Traveller community.

There are two types of discrimination; direct and indirect. Direct discrimination is when a person is treated less favourably than another based on any of the protected grounds. Indirect discrimination occurs when practices, laws or procedures place a person who differs under any of the protected grounds at an unfair disadvantage as compared to another person (IHREC 2020). According to the UN Committee on Economic, Social and Cultural Rights (2009) the principle of non-discrimination seeks to ensure that rights are exercised without discrimination. Within social care the principle of non-discrimination could be interpreted as the provision of care and supports to service user without discrimination based on any of the protected grounds. As social care workers it is important that we uphold and follow principles of non-discrimination in all aspects of our work. Upholding principles of non-discrimination in practice involves supporting other colleagues and staff to promote the rights of service users.

Conclusion

This proficiency can at first appear a challenging proficiency to grasp. However, as shown in this chapter, by breaking down the proficiency we can begin to see how the different aspects of a human rights-based approach, non-discrimination, participation and accountability all interlink and are at times

interdependent on one another. As social care workers it is imperative that we follow these principles throughout the course of our work and that we are constantly making ourselves aware of various legal and regulatory frameworks relating to our work. Embedding the FREDa or PANEL principles into our everyday practice can offset the need for a thorough legalistic knowledge of all these different frameworks. This does not negate the need for social care workers to have knowledge of these legal and regulatory frameworks but rather supports their practical implementation in social care practice.



Tips for Practice Educators

As discussed, this proficiency can at first seem a complex proficiency for students to grasp simply because it can appear to have many different aspects to it. Breaking down the proficiency, as outlined in this chapter, can help the social care student get a grasp of the proficiency's fundamental principles and begin to see how they correlate, relate and interlink with one another. The student can then start to reflect on how they might support this proficiency in practice and what potential obstacles or barriers might be faced by social care workers in practice. It is important that students are supported to reflect on societal views of various marginalised groups and how barriers exist that place these groups at a disadvantage. This proficiency could be linked directly to subjects in the social sciences, including law, public policy and sociology. There is ample opportunity for the student to begin to interlink many theories in these subjects to support their theory-to-practice skill set.

To support the learning for this proficiency, it is fundamental that students to reflect on how they could implement a human rights-based approach in their practice and what different skills could support this. The Guidance on a Human Rights-based Approach in Health and Social Care Services (HIQA 2019) provides many case studies on a human rights-based approach which can be used by practice educators in their teaching with students to help facilitate discussion and reflection on how this approach is supported in practice and on instances where this approach is not supported in practice. The practice educator could utilise reports or documentaries of real-life instances as discussion and reflective pieces.

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Chapter 65 – Antonia Kenny (D5SOP4)

Domain 5 Standard of Proficiency 4

Demonstrate a critical understanding of relevant biological sciences, human development, social and behavioural sciences and other related sciences, together with a knowledge of health and wellbeing, disease, disorder and dysfunction relevant to the role of a social care worker.

KEY TERMS

Social care
work

Health
and
wellbeing –
a holistic
approach

Relevant and
related
sciences

Human
development

Social care is ... working with people in a holistic manner, most importantly recognising the person not just as a label but first and foremost as human, as a whole person.

Social Care Work

In practice a social care worker 'uses shared life-space opportunities to meet the physical, social and emotional needs of clients' (Social Care Ireland 2020). When we leave college, we are equipped with a 'toolbox' of skills and knowledge that we can apply in practice. Practice can vary across the lifespan of service users, in different care settings, and when working with individuals, no one size fits all. This is where, in theory, we dip into our toolbox. However, in practice the reality

can be quite different – social care workers can wear many hats, encounter many challenges, along with plenty of opportunities!

Relevant and Related Sciences in Social Care

The complexities of social care bring with them the requirement for a knowledge base that is vast and varied. In order to practise with a holistic and interconnected approach, it is important for a social care worker to have an understanding of what is meant by the sciences related to social care practice. Science can be defined as ‘a systemically organised body of knowledge on a particular subject’ (Oxford Languages, online) and some of the key sciences used in social care are biological, human development, social and behavioural sciences. Other related sciences include social policy, nutrition and politics. While the biological sciences study areas such as life and organisms, human development looks at improving wellbeing across the lifespan. Social and behavioural sciences relate to the study of society and individual relationships to it.

In relation to health there are a variety of key theories and approaches to wellbeing. With this in mind, the biopsychosocial model, coined by George L. Engel in 1977, is an approach which interconnects the sciences in a way that can be used in our practice.

TASK 1

Watch the video on chronic pain and the biopsychosocial approach: https://youtu.be/B14_2TS7RHM



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://tus.pressbooks.pub/standardsofproficiencysocialcareworker/?p=318#oembed-1>

Determinants of a person's health can also be explored using a framework developed by Dahlgren and Whitehead in 1991. This framework maps the relationship between an individual, their environment and their health.

TASK 2

Watch the video on the social determinants of health



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://tus.pressbooks.pub/standardsoproficiencysocialcareworker/?p=318#oembed-2>

Furthermore, the Ecological Systems Theory, developed by Bronfenbrenner in 1979, is yet another framework which a social care worker can examine individuals' relationships with wider society.

TASK 3

Watch the video on Bronfenbrenner's Ecological Systems Theory



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://tus.pressbooks.pub/standardsoproficiencysocialcareworker/?p=318#oembed-3>

Health and Wellbeing – A Holistic Approach

The constitution of the World Health Organisation (WHO) defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 1946). In order for a service user to achieve fulfilment in these areas, it is important that we as social care workers view health and wellbeing as being interconnected. This means looking at the whole person, not just from the perspective of labels or through one particular scientific or developmental lens. Each area of human health and wellbeing is linked, overlapping with the others in a variety of ways.

Although labels or a diagnosis can be beneficial when accessing correct support services or understanding behaviour and needs, it is also important for a social care worker to keep an open mind, which can have a beneficial impact on the care a person receives in various areas of their lives. For example, a service user declining to get out of bed in the morning may be interpreted as 'displaying behaviours that challenge'. This 'behaviour' may be communicating to staff, e.g., 'I'm not happy' – the reality might be that the person is having mental health issues, possibly due to lack of contact with a family member. Behaviour is communication, and it is important to understand that a particular behaviour may indicate emotional, physical or social ill-health.

Using a holistic and interconnected approach ensures that all the needs of the person at the centre of our care are considered in our practice. It is worth noting that supporting a person with their health and wellbeing means not only applying a person-centred approach but also working in partnership with other stakeholders, including family members, carers and disciplines other than social care.

TASK 4

Take a moment to think what your own current health and wellbeing requirements are. Now make a list under these headings – Physical, Mental and Social. Next think of actions you can take to meet these needs.

Case Study 1

Susan (pseudonym) is a 26-year-old woman who moved five months ago to live in Meadow Lodge, a residential service for people with autism on the outskirts of a large town. Susan lives with two others; however, they have very little in common apart from their age group. Susan enjoys spending time with family, watching television and walking independently to the local park.

During her time in Meadow Lodge, Susan's mood has changed from being smiley and relaxed to withdrawn or agitated. Some days Susan declines to leave her bed and often chooses not to eat. As Susan is non-verbal, she at times communicates her mood by acting out towards staff physically – biting, pinching and hitting out. On other days Susan engages positively in daily activities and shows her mood in positive ways such as smiling.

Taking into consideration Susan's health and wellbeing needs or wants under the headings Physical, Mental and Social, what could be causing Susan's changes in behaviour and mood? The templates below can be used as a guide.

TASK 5

Step 1: Identify each need or want for Susan's care plan under the following headings:

Mental Health & Wellbeing	Physical Health & Wellbeing	Social Health & Wellbeing
1.	4.	7.
2.	5.	8.
3.	6.	9.

Step 2: Make a plan for each.

	Need/want	Action to be taken	Responsibility of whom	By when
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Step 3: Identify the priority areas.

Decision-making Skills

A social care worker's ability to demonstrate in their practice a critical understanding of the relevant and related sciences, human development and health and wellbeing prevents the risk of them making subjective rather than objective decisions. Anyone can learn the theory from books, but the ability to apply it meaningfully is a skill in itself. As the social care worker matures in their role, so will their understanding and ability to apply theory to their practice.

Decision-making occurs on many levels and with many factors that will have an influence or impact a service user at that time or in the future.

Awareness of one's own values, beliefs and attitudes when making decisions, alongside the service user, based on their needs or wants, is also important. As an example, one social care worker might believe that bread or cheese is unhealthy; another believes that they are not. These ideals will impact how the social care worker supports the service user, unless they possess the ability to take a reflective step back and ensure that the service user is at the centre of the plan. Possessing an understanding, knowledge and awareness of the sciences and health and wellbeing leads to objectivity, allowing for support given to be based on the service user's needs and wants rather than our own opinions.

Tools

A structure around making these considerations can be created in the form of care plans. As they are live documents and should be reviewed regularly, they change over time alongside the development of the service user during their life span. Recent times have seen changes in the way care plans are documented. Technology has been developed, such as *Aspiricos iplanit*.

Aspirico's iplanit, which provides a web-based system that captures information digitally around service user care plans (which can be based on the twelve pillars of the New Directions policy). A user of iplanit can choose to share their password with the people they care about. This means that they can give access to the information uploaded and stakeholders can provide support while keeping the person at the centre of it all. For instance, a sibling living in Australia can give support. Features include pictures, videos and audio clips that can be uploaded, and there is a personal calendar. Care plans are available in an accessible format that is easy to use. As the software essentially belongs to the user, their iplanit journey is ongoing, even if they move between services (Aspirico website).



Tips for Practice Educators

Practice placements provide an opportunity for a student to demonstrate and develop their understanding of the knowledge they have acquired in their education setting. In order to achieve the requirements of this proficiency, it is important that the student is afforded the chance to meaningfully apply the theory around the relevant sciences, human development and health and wellbeing in practice.

The practice educator can kick-start the process even before the student starts their placement. As any overarching legislation is streamlined, it leads to each social care setting having different policy and ethos. Social care is diverse not only in settings but also in staffing roles, leading to many titles and responsibilities. To ensure that the student is well prepared for this, the practice educator can provide the student with a pack before they begin their placement, including specific details of their role in the capacity of a student.

The requirements for the student to achieve this proficiency is that they can critically apply the theory to their practice, becoming competent and confident in their assessment and decision-making skills to meet service users' wants and needs regarding their health and wellbeing. To accomplish this a student can be asked to research the relevant sciences and theory around health and wellbeing (including health promotion) before starting their placement. A placement educator can suggest theorists such as Bronfenbrenner, Erikson, Engel or Dahlgren and Whitehead, which will may help structure the thoughts of the student and encourage them to look at the bigger picture for the service user.

A placement should provide a student with a safe place to explore and learn. Mistakes will, no doubt, be made and hopefully learned from, providing valuable knowledge to build on as the student matures in their professional life. Within this competency of critically understanding the related and relevant sciences, human development and health and wellbeing, a practice educator can also challenge the student in their understanding and what values and beliefs they carry regarding these areas by allowing space for reflective practice and giving supervision. A practice educator can also provide the tools to guide the student to facilitate theory in its application, such as in care planning documents.

Top Tips

- Prepare the student before their placement commences.
- Ask the student to define their understanding of the sciences, human development and health and wellbeing.
- Challenge the student's values and beliefs in a supportive manner.
- Use a systematic approach (needs assessment, planning, implementation and evaluation) to set care planning goals.
- Provide opportunities to use care planning tools with guidance from service users and experienced staff.
- Ensure use of a holistic approach when applying theory to practice.
- Address any challenges during supervision.

Suggested list of decision-making questions

Have you gathered information from all sources (service user, stakeholders, multidisciplinary, history)?	Are there any gaps in your knowledge?
Have you identified any forgotten needs/wants of the service user?	Have you eliminated other assumptions before finalising your decision – objective or subjective stance?
What are the implications of this decision?	Is this realistic?
What are the priority areas?	What else can be done?

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Chapter 66 – Helena Doody (D5SOP5)

Domain 5 Standard of Proficiency 5

Know and understand the principles and applications of scientific enquiry, including the evaluation of intervention efficacy, the research process and evidence informed practice.

KEY TERMS

Research process
Evidence-informed practice (EIP)
Principles and applications of scientific enquiry
Evaluation of intervention efficacy

Social care is ... an ever-evolving integrated systems approach to working with individuals to help them lead a fulfilling and meaningful life. It places the person at the centre of the process and encompasses social justice and human rights principles.

TASK 1

Describe something that you researched for yourself – it could be a holiday destination, a college course or a college/university where you wanted to study. How did you carry out your research? Why did you choose the final destination, college, university or course? What influenced your decision? Where did you look for information? What type of information did you look for and what did you find most useful in helping you to make a decision?

Research Process

Humans are naturally inquisitive; we are always trying to make sense of the world we live in. We do this by asking questions, seeking out new information and learning from our own experiences. We navigate life by experience, observation and the example of others, whether they are family, friends, or people we perceive as having authority through acquired knowledge and/or lived experience. The search for knowledge and truth is discovered by research. We all carry out research in some shape or form in our everyday lives and, while this may not be formally conducted, we are nonetheless continually seeking information on how best to achieve our goals and often enquiring how to get the best value for money. The value in conducting research prior to investing our time or finances is that we achieve a better outcome, greater opportunities and/or the best value possible.

The following diagram outlines some of the questions one might ask and some of the steps one might take when conducting research.



Author created diagram based on 'The Research Process' (<https://www.virtuallibrary.info/research-process.html>) from the Virtual Library

When engaging in any form of research or developing interventions for service users, social care workers must act in accordance with and adhere to the *Code of Professional Conduct and Ethics for Social Care Workers*:

In all circumstances where consent is required prior to engaging in any assessment, intervention, treatment or service the following process must be followed:

- take personal responsibility for obtaining consent from the service user, or from someone with legal authority to give consent on the service user's behalf

- ensure that, if you have to delegate to a colleague the responsibility for obtaining consent, such colleague is suitably trained and qualified to undertake this responsibility
- ensure as far as possible that the consent provided is voluntary and not the result of inappropriate pressure from a third party
- provide the service user with sufficient relevant information, in a way that s/he can understand, to enable the service user to decide whether or not to consent
- allow time and space, as far as possible, for the service user to take in and understand the information before reaching a decision
- answer any questions relating to the assessment, intervention, treatment or service from the service user honestly and as fully as s/he wishes
- respect the right of the service user to refuse consent to an assessment, intervention, treatment or service, even if you do not agree with their decision
- follow applicable law, regulation and guidance issued by appropriate authorities in relation to the giving of information and recording of the service user's decision
- respect a service user's advance healthcare directive in accordance with law, regulations and national policies or guidance. In emergency circumstances where it is not possible to obtain consent from the service user, you must
- provide treatment or other intervention where this is necessary to save life or avoid significant deterioration in the health of the service user (SCWRB 2019).

Ethics and ethical approval

Prior to engaging in research it is vital to apply for and receive ethical approval. If you are engaging in research as part of an education programme, your university or college will require that you engage with the ethical approval process. This is to ensure that the principles and practices of good research are being adhered to. The *Code of Professional Conduct and Ethics for Social Care Workers* (SCWRB 2019) outlined above must also be followed. Engaging in the ethical process and applying for approval can be a long process, but research cannot commence until approval from the relevant ethics committee has been obtained.

Miles and Huberman (1994: 290-7) refer to 11 ethical issue and dilemmas that one must consider prior to and during the research process:

- Worthiness of the research
- Competence boundaries
- Free and informed consent
- Benefits, costs, reciprocity
- Harm and risk:
 - minimising harm (non-maleficence)
 - maximising benefit (beneficence)
- Honesty and trust
- Privacy, confidentiality and anonymity
- Intervention and advocacy
- Research integrity and quality
- Ownership of data and conclusions
- Use and misuse of results.

There are approximately 32 health research ethics committees (RECs) in the HSE (Health Service Executive). Some approve research taking place in the organisation to which they belong; others have a regional remit and can approve hospital and community healthcare organisation (CHO) based research. Further information is available at <https://hseresearch.ie/research-ethics/>.

Tusla's National Research Office is responsible for co-ordinating all research activity of Tusla (the Child and Family Agency). Further information is available at <https://www.tusla.ie/research/tusla-research-office/about-the-national-research-office/>.

Evidence-informed practice

Engaging in reflective practice assists social care workers in evaluating both their individual and organisational relationships and practices. This in turn informs key decision-making in social care practice provision, which ultimately impacts on service users' experience.

Evidence-informed practice (EIP) underpins, informs and shapes how the social care profession delivers effective services. Engaging in EIP is a key component in social care and helps to ensure that the mistakes and shortcomings highlighted throughout the history of social care are not repeated. EIP can assist in problem-solving and in preventing harmful procedures and interventions that negatively affected service users (Aveyard and Sharp 2009). The aim of research is to learn about a phenomenon in order to create improved

outcomes and meaningful life experiences. EIP first emerged in healthcare and more recently has been adopted by social care. It is used as a research method in social care to support best practice and deliver the best possible care.

It Indicates an approach to decision making which is transparent, accountable and based on careful consideration of the most compelling evidence we have about the effects of particular interventions on the welfare of individuals, groups and communities (MacDonald 2001: xviii).

As suggested by Rosen (2003), a growing evidence base emanating from the implementation of evidence-based practice can guide the development, implementation and evaluation of new programmes and practices.

EIP gathers data and information that suggest whether a particular practice or intervention is working and therefore having successful outcomes in an individual's life. Research aims to help provide the most effective services based on the best available evidence that offers service users the best possible outcomes alongside enhanced life experiences. As professional social care workers, we are accountable, therefore; we must have a clear rationale for engaging in particular practices and interventions. We must ensure that our practice is informed by reliable evidence that this is the best way of providing services and addressing the needs of the individuals we are supporting. We must be able to justify and provide a clear rationale for the practices we are engaging in.

The benefits of engaging in EIP include:

- Promotes value and addresses service user needs
- Informs the development of education of the profession and social care service delivery
- Highlights the importance of developing and using research in generating new knowledge and evidence as well as a commitment to improving services and outcomes for service users.

Person-centred planning is a good example of how engaging in EIP enhances service user participation and quality of life (Rogers 1961).

Case Study 1

Thomas is a 34-year-old man living in a residential home in a large organisation providing services

to persons with a disability. Thomas has presented with behaviours that challenge, and these behaviours have resulted in him being considered not suitable for independent living. Thomas's key worker introduced person-centred planning and worked with Thomas to identify and achieve personal goals and aspirations. During this process Thomas was provided with strategies to communicate his needs and wants and to self-regulate. This resulted in a reduction in the frequency of the behaviours. As Thomas gained more control and independence the behaviours dramatically reduced. A direct correlation was made with the behaviours and lack of choice of control within his daily activities and wanting a meaningful life.

Thomas was referred to speech and language therapy to develop his communication skills. He also participated in an advocacy group and developed the skills needed to advocate for himself and express his opinions on how he wants to live his life. Thomas's progression was evident in the development of his most recent person-centred plan. Thomas identified that he would like to work towards becoming more independent in his daily life. In particular, Thomas highlighted that he would like to move out of the group home and live in an apartment on his own. This goal presented some challenges, and both Thomas and his key worker faced challenges, including financial issues and accessing suitable housing. To gain more knowledge and to explore how living independently would work, Thomas and his key worker attended a workshop on self-directed living. This gave him a great insight into how independent living can work successfully for a person with an intellectual disability. Thomas has started to put plans in place to gain the skills he will need to live independently in the community. He has learned to manage his finances and is learning to use public transport. He is in the process of securing an apartment to rent in the local town, and has been working with his key worker to build up practical living skills like cooking, cleaning and budgeting, with a view to working towards his first overnight stay in the apartment on his own.

Thomas's key worker also acquired new skills as he attended a course which focused on empowering the individual and on supporting persons to live independently. He used this learning to facilitate Thomas to have more choice and control over the way he wanted to live his life, and to encourage Thomas's circle of support to identify their role in supporting him to achieve his goals. He also engaged in inter-agency collaboration to access resources to help Thomas achieve his goals.

Principles and applications of scientific enquiry

The word science is derived from the Latin phrase *de scientia*, which means 'to know'. Inquiry is the search for information and explanation. It is also referred to as the 'search for truth'. To engage in scientific inquiry is to study our world or a particular phenomenon and, based on the evidence of the research, to offer explanations. The aim of scientific enquiry in social care is to test the effect of interventions and to evaluate their success or otherwise. It is an approach to problem-solving by exploring and developing ideas that are based on scientific evidence.

There are many different ways to engage in scientific enquiry. The basic steps

are listed below. It is important to note that this process can be cyclical; one may have to repeat the steps to reach a conclusion or workable solution.



Author created diagram: A visual guide to the research cycle highlighting six key stages, from asking a question to reporting results, with built-in opportunities for reflection and refinement. This process supports critical thinking and iterative learning in research-based inquiry.

Evaluation of intervention efficacy

TASK 1

Think of something you have researched and invested time and finances in.

Ask yourself: Was the outcome what I expected? Would I invest time and money in it again? Would I recommend the experience/value to family or friends? Would I choose the same service/option again?

In asking these questions, you are evaluating the service you received to ascertain if you achieved the outcome intended or if there are better options/services available. Therefore, you are evaluating the effects of the chosen intervention. In social care work, we must evaluate our practices and ask the questions: Are our services and intervention working? Are our service users and stakeholders satisfied with our approach? Can we do better?

Efficacy evaluation involves assessing the effect an intervention has on a service or service user/s. Engaging in efficacy evaluation and reflective practice is a key component in social care work and helps reduce the risk of harm. We need to demonstrate how services are making a difference. Questions that services and social care workers must ask of themselves are: Why are we/Why am I doing things this way? Is there evidence to suggest this is the best approach or are there more effective ways of doing this? Is there evidence of research that has been carried out, to review the efficacy of the intervention/approach? Are we valuing people's experience?

National and international comparisons can be made on goal setting, inspection, reviewing and evaluation. There are many ways to evaluate the effectiveness of an intervention. Enquiring as to the effectiveness, impact and quality of the intervention is key in evaluating efficacy. It is vital that social care workers and services engage in reflection and evaluation of services and interventions. Evaluation provides feedback on the effectiveness of the intervention and determines if it is appropriate for the service users or intended population.

In order to receive funding and satisfy funders and policy makers, the social care profession requires evidence that services are achieving their stated aims and that their interventions are making positive changes in providing meaningful experiences and supporting service users in their day-to-day living.

We have highlighted the importance of evidence-informed practice and

research which provides a platform for service users' and social care workers' voices to be heard. However, further research is required to provide a better understanding of the relationship between research and the work of social care workers, including what organisational resources are needed to realise the aim of using research to shape practice. Third-level education programmes promote research at undergraduate and postgraduate level; however, access to participants and navigating gatekeepers can be challenging. This proficiency needs to be supported by service providers. Senior management must promote CPD by allocating resources to facilitate social care workers to engage in part-time education programmes that will enhance practice and improve services. A multi-agency inter-collaborative approach is required to create a research culture and encourage social care workers to engage in research that will unravel structures and systems and identify gaps in service provision.



Tips for Practice Educators

Engaging in research can be challenging for students. The terminology used can be off-putting. Exploring research carried out on a regular basis and breaking down the terminology can allay some of these fears and expectations. Educators can play a key role in supporting and developing a culture of research by encouraging students to:

- Engage with peer-reviewed research papers for continuous assessment
- Critically evaluate research carried out historically. Identify gaps in ethical procedures and dilemmas
- Identify evidence-informed practice
- Participate in research. This will provide an opportunity to be the participant as opposed to the researcher
- Carry out small research projects while in a placement setting (if permitted).

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Chapter 67 – Noelle Reilly and Denise Lyons (D5SOP6)

Domain 5 Standard of Proficiency 6

Demonstrate skills in evidence-informed practice, including an understanding of competing theories, concepts and frameworks underpinning social care work and demonstrate an ability to apply the appropriate method in professional practice.

KEY TERMS
Evidence-informed practice
SKIP model
Skills in evidence-informed practice

Social care is ... a process of working with people to support them to flourish and grow. Practice is based on the integration of relevant theories, concepts and frameworks underpinning the wisdom in evidence-informed practice.

Evidence-informed Practice

The Standards of Proficiency for Social Care Workers (SCWRB 2017) require workers eligible to register to apply an evidence-informed **approach** to practice (D3 SOP6 – Chapter 6), to **evaluate** evidence-informed practice (D5 SOP5 – Chapter 66) and finally, in this proficiency, to be able to demonstrate this knowledge as **skills**. ‘Evidence-informed’ is a term commonly used in social work literature as a way of reducing the practice-knowledge gap (Kelly *et al.* 2010). This definition of the term is applicable here as there is an acknowledgement within our proficiencies that social care graduates will need to know competing practice theories, enabling them to choose from a range of responses for each experience they encounter. Evidence-based practice is evidence based on

research, which is when the worker develops theory based on the collection of data. Nevo and Slonim-Nevo (2011) described evidence-informed practice as a more encompassing view of ‘evidence’. As well as including theory based on research, this view also accepts the value of the worker’s practice stories, and their informed decision-making experiences and judgements. Thus, evidence-informed practice takes a broader view of what constitutes evidence. According to Nelson and Campbell, evidence-informed practice includes ‘multiple strategies, processes and activities, which will vary depending on the purposes to be achieved, the contexts of practice, the availability of evidence, the individuals and/or organisations involved’ (Nelson & Campbell 2017: 131). As CORU stresses the role of evidence, it is essential for students, workers and educators to understand what constitutes ‘good’ evidence and the difference between evidence-informed practice (EIP) and evidence-based practice (EBP), which is also mentioned in the standards (D3 SOP9 – Chapter 49).

Evidence-informed Practice (EIP)	Evidence-based Practice (EBP)
An approach to interventions with clients or service users that utilises research evidence in conjunction with knowledge derived from other sources (e.g., practice wisdom and service user preferences) when identifying an appropriate intervention to meet their needs.	An approach to interventions with service users that is based on scientific evidence. Practice is supported by proven rationale.

TASK 1

Please read Chapters 6 and 66 when you have read this chapter for a greater understanding of an evidence-informed approach and how to evaluate evidence-informed practice.

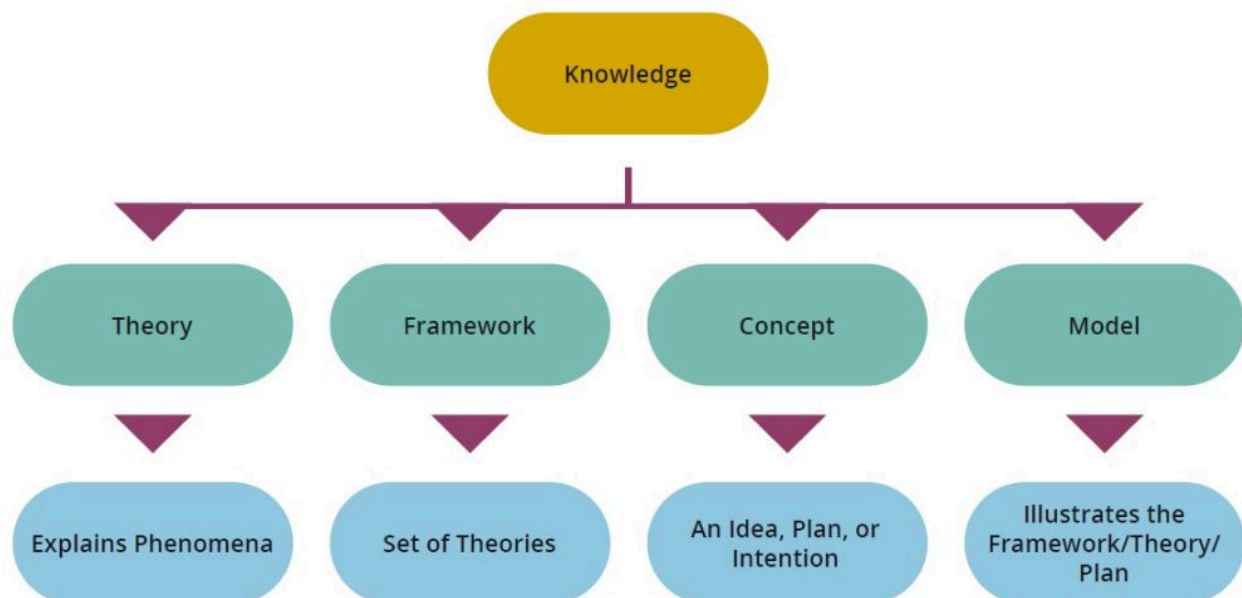
Lewis (2001) defined knowledge as evidence plus practice wisdom (knowledge obtained in practice) plus service user and carer wishes and experiences. Lewis’s definition suggests that best practice in social care incorporates evidence-informed practice coupled with other salient factors. Therefore, practice is informed by evidence, but evidence is just one element (Shlonsky & Stern 2007). Holm (2010) supported this definition, but argued that organisational context, and organisational policies, procedures and guidelines must also be considered as evidence-informed practice in social care. Similarly, Brady *et al.* (2016)

advocated for the development of evidence-informed practice as an approach that facilitates the practitioner to utilise research evidence in conjunction with knowledge derived from other sources when deciding on a course of action to support the service user. The common thread emerging from these studies is the need for social care workers to assess the evidence and integrate it into practice, giving due consideration to contextual influences.

Before we look at what constitutes evidence-informed practice in social care, we will briefly explain the difference between theories, concepts and frameworks and how they underpin social care practice.

Introducing Theories, Concepts, Frameworks

Social care practice is underpinned and shaped by various theories, concepts and frameworks. It is important that we have a critical understanding of theories that are significant in thinking about and practising social care work. In practice, social care workers critically engage with theories, reflect on their application to practice and consider their limitations. Relevant theories and concepts, when applied to social care work, have the potential to inform and improve practice. The following diagram highlights one key difference between a theory, a framework, a concept and model.



Authors created diagram that illustrates the components and structure of knowledge, distinguishing between theory, framework, concept, and model.

A *theory* is an idea or set of ideas that explains something (Stevenson 2010: 1829) and helps clarify a phenomenon, when we are trying to understand facts, experiences and situations. There are three categories of knowledge relevant to social care work: theories of what social care work is; theories of how to do social care work; and theories about the service user's world. A *concept* is an abstract idea (Stevenson 2010: 358), which could be a new intervention or a plan for how to solve a problem that has not been tried before with a specific service user in the setting. A *framework* is a structure which underlies a set of theories or ideas (Stevenson 2010: 685), that are widely accepted, are based on evidence-informed practice, and can become guiding principles for practice within a particular discipline. Although not included in the proficiency, a *model* is a simplified description (Stevenson 2010: 1128) of an idea or theory used to help clarify the information or used as a method of illustrating or representing the framework. The knowledge base for social care is as diverse as the profession itself. Your formal social care education adheres to a performance strategy, for example the Quality and Qualifications Ireland (QQI) Award Standards – Social Care Work (QQI 2014). Nonetheless, each programme differs in its structure and module composition. Each college/university has designed a suite of modules in each year of study to provide specialised evidence-informed knowledge and skills, underpinned by relevant theories and practice experiences. To help students understand the broad but interconnected knowledge bases for social care work, we have developed the **SKIP** Model (**S**ocial Care **K**nowledge **I**nforming **P**ractice) (Lyons & Reilly, forthcoming) to help clarify how the categories of knowledge and skills are equally valid and necessary for your holistic education.

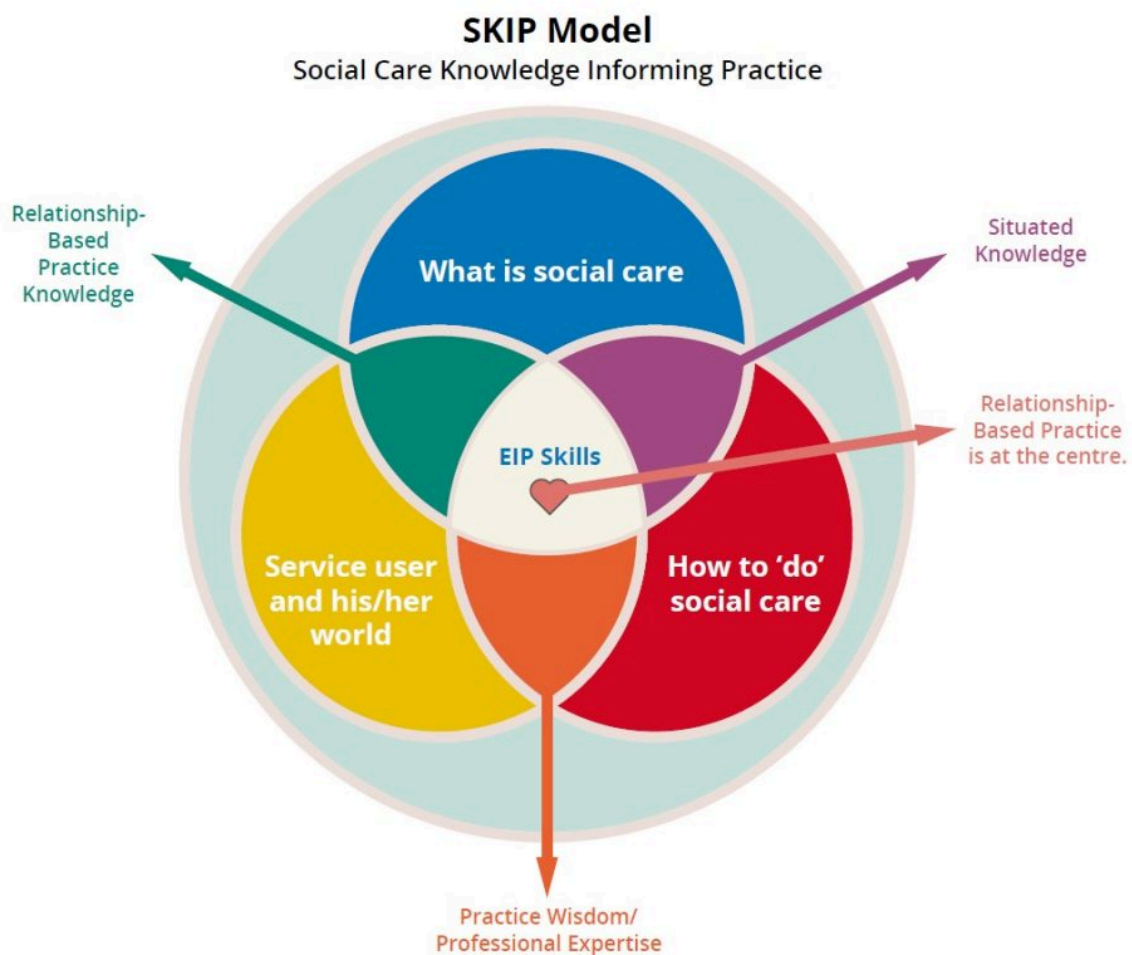
SKIP Model – Social Care Knowledge Informing Practice

This model is evidence-informed (Lyons 2017; Reilly 2018). It aims to illustrate how all the knowledge needed to develop *professional expertise* in social care work is connected. The modules in your social care programme provide specific theories which contribute to one or more categories of knowledge. As you progress, these theories are woven together to become your integrated tapestry of skills and knowledge for professional practice. The SKIP Model (Lyons & Reilly, forthcoming) was designed to communicate the interrelatedness of evidence informing knowledge and skills, illustrating this ongoing process where you are both student (learning from new experiences) and teacher (sharing knowledge and skills gained) at the same time. This model is divided into three broad

categories of knowledge, information, skills and experiences that help us understand (a) what social care is; (b) how to do social care and (c) all about the people we work with and their lived experiences, including the contexts of care in which we work and live together. How these three categories of knowledge overlap are defined as 'situated knowledge' and 'practice wisdom', with an understanding that the relationship between the service user and the worker is at the core of it all.

SKIP Model

Social Care Knowledge Informing Practice



Author created diagram: The SKIP Model highlights the centrality of relationship-based practice in social care, integrating knowledge, skills, and the lived experience of service users through evidence-informed, person-centred approaches.

Knowledge Base: What is Social Care?

'Social care' is a term used to define a milieu of care-based work with 'vulnerable' or 'marginalised' people in society. In most cases, social care workers are the professionals who work on the floor, sharing daily life events with people, in either residential or day services. Social care is historically linked to institutionalised care for children in industrial and reformatory schools (O'Doherty 2003) and Church-run services for children or adults with a disability (Finnerty 2013). The profession has broadened to include new domains, such as: child and adolescent mental health; addiction; services for people who are homeless; and community/family support. The foundational knowledge for social care is provided in your formal education on your social care degree programme. Here the combination of theoretical and practice-based modules are thoughtfully designed to provide the breadth and scope required for best practice in a variety of social care settings.

We included a section in each chapter entitled '*Social care is ...*' to provide a snapshot of how each social care worker in this text defines social care work, based on their lived experience of practice. The following are some examples of what the workers deemed social care is ...

- About meeting people at a particular stage in their lives and supporting them to overcome their challenges and assist them with reaching their goals (Chapter 31 by Garreth McCarthy).
- Supporting people to live their best lives and reach their full potential through meaningful, person-centred interaction; supporting people to empower themselves through non-judgement and advocacy; encouraging and respecting the choices people make; and ensuring respect and dignity for the people we support at all times (Chapter 23 by Lynn Leggett).
- Being an extra support to a person in their time of need, being their information box, a spokesperson for them, a cheerleader behind them (Chapter 16 by Moira O'Neill).
- When I am asked what social care is, I tend to give the same answer again and again. It is about relationships (Chapter 38 by Des Mooney).
- An opportunity to harness human connection and spirit in a structured and purposeful way with the intention of improving the lives of others (Chapter 17 by Lauren Bacon).

The key themes in this random sample are supporting others to overcome

challenges and live their best life; and relationship – making a purposeful connection with a person in their time of need.

TASK 2

Pick three other chapters and write down the key themes social care workers discussed in their 'Social care is' section.

Situated Knowledge

The knowledge required for social care practice is context-specific, shared and learned through mutual engagement and communication. Workers establish the knowledge base within their setting, which is negotiated, exchanged and emphasised between the members of the staff team (Wenger 1998). This is first experienced as a student on placement when you are guided by the practice educator to learn the way social care work is specifically practiced in the service. Lev Vygotsky (1896- 1934) stated that all learning is influenced by the social and cultural context in which it occurs. The central premise of Vygotsky's work is that learning occurs through social interaction, mediated by physical and symbolic tools which are used to interact with the environment (Vygotsky 1978). These tools are passed from one social care worker to the next and are used to understand, engage in and ultimately change the 'physical world' of the service. In all social care settings, interactions happen through the use of tools, either psychological (language, practice stories, and relationships-based practices) or physical (universal records that everyone knows how to fill in, and the in-house policies). If social care workers move to a different setting they need to learn the policies, procedures and tools (physical and psychological) used there.

Social care services become situated learning spaces, similar to 'communities of practice' (Lave & Wenger 1991, Wenger 1998). As a learning theory, 'communities of practice' is based on the following principles: (a) all people are social beings; (b) through learning from work colleagues, workers gain competencies; (c) knowing what to do 'on the floor' is a product of 'active engagement in the world' of practice (Wenger 1998: xvi). We are not trying to define social care settings as communities of practice, but to use this framework as a way of explaining evidence-informed knowledge and how students learn the theories, concepts and frameworks underpinning social care, inside and

outside the classroom. The practice educator shares the knowledge that underpins their approach to social care work, called *situated competencies* (Wenger 1998). Social care workers attribute meaning to particular stories, approaches, tools and interventions, which supports their practice. Students and new employees learn these shared practices from the staff team. Shared practices may include the role of helping and supporting others, the practice of key working, and most commonly, how the relationship is viewed as central to practice (Lyons 2017). Within the service, competing theories, concepts and frameworks help workers to understand likes and dislikes; interpret communication cues; meet needs quickly and effectively; provide support appropriately, and how to be an advocate by communicating accurate information to others.

Knowledge Base: 'How to Do Social Care'

The discussion on situated learning spaces explains why social care workers may perform different tasks depending on where they work. What social care workers 'do' is based on the service in which they work, the specific tasks, duties and policies which frame their day-to-day practice and the role they play within the multi-disciplinary team and management structure of the organisation. Due to the diverse nature of social care, with different service user groups in both day and residential contexts, the practice of care is defined and structured by the setting, which includes how the social care worker is identified and valued. This knowledge category also includes all the theories, facts and policies on how to care for others through a human rights-based approach. Importantly, understanding how to care for or do with others begins with self-awareness, pointing the reflective lens inwards to understand our values, judgements and biases and reason for entering social care (Lyons 2007, 2009).

Practice Wisdom

Practice wisdom is 'a personal and value-driven system of knowledge that emerges out of the transaction between the phenomenological experience of the client situation and the use of scientific information' (Klein & Bloom 1995: 799). This is the wisdom workers use. It is underpinned by theories, concepts and models of best practice (information) and shaped by the worker's lived

experience of being with the service user. Practice wisdom is evidence, based on the combination of theoretical understanding and common sense knowledge emerging from the engagement in practice (Dybicz 2015). The knowledge acquired on how to do social care work and care for others is applied to practice. This knowledge is part of the wisdom used to guide workers in knowing how to respond to the different situations they encounter each day. Practice wisdom includes knowing how to react at a moment's notice to a sudden event or new behaviour. It is also evident in the preventive work that is done to meet ongoing needs, for example having the cup of tea ready, knowing a service user likes to sit down when they come in from the day service. Time with service users was viewed as the most important way for social care workers to develop practice wisdom as they transition from the inexperienced newcomer to the status of competent and present old-timer (Lyons 2017). The social care setting frames the practice wisdom experienced there, and this 'situated knowledge', when combined with practice wisdom, becomes professional expertise.

Professional Expertise

When defining a model for social work, Gambrell (2013) argued that practitioners can draw on their clinical expertise to integrate information regarding the individual client's personal characteristics and preferences with external research findings, thereby establishing the best intervention to address their needs. In social care practice, this is professional expertise; the worker performs best practice, underpinned by an integration of relevant evidenced-informed theory and practice wisdom, all led by their in-depth relationship and understanding of the service users' likes, dislikes and actions within the specific context of care. It is important to note that research is always evolving, and as new information becomes available, some research, ideas, concepts and practices become invalid. Consequently, all sources of evidence, from empirical research to practice wisdom, are valid and necessary to enhance the worker's expertise in how to best support service users (Rycroft-Malone *et al.* 2004). The development of evidence-informed practice skills is dependent on the sharing of knowledge and experience between workers, educators and managers involved in social care practice. This process of 'knowledge mobilisation' promotes the co-creation of evidence derived from research studies by academics and students about practice, the situated knowledge and case studies from workers and managers in different practice contexts, the practice wisdom developed

from many years' experience of critical thinking and problem-solving. If social care workers are to demonstrate skills in evidence- informed practice, including an understanding of competing theories, concepts and frameworks underpinning social care work, they need to keep talking to each other, share their expertise and value equally the role of each professional in the creation of evidence-informed practice.

Knowledge Base: 'Service Users and their World'

The people we work with are described in this text as 'service users', a term currently used to describe vulnerable or marginalised adults, children or young people requiring care and support. We also work with children, young persons, residents (homeless services), trainees (day services), to name a few of the different titles used. A central component of social care education is learning about the lived experiences (disability, deprivation, abuse, addiction, homelessness, mental health, among others) of the people we work with, including how they communicate (all behaviours, sounds, language and colloquialisms). Although your social care programme will provide in-depth knowledge on the possible impact of a variety of experiences, social care is person-centred practice and the people we have the privilege to work with are experts in their own life, needs and care. This knowledge category also includes all information relevant to the development of quality service provision and how over time improvements are made to ensure the provision of safe, accountable and person-centred practice.

Relationship-based Practice Knowledge

TASK 3

1. Please read Chapter 69 for more information on 'relationship-based social care practice'.
2. Please read the case study and complete the task below to give you an exercise on how this theory can apply to social care work.

The relationship is what makes social care work distinct; it is the most important learning space in practice and this is why it is presented as the heart of evidence-

informed practice in social care work. We provide care and meet needs through the relationship using our personality, our self and our relationship skills from the social care worker's toolbox (Lyons 2013). The relationship between a worker and service user is meaningful (Digney & Smart 2014) and trusting (Howard and Lyons 2014). The relationship is the 'core' of this practice (Kennefick 2006; Lyons 2009). Developing a relationship requires the personal skills of engaging, remembering details about the person, actively listening without interrupting them, and remembering the things they love and little personal things about them (McHugh & Meenan 2013). Listening in for the rhythm of each service user and tuning in to where they are in their life is also important (Maier 1992; Digney & Smart 2014). Being cognitively engaged also includes concentrating on the person and ensuring that your thoughts remain present and focused on meeting their needs (Garfat *et al.* 2018).

Case Study 1

Mary is 15 years old. She is witty, kind and mischievous. When Mary was 11, her mother passed away and Mary entered residential care. Mary had a turbulent couple of years. This is Mary's third placement and she has lived here since she was 13. She is settled and seems content. Mary has attempted to go to school but due to social anxiety has not been able to maintain her attendance. She is currently on an education programme that she attends at home and has demonstrated that she is very bright. She completes her school work daily under the guidance of a tutor, who is currently being funded privately by the residential service pending input from the Department of Education. The care team support Mary in her studies with copious supplies of tea and praise. For the most part she can study independently. Mary's father is incarcerated. Mary is very close to her older brother. They spend a lot of time together; however, he has limited means and it is not possible for Mary to live with him on a more permanent basis. Mary visits her dad once a month and they have weekly telephone contact.

Reviewing the Case Study through the Lens of the SKIP Model

Relationship-based practice knowledge:

In the case study we know that Mary has the intellect to be successful in school, but that her social anxiety is preventing her from accessing an education. We know that she has tried to overcome her anxiety but has not been able to maintain her attendance in school. So the care team supporting Mary have found another way for her to attend school that does not cause her anxiety, thereby ensuring that she has an opportunity to achieve her potential. You may also note that the type of support Mary requires is emotional support, for example 'tea and praise'. She needs the reassurance that she can complete the tasks asked of her, and the comfort that small gestures such as bringing her a cup of tea brings. These gestures tell Mary that she is important, that she matters, that her needs are to the forefront of decisions made and that people around her care about her. Mary will feel validated, heard and empowered through the actions both of the service that she is placed with and the team who work with her.

Situated knowledge:

Considering the knowledge that is informing the actions of the care team in the above scenario, this service places a strong emphasis on the importance of education and on the importance of supporting Mary's relationship with her family. The practice of the team demonstrates the use of therapeutic interventions in how they support each of these components in Mary's life (see Byrne 2013 for an exploration of therapeutic social care practice). The team are tuned into Mary's likes and dislikes, her needs and wants, and her family dynamic. Such support will encourage Mary to maintain important relationships and to access her education.

Practice wisdom:

In the case study above, the care team are relying on their knowledge of various theories, for example: Ainsworth (1978), Becker (1963), Biestek (1953), Bowlby (1969), Goffman (1959), Rogers (1961) and Winnicott (1960), and coupled with their experience of working with Mary (is intelligent, finds tea comforting, can only study/learn in a positive nurturing environment, family are important to her) to inform their approach so that Mary's needs are appropriately met in a way which is empowering and supportive.

The SKIP Model and the Standards of Proficiency for Social Care Workers

The eighty standards of proficiency for social care workers are the threshold standards of practice set by the Social Care Worker Registration Board for safe and effective practice. The standards of proficiency provide statements indicating the knowledge and skills that all those who enter the register as a social care worker must have (SCWRB 2017). Your degree programme has been carefully designed to ensure that every student will, when they graduate, have demonstrated their achievement of the standards of proficiency for social care workers. Across the higher education sector, the various institutes will have

taken different approaches in how this is achieved. However, every programme is evaluated by CORU and is subject to ongoing monitoring and auditing by CORU to ensure that each student meets the threshold prior to graduation. All eighty proficiencies are relevant to the three categories of knowledge in the SKIP Model.

TASK 4

Select two proficiencies that relate to each one of the three knowledge categories:

1. What is social care?
2. How to do social care work.
3. The service user and his/her world.

Professional Skills in Evidence-informed Practice

As a social care student, you will need to demonstrate proficiency in the skills of evidence-informed practice. The SKIP Model is a framework providing examples of the knowledge underpinning social care work. Understanding and applying this model is confirmation of your skills in evidence-informed practice. Gambrill (2013) identified three key traits which, she argues, are necessary to effectively engage with and pursue evidence-informed practice. These are critical thinking, advocacy and clinical expertise. The SKIP Model has reframed clinical expertise into the section entitled Professional Expertise, and the other two skills – critical thinking and advocacy – are also ways to demonstrate your evidence-informed practice.

Critical Thinking

Gambrill (2013) argued that critical thinking is a key component to any practice that is based on evidence. According to Paul (1993), the specific intellectual traits that are essential for critical thinking to be effective are courage, integrity and perseverance. Finn (2011) suggests that there are four thinking styles that enhance the development of critical thinking capacity in workers:

- Open-mindedness – a disposition that is interested in finding new evidence,

new ways of working and new ideas

- Fairmindedness – the capacity to take on board views, opinions and perspectives which may be in contradiction to one's own previously held beliefs
- Reflectiveness – the individual's willingness to take time to review any new information and to look at the advantages and disadvantages of each without accepting the first apparent solution
- Counterfactual thinking – the capacity to look at the research and the situation from a range of different perspectives and to endeavour to think through possible alternatives and outcomes.

TASK 5

Think of recent experiences where you practised (1) open-mindedness, (2) fairmindedness, (3) reflectiveness and (4) counterfactual thinking.

Advocacy

The second key trait is for the worker to be an effective advocate for their service user(s). There is consensus across the social care literature in Ireland that social care workers' advocacy role encompasses the promotion of the needs of the client (SCWRB 2017), ensuring that clients have access to an advocacy service (HIQA 2017) and a preparedness to advocate for resources and services subject to the needs of the client (Tusla 2016). Incorporated in the advocacy role is the need to ensure that the supports to empower service users are in place; for example, scheduling meetings in venues accessible by public transport or being aware of the need to avoid professional jargon in meetings. Service users may also rely on the interpersonal skills of social care workers to empower them to engage with other professionals or in certain situations (Evans & Kearney 1996).

TASK 6

1. Think of recent experiences where you were an advocate for a service user or family member.
2. Read Chapter 75 and Chapter 37 for more information on advocacy.

Social care knowledge is always evolving, building on the work and expertise of social care professionals and lived experiences of service users. The SKIP Model emerged from our own evidence-informed research, where we interpreted theories, concepts and the practice experiences of social care workers to enhance our work as educators. This model will also evolve and develop as we learn more. As a social care student this model may be useful to help you demonstrate your skills in evidence-informed practice.



Tips for Practice Educators

1. Ask the student to present the SKIP Model to the social care team, as a way of gathering information on the evidence different workers use to inform their practice.
2. To support your team to demonstrate their knowledge of and skills in evidence-informed practice (Standards of Proficiency for Social Care Workers), create environments for workers to discuss the evidence (knowledge and skills) used in their practice.
3. Give the student on placement a piece of action research to conduct under your supervision. Action research is an approach to research in which the worker is the researcher, and the research topic is an investigation into the worker's own practice. Workers examine what they do, why they do it and what results they hope to accomplish. The purpose of engaging in such research is to enable workers to create new theories regarding how the research has impacted on their personal practice. Through engagement in the process of action research, day-to-day work practices can become transformed into theories, thereby expanding the research in the field of residential care.
4. Critical thinking skills:

The following tips are aimed to support students on placement to engage with Finn's (2011) four thinking styles.

- a. Open-mindedness – a disposition that is interested in finding new evidence, new ways of working and new ideas:

TASK 7

Read the blog by Carol Dweck, 'A Summary of Growth and Fixed Mindsets' (<https://fs.blog/2015/03/carol-dweck-mindset/>) and discuss the impact of the growth mindset on your thinking.

- b. Fairmindedness – the capacity to take on board views, opinions and perspectives which may be in contradiction to one's own previously held beliefs:

TASK 8

Read Kendra Cherry's article 'Unconditional Positive Regard in Psychology' (<https://www.verywellmind.com/what-is-unconditional-positive-regard-2796005>) and consider how understanding self-worth develops a sense of fairmindedness.

c. Reflectiveness – the individual's willingness to take time to review any new information and to look at the advantages and disadvantages of each without accepting the first apparent solution:

TASK 9

Reflect on the impact of one theory on how you practise social care. Discuss why you chose this theory and how it applies to practice in your service.

d. Counterfactual thinking – the capacity to look at the research and the situation from a range of different perspectives and to endeavour to think through possible alternatives and outcomes:

TASK 10

Discuss one research idea at a team meeting, provide two different approaches and brainstorm the possible alternatives and outcomes.

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Chapter 68 – Lindsay Malone (D5SOP7)

Domain 5 Standard of Proficiency 7

Demonstrate an understanding of the theories of individual and social development across the lifespan and contexts and within different cultures including the knowledge required to work with individuals, children, vulnerable adults, families and marginalised groups

KEY TERMS

Nature
versus
nurture
Lifespan
Adverse
childhood
experiences

Social Care is ... a relationship-based approach to the provision of care in the lives of those who are marginalised or in need of additional support or protection.

TASK 1

Nature versus Nurture – Consider how we develop – is it because of our genetics and biology or is it because of our environment?

Introduction

This chapter will explore the theories of individual and social development across the lifespan and contexts and within different cultures. The information provided and the tasks have been developed in order to enable you to develop the knowledge required to work with individuals, children, vulnerable adults, families and marginalised groups. This proficiency is essential for social care practice as

there is currently significant a focus on understanding trauma and how it links to theories of individual and social development.

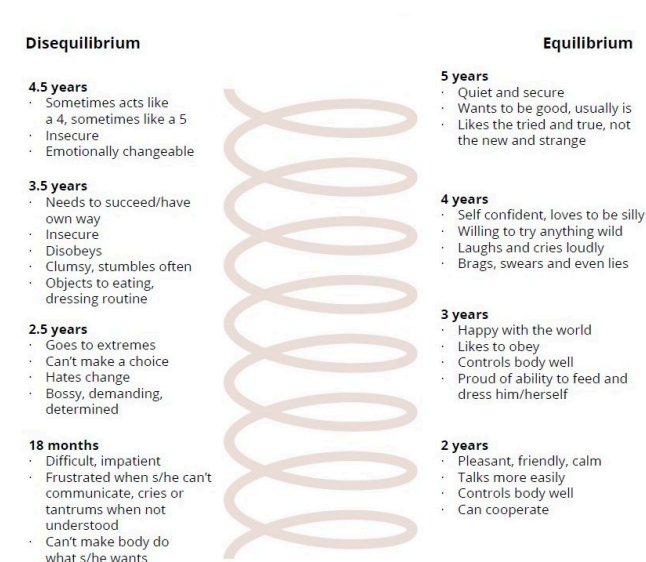
Nature and Nurture

The narrative surrounding how individuals develop over their lifetime has its roots firmly based in the nature versus nurture debate. The naturalists understand development to be influenced by genetic inheritance whereas those on the nurture side of the debate consider development to be the product of exposure to life experiences (Levitt 2013).

Key Message

Physical and Cognitive Development occur in universal sequential stages

Gesell's Maturation Theory



Author created diagram based on the representation from the Gesell Institute (2020)

From a naturalist perspective, In the early 20th century clinical psychologist and paediatrician Arnold Gesell developed Gesell's Maturation Theory. This theory focused on the physical and cognitive development of children. Gesell believed that children will go through the same stages of development, in the same sequence but each child will go through the stages at their own rate as patterns of development are determined by the individual's heredity. The core emphasis of Gesell's theory was that growth always

progresses in a pattern through predictable stages whereby sequential development begins within the embryo and continues after birth (Couchenour & Chrisman 2016).

According to Gesell growth and development should be thought of as a cyclical spiral which alternates between patterns of equilibrium and disequilibrium, each cycle of the spiral encompassing the time it takes to move through six stages that alternate between equilibrium and disequilibrium. These cycles of development are divided into six definitive stages which are repeated throughout life. See figure below of the cycles of development (Couchenour & Chrisman 2016).

To further illustrate an example of how Gesell's theory of maturational development always unfolds in fixed sequences consider an embryo. The embryo's heart is always the first organ to develop, which is then followed by central nervous system and then followed by the peripheral organs. Continuing with the sequential stages, following birth, a baby will first gain control over their mouth, followed by eye movement, followed by control over their neck, shoulders, arms, legs, and feet. Once the baby further develops, they learn to sit up, stand, walk, and run; these capacities develop in a specific order with the growth of the nervous system, even though the rate of development may vary from child to child. Gesell believed that individual differences in growth rates are a result of the internal genetic mechanisms (Lerner 2015).

Maturational theory states that while the child's social and cultural environments also play a role in their development, these socializing forces are most effective when they are harmonious with the inner maturational timetable. Maturation is the genetically programmed sequence of change that individuals all go through in life. Gesell fundamentally believed development is predetermined, with little influence from the environment. If a child experiences delayed development, then the problem is heredity not environmental.

Key Message

Cognitive Development happens in sequential stages

Piaget's Theory of Cognitive Development

Offering another way of looking at development through sequential stages, Jean Piaget developed his theory of cognitive development which suggests that individuals progress through four developmental stages: the sensorimotor, preoperational, concrete operational and formal operational period. Focusing on cognitive or mental development, the theory offers an explanation of the nature of knowledge itself and how individuals gradually acquire, construct, and use it (Piaget 1972).

Sensorimotor Stage

The first stage is the Sensorimotor stage, which covers birth to two years. In this stage, children seek to understand objects in the world around them by using sensory activity. The key milestones here are object permanence and deferred imitation. The former being the child's ability to know that objects remain in the environment even when they cannot see them and the latter meaning the child's ability to imitate others (Piaget 1972).

Critical Lens

According to the findings from Bauer et al. (2019) cognitive abilities amongst infants can develop much sooner than Piaget inferred.

Preoperational Stage

The second stage is the preoperational stage which covers two to seven years of age. This stage focuses on symbolic ability which is the child's ability to use symbols and words to understand the world around them. Two core components of this stage are animism and egocentrism. Animism occurs when children believe everything in the world around them is alive, including inanimate objects. An example of this is evident when a child will not leave a teddy bear outside at night time as the child believes the teddy will be cold and lonely.

outside on its own. Egocentrism refers to the child's inability to see a situation from another person's point of view as they believe that others see, feel and experience things in the same way they do (Piaget 1972).

Critical Lens

A study by Gelman (1972 cited in Berk 2006) revealed that children aged 3 could perform the conservation task successfully which proves Piaget's theory incorrect and demonstrates that Piaget underestimated the ability of pre-school children.

TASK 2

You can view the Three Mountains Task which examined Egocentrism here:

[Three Mountain Task](#)

Operational Stage

The third stage is the concrete operational stage which spans from the age of seven to eleven. The key milestones of this stage are conservation and classification. The former is the child's conservation abilities, in other words, they develop the ability to understand that a litre of water remains the same in different sized glasses. During this stage they also develop the ability to classify objects into different sizes, shapes and value. They also develop the ability to understand sets and subsets, for example that a mother can be a sister and daughter all at the same time (Piaget 1972).

Critical Lens

Research by Comer et al. (2011) revealed that children in this stage cannot understand the relationship between things that do not exist in the physical world.

Formal Operational Stage

This final stage occurs from the age of eleven into adolescence and is defined by significant development in the child's thinking and reasoning skills whereby they develop the ability to use logic and abstract reasoning (Piaget 1972).

Critical Lens

Research by Bernstein et al. (2008) revealed that not all adolescents acquire this ability as in some societies only half do due to educational disadvantages

TASK 3

Consider whether Piaget's theory is a true reflection of all children and young people or is it culturally specific?



"I use Piaget's Theory all the time in practice as it helps me to understand the normative stages of development. By having an understanding of normative milestones, it becomes easier to see when a child may be experiencing developmental difficulties. For me, the theory provides a roadmap of development milestones which I can use to support and scaffold a child's learning and development" (School Completion Officer 2020)

Key Message

There are 4 types of Attachment and each have an impact on a person's behaviour

Attachment Theory

Attachment is a bond from one person to another which lasts a lifetime. The evolutionary Theory of Attachment originates from Bowlby (1958). According to Bowlby, infants have a universal need to seek closeness when they feel threatened and attachment occurs when the caregiver provides safety and security for an infant. Essentially, from a nature perspective, infants are biologically predisposed to form attachments and from a nurture perspective, how the caregiver responds is vital in how it forms. Bowlby defined the following four stages of attachment.

Pre-attachment (Birth – 2 months)
Baby shows no particular attachment to any caregiver

Discriminate (7 months +)
Infant shows attachment to one primary caregiver

TASK 4

Watch Ainsworth Strange Situation Video Here: [Ainsworth Strange Situation Video](#)

Building on Bowlby's work, Mary Ainsworth devised an assessment technique called the Strange Situation Classification in order to investigate how attachments might vary between children. Observing infants aged between 12 and 18 months covertly, the experiment sample comprised of 100 middle-class American families where the behaviour of the infant in a series of eight episodes lasting approximately 3 minutes each was measured. From the findings, Ainsworth (1970 cited in Brown and Ward 2013) identified three main attachment styles, insecure avoidant (type A), secure (type B), and insecure ambivalent/resistant (type C) and a fourth attachment style known as disorganised was later identified. She concluded that these attachment styles were the result of early interactions with the caregivers and the results can last a lifetime.

Secure attachment occurs when the child is cared for by sensitive and responsive caregivers. Securely attached children are able to regulate their distress and know they can show their needs and feelings and won't be rejected.

Insecure avoidant tends to occur when the caregiver finds it difficult to accept or respond sensitively to the infant's needs. These children tend to experience parenting that is hostile, rejecting and controlling. They come to see themselves as neither loved nor loveable. Children respond to this by shutting down on their feelings because of their anxiety that any display of need or emotion may drive their caregiver away.

Insecure ambivalent attachment tends to occur when the caregiver responds inconsistently to the child's demands. These children exaggerate their attachment behaviour to attract attention. They are not always successful at being noticed and their ambivalence reflects their need for and anger with their attachment figure.

Disorganised attachment occurs in children who are cared for by people who are frightening. Children may fear approaching their caregiver because they cannot predict whether they will respond positively or negatively. Consequently these children are not able to 'organise' their own behaviour and have difficulty regulating their emotions.

(Brown and Ward, 2013)



"Understanding attachment theory is vital in my role as a Residential Social Care Practitioner as our referrals are awash with the word attachment. Therefore, to not understand the different types of attachment, would be detrimental to how we engage, support and care for young people in our unit. Understanding attachment theory also enables me to understand how the life history of a young person has played an important role in how they behave now" (Residential Social Care Worker 2020).

Thus far consideration has been given to the naturalist views of development. From here, the discussion will move more to the nurture side of the debate.

Social Learning Theory

TASK 5

Watch Bandura's Bobo Doll Experiment here: Bobo Doll



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://tus.pressbooks.pub/standardsproficiencysocialcareworker/?p=332#oembed-1>

Bandura's Theory of Social Learning suggests that people learn through observing how people behave in the world around them. More specifically, individuals that are observed are called models. In society, people are surrounded by many influential models, such family, friends, the media etc. These models provide examples of behaviour to observe and imitate, e.g., masculine and feminine, pro and anti-social, etc. Children pay attention to models which enables them to encode their behaviour so that they can imitate the behaviour they have observed. This is illustrated during the famous Bobo doll experiment (Bandura et al. 1961).

Social Learning Theory also infers that observational learning only occurs because cognitive processes are at work. These mental factors intervene in the learning process to determine whether a new response is acquired. Thus, individuals do not automatically observe the behaviour of a model and automatically imitate it. This is because thoughts occur prior to imitation, and this consideration is called mediational processes. This process occurs in between when the individual observes the behaviour (stimulus) and when they imitate it or not (response). There are four mediational processes proposed by Bandura as outlined below.

Attention: The extent to which an individual is exposed to a behaviour. For a behaviour to be imitated, it has to grab their attention. Attention is therefore extremely important in whether a behaviour influences others imitating it

Retention: How well the behaviour is remembered. The behaviour may be noticed but is it not always remembered which prevents imitation.

Reproduction: This is the ability to perform the behaviour that the model has just demonstrated. People are limited by our physical ability and for that reason, even if they wish to reproduce the behaviour, they cannot.

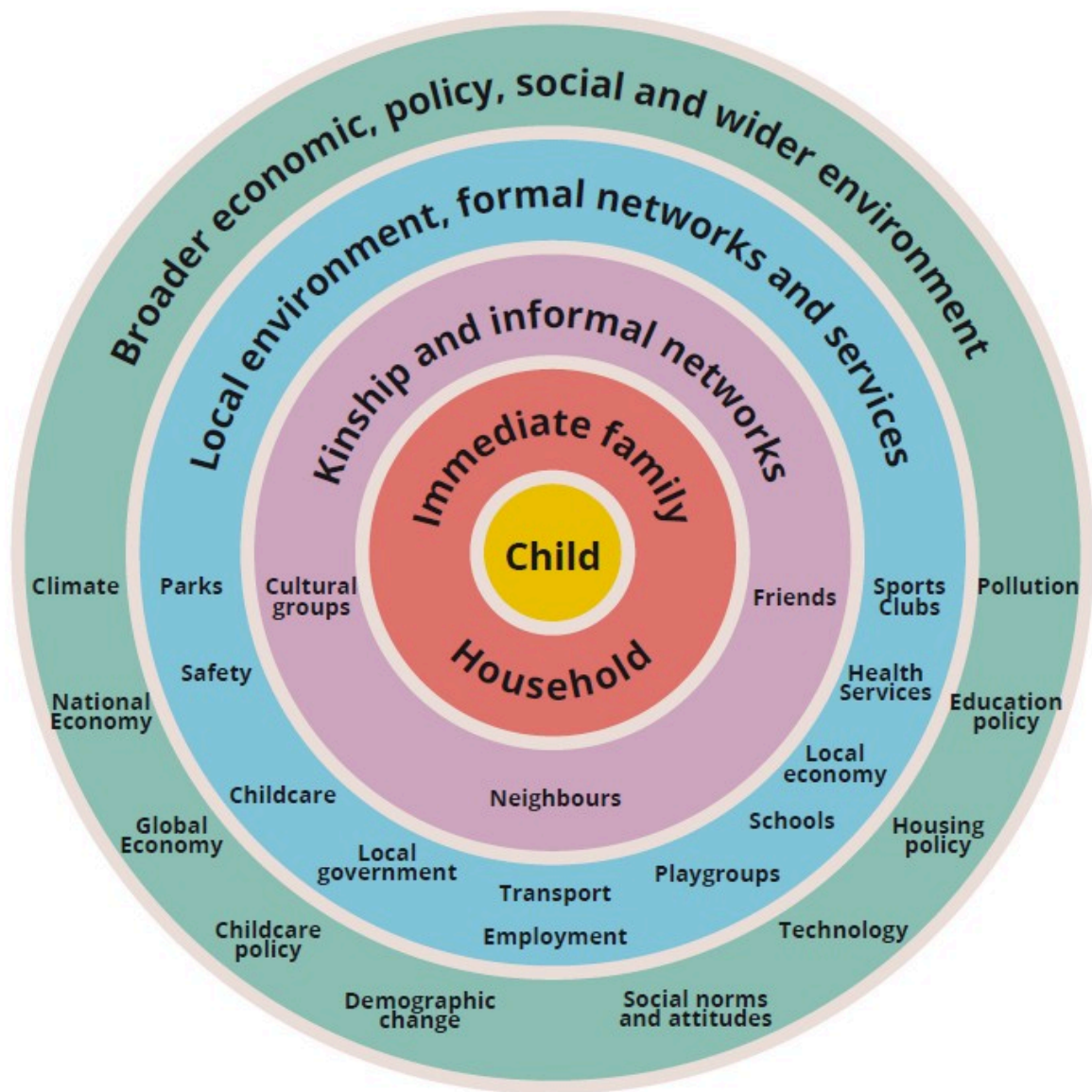
Motivation: The will to perform the behaviour. The rewards and punishment that follow a behaviour will be considered by the observer. If the perceived rewards outweigh the perceived costs, then the behaviour will be more likely to be imitated by the observer.

Key Message

The direct and indirect environment around the individual shapes their development

Bronfenbrenner's Ecological Systems Theory

Continuing with the focus on how the environment can shape a person's development, Bronfenbrenner's Ecological Systems Theory depicts five ecosystems. Bronfenbrenner believed that a person's development was affected by everything in their surrounding environment. He divided the person's environment into five different levels: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem (Bronfenbrenner 1979).



Author created diagram: Bronfenbrenner's Ecological Systems Theory adapted from Gibbs (2016).

TASK 6

Using the case studies below, apply Bronfenbrenner's Theory to John, Mary and Florence's lives in order to examine their ecosystems and how they affect their development

Case Study 1

John is 15, he has Autism Spectrum Disorder and lives in Residential Care. He has two younger brothers who are in Foster Care. John's mother is in prison and John's father is deceased. John sees his brothers every second weekend. John is on a reduced timetable at school and is engaging with the School Completion Programme, as he is at risk of leaving school early. The Residential Unit is based in a small rural village which is close to John's school, so he walks to school with friends.

Case Study 2

Mary is 37. Mary is in active addiction and is homeless. Mary has two children who are in Foster Care. Mary does not currently see her children. Mary has a partner who is also in active addiction.

Case Study 3

Florence is a 28 year old Refugee with two young children. Florence is living in direct provision and is working with a keyworker in order to reach her goal of finding employment and a home of her own.

Key Message

Development continues over the life span and this occurs over a series of stages

Erikson's Theory of Psychosocial Development

Erikson's Theory of Psychosocial Development suggests that personality develops in a predetermined order through eight stages of psychosocial development, from infancy to adulthood. During each stage, the individual will experience a psychosocial crisis which could have a positive or negative outcome for personality development. For Erikson (1959), these crises are of a psychosocial

nature because they involve psychological needs of the individual (i.e., psycho) conflicting with the needs of society (i.e., social). According to the theory, successful completion of each stage results in a healthy personality and the acquisition of basic qualities. Basic qualities are characteristic strengths which the ego can use to resolve subsequent crises. This theory is further illustrated below.

Age and Stage	Crisis	Explanation
Infancy: Birth-18 Months Old	Basic Trust vs. Mistrust – Hope	The major emphasis is on the caregivers nurturing ability and care for a child, especially in terms of visual contact and touch. The child will develop optimism, trust, confidence, and security if well cared for and handled. If a child does not experience trust, he or she may develop insecurity and general mistrust to the world.
Toddler/ Early Childhood Years: 18 Months to 3 Years	Autonomy vs. Shame – Will	At this point, the child has an opportunity to build autonomy as they learn new skills and right from wrong. The well-cared for child is sure of himself, carrying themselves with pride rather than shame. Children tend to be vulnerable during this stage, sometimes feeling shame and low self-esteem during an inability to learn certain skills.
Pre- schooler: 3 to 5 Years	Initiative vs. Guilt – Purpose	During this stage the child will experience a desire to copy the adults around them and make up stories through imaginative play. This enables the child to play out roles in a trial universe, experimenting with the blueprint for what we believe it means to be an adult. The most significant relationship is with the basic family.
School Age Child: 6 to 12 Years	Industry vs. Inferiority – Competence	During this stage, the child is capable of learning, creating and accomplishing numerous new skills and knowledge, thus developing a sense of industry. This is also a very social stage of development and if we experience unresolved feelings of inadequacy and inferiority among our peers, they can experience serious problems in terms of competence and self-esteem. The most significant relationship is with the school and neighbourhood.
Adolescent: 12 to 18 Years	Identity vs. Role Confusion – Fidelity	Up until this fifth stage, development depends on what is done to a person. At this point, development now depends primarily upon what a person does. An adolescent must struggle to discover and find their own identity, while negotiating and struggling with social interactions and “fitting in”, and developing a sense of morality and right from wrong. Some attempt to delay entrance to adulthood and withdraw from responsibilities (moratorium). Those unsuccessful with this stage tend to experience role confusion and upheaval. Adolescents begin to develop a strong affiliation and devotion to ideals, causes, and friends.
Young adult: 18 to 35	Intimacy and Solidarity vs. Isolation – Love	At this stage, people tend to seek companionship and love. Young adults seek deep intimacy and satisfying relationships, but if unsuccessful, isolation may occur. Significant relationships at this stage are with marital partners and friends.

Age and Stage	Crisis	Explanation
Middle-aged Adult: 35 to 55 or 65	Generativity vs. Self absorption or Stagnation – Care	Career and work are the most important things at this stage, along with family. Middle adulthood is also the time when people can take on greater responsibilities and control. For this stage, working to establish stability and Erikson's idea of generativity – attempting to produce something that makes a difference to society. Inactivity and meaninglessness are common fears during this stage. Major life shifts can occur during this stage. For example, children leave the household, careers can change, and so on. Some may struggle with finding purpose. Significant relationships are those within the family, workplace, local communities.
Late Adult: 55 or 65 to Death	Integrity vs. Despair – Wisdom	Erikson believed that much of life is preparing for the middle adulthood stage and the last stage involves much reflection. As older adults, some can look back with a feeling of integrity – that is, contentment and fulfilment, having led a meaningful life and valuable contribution to society. Others may have a sense of despair during this stage, reflecting upon their experiences and failures. They may fear death as they struggle to find a purpose to their lives.

(Erikson 1959)

TASK 7

Reflecting on Erikson and Bronfenbrenner's theories, consider how the 8 stages from infancy to late adulthood relate to Bronfenbrenner's ecosystems – can you link the ecosystems to each of the 8 stages?

Adverse Childhood Experiences

Key Message

Adverse Childhood Experiences have lasting effects and can be prevented

Studies are increasingly identifying the importance of early life experiences to

people's health throughout the life course. Individuals who have Adverse Childhood Experiences (ACEs) during childhood or adolescence tend to have more physical and mental health problems as adults than those who do not have ACEs. ACEs that affect children directly include abuse and neglect. Indirectly, ACEs may occur through their living environments e.g., parental conflict, substance abuse, or mental illness.

More specifically, ACEs, are potentially traumatic events that occur in childhood (0-17 years). For example:

- experiencing violence, abuse, or neglect
- witnessing violence in the home or community
- having a family member attempt or die by suicide

Also included are aspects of the child's environment that can undermine their sense of safety, stability, and bonding such as growing up in a household with:

- substance misuse
- mental health problems
- instability due to parental separation or household members being in jail or prison

ACEs are linked to chronic health problems, mental illness, and substance misuse in adulthood. ACEs can also negatively impact education and job opportunities. However, ACEs can be prevented (Centre for Disease Control and Prevention 2020).

There is a significant body of evidence available on the benefits of early intervention in the lives of children (Lacey and Minnis 2020). Early intervention in children's lives when there are difficulties can prevent problems escalating, strengthen families' capacity to nurture children, and encourage and enable families to solve their own problems. Early intervention and improved cooperation, means that apparent difficult issues can be dealt with quickly and effectively, getting a full picture of a child's circumstances and getting appropriate people involved early. The role of prevention is not only to combat risk factors but also to enhance and promote the positives in a child's life as well as opportunities for child development. Changing the balance between risk and protective factors so that protective factors outweigh risk factors is an effective prevention and early intervention strategy (Tusla 2020).

TASK 8

Examine the findings from CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study. This is one of the largest investigations of childhood abuse and neglect and household challenges and later-life health and well-being: ACE Case Study

Conclusion

This chapter has explored the key theories of individual and social development across the lifespan and contexts and within different cultures. The information and tasks provided have been developed in order for you to enhance your knowledge and understanding of these key theories in order to underpin your practice. This chapter has been designed to address Domain 5 Standard of Proficiency 7 in order to support you demonstrate an understanding of the theories of individual and social development across the lifespan and contexts and within different cultures including the knowledge required to work with individuals, children, vulnerable adults, families and marginalised groups.



Tips for Practice Educators

This proficiency is best understood for many students in the context of observations on practice placement.

- Provide the student with opportunities to observe practice where your agency demonstrates theories of individual and social development in interactions/engagement with service users.
- Suggest that students use their reflective diary to record their understanding of the application of this proficiency in practice.
- Provide an opportunity where students can plan activities and tasks that demonstrates their understanding of the importance of social development,
- Help students to plan strategies that ensure service users have a opportunity to reach their potential.
- Explore with your student in supervision their understanding or experiences of ACE.
- Support the student in identifying possible programmes/activities from their academic studies, that may support a service user with ACE.

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Chapter 69 – Denise Lyons and Sharon Claffey (D5SOP8)

Domain 5 Standard of Proficiency 8

Understand the role and purpose of building and maintaining relationships as a tool in the delivery of social care across the lifespan in a variety of contexts.

KEY TERMS

Variety of contexts
Relationships
p-based
social care
work
Building
and
maintaining
relationships

Social care is ... relationship-based practice that involves having a non-judgemental attitude, being consistent in using a strengths-based approach and, in turn, empowering people to reach their full potential.

Five proficiencies of the eighty are about relationship, referring primarily to the relationship between the worker and the service user (Chapters 35, 36, 69 and 70); the professional relationship with colleagues (Chapter 38) is also acknowledged and valued.

Domain	Chapter in this book	Focus on the Relationship
D2 SOP12 (2017: 6)	Ch 35 by Natasha Davis	<i>'Be aware of the concepts of power and authority in r</i>
D2 SOP13 (2017: 6)	Ch 36 by Des Mooney	<i>'Understand the need to build and sustain profession</i>
D2 SOP15 (2017: 6)	Ch 38 by Des Mooney	<i>'Understand the role of relationships with professional</i>
D5 SOP9 (2017: 9)	Ch 70 by Teresa Brown	<i>'Critical understanding of the dynamics of relationships transference'</i>

This chapter focuses on explaining the role and purpose of relationships through a discussion on relationship-based social care work, concluding with practical recommendations on how to build and maintain relationships across the lifespan and within different contexts.

Variety of Contexts

Social care workers build and maintain relationships with children and/or adults, through the delivery of care across a variety of social care services. Depending on the nature of the service and the needs of the service users, this relationship may be short and focused, or long and spanning several years, or a full life-time, terminated only by the death of the service user or the retirement of the worker.

The context, the social care setting, will determine the length of time and the quality of access the worker has with the service user. McCormack *et al.* (2002: 94) state that 'context specifically means the setting in which practice takes place'. Context is also defined as the background for all social interactions which are influenced by cultural, historical, political and economic constructs (Burr 2015). However, context is more than a backdrop; context is a social, active and emergent space (Wenger 2010), shaped by the relationships within. Therefore, context is practice (Barnett 1999), people, structures and relationships. Social care services are always in a state of flux, changing to meet the diverse needs of service users, adapting to new people, and adjusting to the current economic and political climate. The context is the physical representation of how the practice is influenced by policy and valued by society. These socially constructed and ever-changing contexts are places that are meaningful (Tuan 2012) and spaces that are lived-in and loved (Merleau-Ponty 2012).

Social care workers inhabit the contexts of practice; they engage in the activities and movements of social care, through their holistic and embodied practice, from physically pushing a wheelchair or using a hoist, sitting beside someone in the shared space, to cognitively and emotionally ‘being present’ (Digney & Smart 2014). The contexts of practice are diverse, and each worker is engaged in completely different activities depending on the needs of the service user in that place, space and time. The discussion on varied contexts of care requires some understanding of the concepts of place and space (Lefebvre 1991). McDowell (1996: 29) articulated a relational definition of space, where ‘all social relationships occur somewhere and result in connections between people and places’. Place is presented as the ‘nodes’ of space, a ‘symbol’ of space that is ascribed with ‘personality and spirit ... the sense of place’ (Tuan 2012: 388-9). The personality of a place is felt, remembered with affection or hate, and recollected from a smell (Tuan 2012), taste or photograph. Workers and service users shape the varied contexts of social care practice and are ultimately shaped by them.

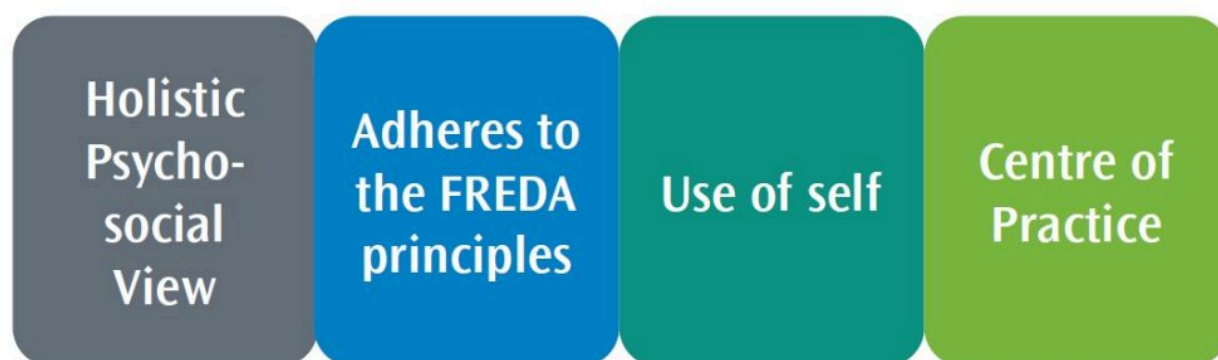
The theory of material culture, which studies the relationship between people and objects, is also relevant to understanding the impact of social care contexts (Hicks & Beaudry 2010) on people, relationships and practice. The material culture of contemporary social care (Woodward 2007) includes the objects and practices of everyday life in the different settings. This includes, but is not limited to the furniture, decorations, utensils, fabrics, and also the objects used to provide care; the wheelchairs, hoists, slings, medicine cabinets, the locked press, the keys, the office and the records, to name a few (Hicks & Beaudry 2010). Material culture also includes the remnant artefacts from the past which continue to influence the use and feel of the space, from the architecture of the building, including the location of the setting, to the size of the rooms, the previous use of the space, and the dated photographs that adorn the walls (Davies *et al.* 2013). Within these buildings converted into social care settings, social care workers, through relationship-based practice, give life to ordinary places for meaningful practice.

TASK 1

Think of a social care setting, focusing on the building itself. Did it feel homely, clinical, warm or cold? How did the ‘context’ and its ‘material culture’ make you feel?

Relationship-based Social Care Work

As the view of the relationship in SCWRB's 'standards of proficiency' is presented as a threshold, social care needs a theoretical frame underpinning the knowledge base that presents the relationship as core and central to practice (Lyons 2017). Scholarly discourses on the relationship in social work, social pedagogy and child and youth care (Garfat 2004, 2008; Stephens 2013; Egan 2014) have influenced social care workers and educators in Ireland (McHugh & Meenan 2013; Lyons 2009, 2013; Digney & Smart 2014). The various relationship approaches may differ slightly in position and context, but all involve one person engaging with another while they are doing things together and being with each other. Trevithick (2003: 163) presented a history of how the relationship, once seen as essential for best practice, had fallen 'out of favour', which led to the revisionist 'relationship-based social work' framework. The characteristics of this framework (Wilson *et al.* 2011) are relevant to the relationships in social care work and form part of the four core characteristics discussed in this chapter. The relationship-based social care work framework presented here is influenced by Wilson *et al.* (2011), the Standards of Proficiency for Social Care Workers (SCWRB 2017) and the perspectives of social care workers in Ireland (Brown 2016; Lyons 2007, 2017).



Author created diagram: This visual highlights four foundational elements of social care practice: a holistic psychosocial perspective, adherence to the FREDA principles (Fairness, Respect, Equality, Dignity, and Autonomy), the reflective use of self, and a person-centred approach at the core of practice.

In relationship-based social care work, workers begin to understand a person through the sharing of a life story. Stories about the past, and present experiences, help us 'to understand oneself and others' (Chamberlayne *et al.* 2000: 7). Through listening empathically to others, we can learn how they

became who they are and ‘understand our own histories and how we have become who we are’ (Chamberlayne *et al.* 2000: 7). The following case study was extracted from two chapters in Howard and Lyons (2014) *Social Care: Learning from Practice*. The two chapters (Fenton 2014; King 2014) are based on the relationship between the social care worker (Maurice Fenton) and a young person in residential care (Keith King). Segments from the two chapters are presented here as examples of the four characteristics of relationship-based social care work. Although relationships take time to develop (Lyons 2017), Keith and Maurice’s relationship in the children’s residential centre lasted approximately five months.

Holistic Psychosocial View

All people are unique and therefore our relationships with them are different from all other relationships we have developed and experienced. The people we work with are complex and multifaceted and relationship-based social care work accepts that people are influenced both by the internal world of feelings, emotions and behaviours, and also by the external world, including their past experiences and how they are treated by society, policy and the people around them (Wilson *et al.* 2011). This is a psychosocial approach (Newman & Newman 2012) to social care work that acknowledges the interaction between biological, psychological and societal systems and their influence on the service user. ‘Holistic’ refers to the relationship of the whole person (body and mind) of the worker with the whole person (body and mind) of the service user. We need to know people well in order for them to be comfortable with us, physically, emotionally and cognitively. Social care practice is the embodiment of both the worker and the service user in the shared space of practice; we work and live together. ‘Head, heart and hands signifies this holistic approach’ (Ghate & McDermid 2016: 6) and ‘all three being essential for the work’ (Petrie *et al.* 2006: 4). We can apply a holistic, psychosocial approach within our relationships with others by learning about them through their story.

Case Study 1

Keith was born into a large family ‘that suffered physically, socially and psychologically through domestic violence and alcoholism’ (King 2014: 37). Keith’s parents were loving when alcohol was not involved, and he learned to read their mood and level of intoxication by their body language and dress. Keith had a reputation in school and local community as a thief (explained in his chapter) and spent large amounts of time without adult supervision or care.

Fenton (2014: 48-49) described Keith’s focusing on the positives in his relationship with Maurice and with his mother, as Keith’s way of “distinguishing the love from the harm”. Maurice understood Keith’s need to ‘act in socially unacceptable ways’ as a response to childhood trauma and a need to survive. Keith presented with a ‘range of complex and challenging behaviours’, which Maurice understood as communicating trauma and he responded with kindness, care, patience and trust, which had an emotional and long-lasting impact on Keith.

Adheres to the FREDA Principles

The FREDA principles (Curtice & Exworthy 2010), which were adopted by the Health Information and Quality Authority (HIQA 2019), are fairness, respect, equality, dignity and autonomy. They represent the values within the relationship-based social care relationship.

Case Study 2

Keith noted how Maurice ‘made a massive impression’ on his life (King 2014: 40) and that he knew he could trust him because he experienced equality when Maurice ‘always stood up and advocated for me’. Keith experienced respect when Maurice showed genuine interest in him and his needs. Keith experienced fairness, dignity and autonomy when he felt heard, listened to and nurtured by Maurice. Also, when the manager of the unit genuinely apologised to him for making a mistake in the way she had spoken to him.

TASK 2

Please read HIQA's Guidance on a Human Rights-based Approach in Health and Social Care Services (2019) and list examples of times Keith was shown equality, respect, fairness, dignity and autonomy.

Use of Self and Body

Relationship-based social care work acknowledges role of self in practice including the body and the mind. Relationship-based practice in social care is holistic and embodied, a mutual collaboration between the worker and service user, centring on being supportive, and working within the relationship (Cameron & Moss 2011). Johnson (1987) described embodiment as involving the whole body in meaning-making within practice. Social care work is embodied through the lived experience, decision-making, and all the movements and practices of the people we work with and the services we work in. Social care workers have 'a body' (Johnson 1987) 'through which [they] act in the world' of practice (Merleau-Ponty 2012: 140). Workers also have a mind, which is engaged in being present and thinking about how to care for the person; and hands, used in physically supporting them to meet their needs. Embodiment for social care workers is not just about the engagement of the body, the thoughts and feelings connected to practice, but the overall experience of being in the world.

Case Study 3

When Keith entered residential care, he was introduced to the man (Maurice) who would become his key worker. Keith recognised him immediately as the man he had observed playing naturally with another child and noted he was kind and caring; he felt he could trust him. Maurice was using his authentic self (Brown 2016) in his play and care, which is a part of his relationship with the children in his care. Maurice described this as a 'willingness to show vulnerability and appropriately admit mistakes' and to show 'unconditional positive regard' (Fenton 2014: 50-2). Maurice made sure that Keith knew that he liked him and enjoyed spending time with him and was invested in their relationship. Keith experienced this as trust.

When we have a relationship with another person, we share a part of ourselves, and we also put at risk our emotional self (Clarke 2003; Lyons 2013). Potentially, there is pain in relationships, especially when the worker has become

emotionally involved in trying to create an experience that is genuine, warm and real (McMahon 2010). Workers are challenged in their training and practice to adopt the values and beliefs of unconditional positive regard and empathy (Lalor & Share 2013) for the service users (Payne *et al.* 2009). But helping and supporting people can be emotionally difficult and challenging for the worker and workers need to recharge with self-care and learning how to switch off and resist bringing work (feelings, thoughts and concerns) home.

Relationship is the Centre of Practice

Relationship-based social care work is the centre of all interventions in planned practice, and the service user is the centre of everything. In Chapter 67, the SKIP Model (Lyons & Reilly, forthcoming), describes the relationship as the heart of evidence-informed practice in social care work. Social care workers learn 'what social care work is' within their specific setting, how to 'do' social care work in order to meet the needs of the people using the service through the relationship. The relationship is the core of social care practice in all settings (Kennefick 2006; Lyons 2009). Workers provide care and nurturing, demonstrate meaning and create meaningful moments (Digney & Smart 2014) and establish trust by being genuine and consistent (Howard & Lyons 2014). Social care work involves getting to know a person and sharing your time, experience, knowledge, humour, values, feelings and emotions with them. During the time you spend with the service user, information is being communicated, non-verbal and/or verbal, from you and between you. By viewing the relationship as the centre of practice, organisations will value and support the time needed to develop a relationship.

TASK 3

Read the two chapters and find more examples of the four characteristics of relationship-based social care work within the text.

Fenton, M. (2014) 'The Impossible Task: Which Wolf will Win?' in N. Howard and D. Lyons, *Social Care: Learning from Practice* (pp. 48-59). Dublin: Gill and Macmillan.

King, K. (2014) 'There's no Place Like Home: Care and Aftercare' in N. Howard and D. Lyons, *Social Care: Learning from Practice* (pp. 37-47). Dublin: Gill and Macmillan.

Building and Maintaining Relationships

This section of the chapter outlines the steps required for building and maintaining relationships.

The first step encourages the worker to take a step back, **look inwards** and examine their own values and attitudes, step two, **establishing rapport**, is the 'getting-to-know-you' phase, which moves to step three – the '**relationship dance**' between the worker and the service user.

Step 1 – Look Inwards

The skills in building a relationship with others begins with the worker, and the attitudes, values and beliefs they hold about people. *The Casework Relationship* by Felix Biestek (1957) has seven principles which outline the appropriate values, attitudes and knowledge needed before you start to build a relationship with a service user. Although this theory was published in 1957, and was part of my own social care education in the 1990s, it is still relevant today.

The Casework Relationship by Felix Biestek (1957)



Author created diagram based on The Casework Relationship by Felix Biestek (1957)

'As with all practice approaches, a great deal depends on the knowledge, skills, values and qualities that' social care 'workers bring to the work' (Trevithick

2003:164). The seven principles are difficult to achieve and require a commitment to consistently reflect and check in on your attitudes and beliefs and update your knowledge on how to become more empathic and less judgemental in practice.

TASK 4

Watch the video on the Seven Principles of the Casework Relationship:



One or more interactive elements has been excluded from this version of the text. You can view them online here:

<https://tus.pressbooks.pub/standardsproficiencysocialcareworker/?p=337#oembed-1>

Write down the key steps involved in each principle.

Step 2 – Establish Rapport

The aim of the first stage of building a relationship is to help the service user to feel relaxed and safe in your company. You are not trying to 'do' in this stage but aiming to 'be' your genuine self (Kroll 2014).

Start by learning the names of all the service users you will encounter daily, then give yourself the task of remembering one important fact about each person. You may be tested by the service user at this stage of relationship building, so take a mental note of all their likes and dislikes, what team they support, what music they like, if they take sugar in tea or where they like to sit. By mirroring and matching the service user, by folding your arms if they have folded their arms (mirroring) or folding your legs if they have folded their arms (matching). As you tune into the person's rhythm (Garfat & Fulcher 2012), their breathing and speaking, and use of space, you will help them to feel heard, seen and valued. Remember, every person is unique, so relax, watch, listen and learn.

Step 3 – The Relationship Dance

As you begin to establish familiarity with each other the relationship moves from the 'establishing rapport' stage to the 'relationship dance'. Kroll (2014: 73) called

this stage the 'coming together stage' where communication is received and responded to, people are tuning in to each other, and a safe holding space is created, where 'taking risks can be thought about'. The following vignette from Garfat (2004) explains the 'dance of the unknowns', where the relationship is new and they dance betwixt and between this liminal and unknown space within the developing relationship.

'We don't know her, so we tread gently; we are unsure how to be so we move to our neutral therapeutic place and reach out tentatively, exploring, like her, the unknown territory. And because we move gently, we avoid any provocation which might cause a reaction. So, if this is correct, here we are, us and the young person, exploring the territory together, reaching out to see how the other will respond, finding out what is safe, how we can be here, what works. It is the 'dance of the unknowns', and it continues until one of us pushes a little more, moves to test the reality of her perceptions, reaches beyond the superficial safe place we establish in the early stages of relationship development. And in this, it is all so normal. We explore who this new person is; we explore how they are with us; we explore whether or not we are interested in taking this relationship to a different depth. We test. We move closer and move back. We explore' (Garfat 2004).

In this dance, *'the experiences, feelings and expectations that both participants bring into the relationship, the way in which connecting biographies play their part, and the defence mechanisms that come into play'* (Kroll 2014: 73) become the steps we navigate together. This unknown space in the dance is defined as the 'safe uncertainty' stage of relationship development in relational child and youth care (Featherstone *et al.* 2014). 'Preparation, making a warm, human connection, empathy, sympathy and intuition' (Kroll 2014: 78) are the ingredients needed to create safety and establish trust. Emotional intelligence is essential to read the dance and to respond appropriately, and to know when to apologise when you get the steps wrong. Sometimes relationships are difficult and experienced as 'stumbling through' (Hingley-Jones & Ruch 2016), especially if the person does not trust or know the staff member, or is dealing with their own issues. Ormond (2014) argues that even though the work can be very difficult and sometimes threatening, it is very important to relate to others in a non-blaming way, and 'survive' the work without becoming vindictive. He advises workers to be slow to judge, quick to use humour, and to become less self-conscious (Ormond 2014).

To conclude, relationship-based social care work is a useful framework to help workers remember that the relationship is the centre of our practice. This approach acknowledges the role of self, the uniqueness and complexity of the

people we are building relationships with and how they are influenced by the systems that surround them, and finally, how the FREDA principles (Curtice & Exworthy 2010) will help us remember to treat people with respect and dignity. We can learn how to build and maintain relationships by becoming more aware of our own values and beliefs, learning techniques to establish rapport and developing our emotional intelligence so that we can understand the subtle communication cues and steps to help us to 'dance' and ultimately make a difference in one person's life.



Tips for Practice Educators

As building and maintaining relationships is the 'nuts and bolts' of your social care practice:

1. Share your knowledge on how to establish rapport with the service users in your unit. Do you mirror or match in your body language and gestures?
2. Ask the student to learn the names of all service users and at least one piece of information that is relevant and important to them.
3. In the relationship dance, talk about relationships that you found challenging and discuss with the service user the ways you worked this through.
4. Do a relationship chart of the service that outlines:
 1. The length of time people have used the service and worked there.
 2. The people who used to live or work there.
5. Ask questions about the building, what changes have happened over the years and how have these changes impacted on the services and the 'feel' of the building.
6. Review the seven principles of the casework relationship. Discuss how you apply individuation, purposeful expression of emotion, controlled emotional involvement, acceptance, non-judgmental attitude, recognise client self-determination and adhere to confidentiality in your relationships with the service users.

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Chapter 70 – Teresa Brown (D5SOP9)

Domain 5 Standard of Proficiency 9

Have a critical understanding of the dynamics of relationships between social care workers and service users and the concepts of transference and counter-transference.

KEYTERMS
Dynamics
Practice
environment
Transference
and
counter-
transference
Support/
supervision
First voice

Social care is ... a profession where we endeavour to work in solidarity, not them and us. It is a relationship based on respect and empathy.

Dynamics

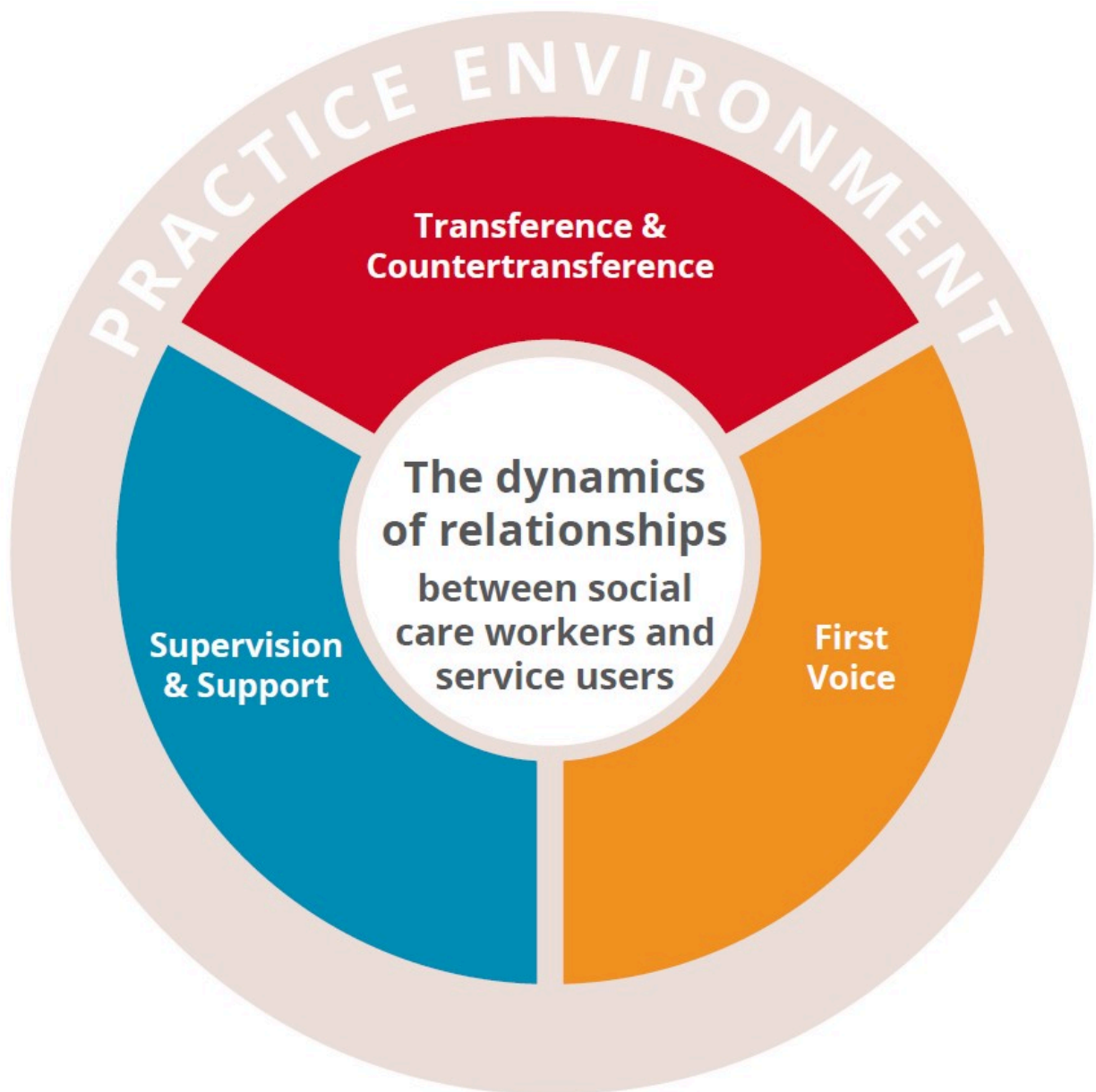
A consistent area of agreement in social care practice is the acknowledgement that effective social care revolves around relationships. The Social Care Workers Registration Board (SCWRB) defines social care as a relationship-based practice through which a planned and purposeful provision of care, protection, psychosocial support and advocacy is provided (SCWRB 2017). Despite this recognition, reiterated in social care policies and literature, a certain amount of ambiguity exists on how relationships are practised. It is my view that the dynamics of social care relationship, ***the actualdoing of relationships***, warrants more visibility and discussion in both academic literature and social care policies.

Although consideration must be given to variables such as gender, sexuality, culture and class that shape the complex dynamic of the social care relationship, the argument put forward in this chapter centres on the importance of locating our critical understanding of this proficiency in the current social care practice environment.

The model of the dynamics of relationship put forward in this chapter endeavours to capture some of the visible and invisible individual and structural dynamics that impact on the relationship between the social care worker and service user. These include:

- **The Practice Environment:** Arguably the practice environment is an unexamined component in the dynamics of the social care relationship. It is the backdrop to our practice, the organisation culture, which includes such things as *'attitudes and beliefs, patterns of relationships, traditions, the psychosocial context in which work is done and how people collaborate in doing it'* (Menzies-Lyth 1990: 466-7). The practice environment is also shaped by legislative, social and economic influences, unconscious assumptions, attitudes and beliefs about the work task – the unspoken shared attitudes, the unacknowledged anxieties, conflicts, as well as the work atmosphere. The practice environment also includes the dynamics of multi-disciplinary and inter-agency practice, all shaping the dynamics of the social care relationship.
- **Doing the Relationship:** An understanding of the dynamics of transference and counter-transference in the social care relationship provides us with insight into service users and our own inner world. Using our first voice (Weick 2000) we can highlight the complexities of 'doing the relationship', advocating a move to work in solidarity, moving away from a 'them and us' attitude.

Supervision and Support: Supportive supervision practice allows us to reflect, self-analyse and respond to visible and invisible dynamics operating within the relationship as well as the complexities of the wider practice environment. Social care workers' experience of support and being supervised is crucial to them being able to develop the capacity to recognise transference and counter-transference, individual and structural dynamics and the complexities of professional relationships.



Author created diagram that highlights the core dynamics shaping relationships between social care workers and service users, emphasising the roles of transference, service user voice, and professional supervision, all within the broader context of the practice environment.

The chapter begins with a discussion on the backdrop to all relationships; the practice environment.

Practice Environment

Against a backdrop of rapid societal and organisational change in the social

care practice landscape, engaging in relationship-based practice presents challenges. The central argument based on research on relationship-based practice (Brown 2016) is that a culture of fear and risk underpins the practice environment, shaping knowledge, permeating the everyday norms and practices within the sector; and manifesting itself in the ways that relationships between social care workers and service users are constructed, experienced and lived out.

Discourses around 'risk' and a 'risk society' create the context in which fear emerges. Emotional responses to 'risk' and living in a 'risk society', it is argued, are designed to minimise and negate risks (perceived or real). Douglas notes that risk provides a powerful '*forensic resource [...] a language with which to hold persons accountable*' (Douglas 1999: 22), making it difficult for workers to work in risk-enabling ways due to fear of blame or liability (Ellis 2014) and in turn being held personally accountable (Furedi 2006; Gharabaghi & Phelan 2011). This can result in social care workers feeling fear in their daily experiences of practice (Smith 2009; Howard 2012). These fears can contribute to a climate where '*not taking risks is positively advocated*' (Furedi 2006: 71) and where risk-taking becomes viewed as irresponsible behaviour and accidents the result of risk management failings. Consequently, risk is understood as a form of governmentality that undermines traditional practices of relationship-building (Furedi 2006).

Arguably social care workers' responses to risk can be underpinned by anxiety and fear. The consequence of these fears and anxiety are manifested in relationships between social care workers and service users, where the main focus is often primarily on self-protection as the prelude for any professional interactions. In other words, staff and organisations have come to take their own safety as the starting point for 'professional' interactions (Steckley & Smith 2011: 84). It could be argued that this orientation has shifted relationship-based practice into a subsidiary of safe practice. In the context of daily professional practice where the relational aspects of the child-adult relationship, for example touch (Soldevila *et al.* 2013), have become the subject of regulation, constraint or have resulted in worker avoidance for fear of an allegation or complaint regarding improper, inappropriate and/or over-familiar contact. Steckley (2012) refers to these as the 'damaging cultures of "no touch"'.

There has, and continues to be, much commentary in the literature on the impact of these regulatory and prescriptive procedures on professionals' practice and the associated high levels of anxiety (Littlechild 2008; Brown 2016). Although the need to protect service users through improved regulation and inspection is viewed as a positive development, my research found that social care workers

ability to develop and maintain relationships was constrained by bureaucratic requirements and the regulation of the relational space between workers and service users. Similar to recent criticisms in the literature (Smith 2009; Munro 2011; Howard 2012) reveal that regulatory responses were often in conflict with social care workers' professional values and views on relational engagement. In some sectors of social care practice, relationships are now conceptualised in a way that is for utilitarian purposes of compliance (Murphy *et al.* 2013). This is where we can see the dynamics of the relationship between the social care worker and service user. In a national consultation with young people in care, 'Listen to Our Voices', one participant noted, *'after the social care worker played a role in me being arrested, it was difficult to understand the relationship, as the next day they would be nice to me'* (McEvoy & Smith 2011: 18).

Maintaining relational engagement while following procedure-led practice can frequently undermine and impact on established relationships of trust; in fact, procedure-led responses have often reinforced and contributed to the escalation of challenging behaviour. The focus on managing behaviour primarily through procedure-led responses with no space for professional discretion and professional judgement can hinder the development of positive relationships. Despite an increased awareness of the need for organisations to create a relational-oriented culture, criticism continues to be levelled at adherence to a bureaucratic culture with regularised systems taking precedent over relational-oriented practice.

Multi-disciplinary/Inter-agency Practice

The challenge and complexities of multi-disciplinary and inter-agency practice have been consistently highlighted in the literature (Ferguson & Kenny 1995; Horwath & Bishop 2001; McWilliams 2006; Duggan & Corrigan 2009). The complexities of multi-disciplinary practice are evident in the daily experiences of workers, impacting on the dynamics of the relationship between social care worker and service user. In addition, the relational dimensions of social care can often place heavy burdens on service users, who are required to navigate relationships with a number of professionals. Navigating these relationships can be challenging, particularly when they experience poor inter-agency and multi-disciplinary practice. An example of poor inter-agency communication was noted in Buckley's (2009) research: service users stated how they had to give the same information over and over again to different professionals whom they

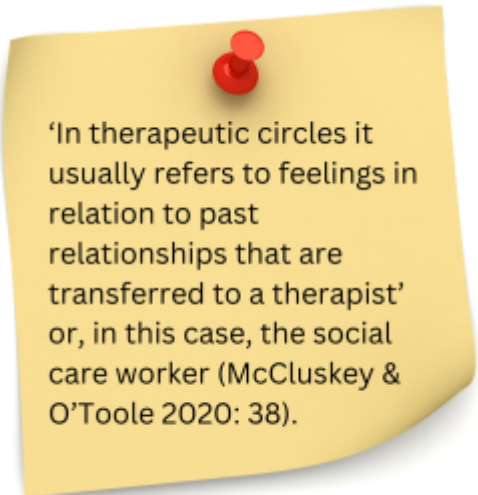
considered should be more connected to one another (Buckley 2009). Arguably, these kinds of experiences add further to the challenges service users are endeavouring to deal with.

Organisation structures in social care reflect an established hierarchy which is reflected in the way decisions are made. A number of social care workers feel their role and contribution are judged as lower in the hierarchy, and not sufficiently recognised and acknowledged in inter-agency working relationships (Brown 2016). The lack of shared responsibility is exacerbated by what Buckley (2003) calls the 'exaggeration of hierarchy'. This refers to the privileged position afforded to the views of higher professionals such as psychologists over those of the workers who are in closest contact with children and families. The notion of the 'closer to the child, the further from the decision' was reiterated in the Brown (2016) study. Despite the regulations and official ideology emphasising the importance of professionals working together in meeting the needs service users, for some workers it is experienced as a discourse rather than a practice (Houte *et al.* 2013). It is argued that effective collaboration will only be achieved if efforts are made to articulate challenges, both long-standing and current. It is further argued that these challenges, if left unspoken, will continue to manifest in professional relationships and in the dynamics of relationship between service user and social care worker.

The poor quality of multi-disciplinary practice, or its failure to occur at all, has been identified in every inquiry report to date. Buckley (2009) highlighted that failings within multi-disciplinary practice reflect the dynamics between professionals and the tensions between and within agencies. She posits that these issues will not be solved with regulatory measures; they need to be addressed by supervision and capacity building within a supportive framework (Buckley 2009). With the reconfiguration of services, efforts have been made to promote multi-disciplinary practice with the establishment of collaborative structures and systems. However, as advised by Horwath and Morrison (2007), collaborative structures do not necessarily guarantee the realisation of collaborative activity; it is the informal relationships that are pivotal in inter-agency work, but they need to be supported by more formal linkages and acknowledged as an essential component of inter-agency practice.

Transference and Counter-transference

'From a relationship-based perspective identifying conscious and unconscious constraints on practice responses is vital' (Ruch 2009: 358).



'In therapeutic circles it usually refers to feelings in relation to past relationships that are transferred to a therapist' or, in this case, the social care worker (McCluskey & O'Toole 2020: 38).

This proficiency centres on the dynamics of relationship practice, focusing specifically on transference and counter-transference, terms associated with a psychodynamic perspective (McCluskey & O'Toole 2020). Transference and counter-transference are based on the tenet that an unconscious previous experience can influence the dynamics of the relationship process. Transference is a dynamic that happens in the relationship between service user and

social care worker. Transference is when the service user unconsciously transfers feelings from another person/experience onto the social care worker. It is considered a form of projection, e.g., a previous negative experience of male relationship being transferred by a service user into the relationship with their male social care worker. Ruch (2012: 63) states that transference occurs when someone treats another person as if they were a significant figure from their past and behaves towards them as if they were that other person.

Counter-transference

'[U]sually refers to the therapist's ability to note and make sense of emotions he or she is experiencing in the presence of the client and to consider these as important, if unconscious, communication from the client' (McCluskey & O'Toole 2020: 38).

Counter-transference is described as the inner emotional reactions of a social care worker to the service user's transference. It can be a conscious or unconscious emotional reaction experienced by the social care worker. Counter-transference also refers to the social care worker independently transferring their own feelings to the service user. In our practice, we may encounter service users who have gone through similar experiences to us, for example the loss of

a parent at young age. This can evoke emotional reactions in the social care worker, leading to counter-transference in practice.

The social care worker's counter-transference reaction may manifest in certain types of behaviour, e.g., feelings of sadness on days you are engaging with the service user, becoming tearful when you thinking about the service user's situation. The challenge for the social care worker is being effectively engaged with the service user in the moment, while also being sufficiently detached to identify what is happening in the transference or counter-transference as it emerges. This dynamic can often be difficult to understand and manage and social care workers can, in turn, find themselves reacting unconsciously.

In teaching students about transference and counter-transference, van Breda and Feller (2014: 470-1) utilised Sedgwick's (2013: 108) idea of 'cup hooks' through the following analogy.

THE CUP HOOKS – EXPLAINING TRANSFERENCE AND COUNTER-TRANSFERENCE

Imagine that you have cup hooks sticking out of your body. Lots of cup hooks. Each hook is something about who you are and what you have experienced. There are hooks for your gender, race, weight, education and town of origin. There are hooks for your experience of growing up as a lonely child, there are hooks for your views about your body image.

As you practise the service user is constantly throwing out little lassoes – strings with a loop at the end. The service user throws them your way the whole time, unconsciously of course, their string is going to hook onto one of your hooks. When that happens, the service user ropes you in, establishing a connection, a relationship.

Not only you, but the service user has hooks for all their characteristics and experiences. And you yourself are also throwing out strings and making connections. The relationship involves these unconscious connections, tapping into service users' vulnerabilities and strengths. This is termed transference and counter-transference.

First Voice

Consider this Quote:

'Any developed theory of what counts for good practice should at least start with the hard-earned wisdom of its practitioners' (Sinclair & Gibbs 1998: 115).

A key question is how we get beyond this to a position where the dynamics of the social care relationship are explored and understood at both micro and macro level. While the relationship has been broadly discussed in the literature, there is a need for further discussion on the dynamics of relationships; in a knowledge vacuum, relationships are considered a 'largely empty word' (Smith *et al.* 2013: 12). Arguably, because relationships do not sit neatly in an evidence-based intervention, and neither can they be scientifically measured, this could explain the lack of critical analysis on the conceptualisation and dynamics and reflect a view that relationships between workers and service users evolve organically. In conceptual and policy terms, positive relationships are recognised and valued; however, a current critical understanding is largely absent. Weick's (2000) advice to social workers to avoid using their dominant professional voice and instead use their first voice, is relevant to the social care relationship. Within the social care field, excellent practice is not hard to find (Flynn 2020), but we

need to make this visible. We need to continue to work in solidarity with service users, and distance ourselves from the 'them and us' attitude.

Furthermore, qualities and skills that make up relationship-based practice often remain invisible for fear of being negatively labelled as 'over involved' or 'unprofessional'. It is this lack of fundamental recognition for all the elements that make up relationship-based practice (that is, use of personality in acts of individual and spontaneous kindness, humour; use of body through touching, hugging, comforting; and use of self as a social subject in the exercise of individual judgement, for example) that needs to be challenged and changed. In using our 'first voice', as workers we may move away from feelings of alienation and gain visibility and recognition in the wider context of practice. (Lack of visibility was particularly noticeable during COVID-19, with little acknowledgment in the media regarding the social care profession working at the coalface during the pandemic).

Part of the responsibility of social care workers in asserting their voice is not only to assert their experiences and views regarding best practice, but also to use their voice to challenge and change society's perceptions of service users. We need to highlight that many of the challenges service users experience have origins in inadequate systems of support, e.g. education, housing. Inequality can manifest itself in different forms and impact a myriad of fields, such as employment, housing discrimination, education. For many service users whose trust has been abused in the past, either by a neglectful family or by a system that has failed to take their needs and wishes into account, 'relationships are not easily constructed' (Millham *et al.* 1986: 118). Past experiences of relationships often influence how we engage in current relationships (Cashmore 2002). These factors shape and influence the dynamics of the social care relationship.

There is one serious omission in the writings and reports on service users, despite the adversities they have experienced in their lives; they have an inner strength and sense of humour, which needs to be recognised in the literature. Professionals need to draw attention to their wisdom and resilience and policy makers need to learn from their lived experiences. Our recent Olympian champion Kellie Harrington's brother encapsulated this when he stated that the area his family live in, although considered disadvantaged, is 'one of the richest areas in the country because it is rich in support, camaraderie and community values'.

Going forward, it would be helpful if changes in the educational landscape could be effected to bring to the forefront, in training and teaching, themes such as 'use of self' and reflective practice, dynamics of transference and counter-transference within the wider ambit of relationship-based practice. A particular

practical example of this, and following on from Anglin's work (2015) on training, is to make workers aware of their own pain-based anxieties in order to be responsive rather than reactive. This will require course delivery that centres on tutorials and individual contact with the aim of increasing the level and quality of contact. Another way of enhancing training is through multi- disciplinary training, particularly on accredited courses. The training would require a strong focus on the '*emotional dimensions of practice*' (Munro 2011: 91), which is probably best achieved by a combination of tutorial input and professional practice input.

TASK 1

Read the Listen to Our Voices report (McEvoy & Smith 2011), available as a free PDF from <https://www.lenus.ie/handle/10147/139489?show=full.Q>. Consider how you would address young people's concerns with regard to relationship-based practice.

TASK 2

Read the Crisis, Concern and Complacency Report (Keogh & Byrne 2017), available as a free PDF from https://www.researchgate.net/publication/312211150_Crisis_Concern_and_Complacency_A_Report_on_the_Extent_Impact_and_Management_of_Workplace_Violence_experienced_by_Social_Care_WorkersQ. Reflect on the changes that have occurred as a result of the findings in the report.

TASK 3

Read Buckley et al., Service Users' Perceptions of the Irish Child Protection System: https://www.researchgate.net/publication/284722126_Service_User's_Perceptions_of_the_Irish_Child_Protection_SystemQ. In small groups, discuss how the service user's views and experiences impact on dynamics between social care worker and service user.

Support/Supervision

'The more we can create a space inside ourselves that has capacity to relate to where service users find themselves, the more effective we will be' (Simmonds 2018: 235).

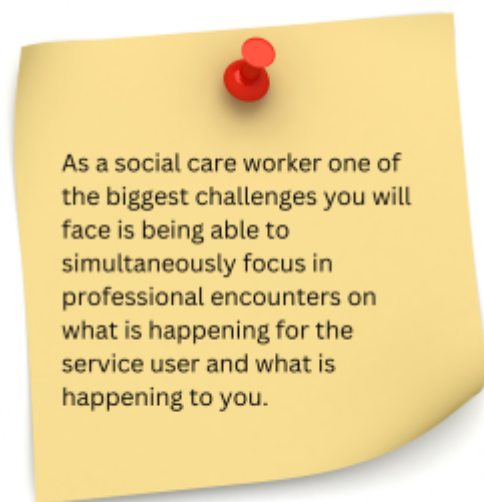
Working in systems governed by processes that are procedural, bureaucratic and have the tendency to enforcing regulations, emotional support for staff is identified as a prerequisite for the positive development of relationships (Trevithick 2014). The importance of social care workers being afforded reflective spaces and opportunities for reflective practice (Ruch 2007), in a supportive practice environment, cannot be over-emphasised. However, inadequate levels of support and supervision for front-line workers has been highlighted in every inquiry report to date. Within the context of supervision, in recent research by Keogh and Byrne (2016), social care workers articulated feeling a lack of emotional support, mainly from the wider organisation, with 'supervision ... never or only sometimes provided by management for the majority of social care workers' (2016: 75). This is particularly concerning because regular professional supervision for social care workers is a statutory standard inspected and monitored by the relevant authorities.

A theme emerging in the literature is that supervision appears to be become skewed towards policy and procedural imperatives, rather than towards reflection and professional development (Jones & Gallop 2003; Ruch 2007). Policies and guidelines clearly articulate the importance of regular supervision; however, there is a tendency in the literature to focus primarily on providing regular formal supervision. The relationship between workers' engagement at supervision in terms of their feelings of value is given insufficient attention. This can mean that unexplored fears and anxiety that can manifest in the day-to-day practice of relationships remain unexplored, thereby affecting the day-to-day effectiveness of relationship-based practice. It is argued that the emotional climate (Ward 2010) needs considerable attention to enable workers to process feelings (Sharpe 2008), understand the dynamics of transference and counter-transference and embrace the emotional elements of practice (Trevithick 2014). We need to create a practice environment that is characterised by respect, safety, trust and openness, which we can mirror in our relationship with service users.

Reflections on Transference and Counter-transference in Practice

- Understanding how transference and counter-transference is manifested in the relationship can help the social care worker and service user engage appropriately with these dynamics.
- Transference and counter-transference, when understood, are windows to our inner worlds. It is important to support the service user in identifying when transference is happening and understand where it is coming from.
- Having shared experiences with a client may enhance one's ability to empathise with a client, for example if you have shared experience of losing a parent at a young age.
- Transferential responses need to be understood in their cultural context.
- There are many other ways to categorise and conceptualise transference.
- Transference and counter-transference can emerge in any relationship and may happen at any time in the relationship, from beginning to disengagement stage.

Conclusion



The pivotal argument in this chapter centres on recognising and addressing the contextual factors at the organisational levels (practice environment) that impact on the dynamics of the relationship between social care worker and service user. Social care's remarkable strength as a profession is our persistence and commitment to relationships in practice environments that can be challenging and complex. We need now to create openings and opportunities to ensure

that we are no longer at the periphery and contribute to a practice-based body of knowledge on the dynamics of the social care relationship.



Tips for Practice Educators

- Placement experience is usually students' first opportunity to experience relationships in practice. Students need to be encouraged to use their reflective diaries to record their feelings and views on relationships in their practice placement.
- Practice educators can observe the student engagement in relationships with service users and the staff team and use these observations as discussion points in supervision.
- Practice educators have a pivotal role in supporting the student by creating a safe space in supervision for the student to explore their vulnerabilities and supporting them in identifying tools to recognise and manage transference and counter-transference patterns.
- It is important to highlight that the student's supervisory experience can be a prototype of how relationships with service users should work.
- Fenton's (2015) SOS model of relationship-based self-care incorporates three forms of relationship that the students can explore and use as an agenda for supervision sessions. These are: relationship with Self; relationship with Others; relationship with the System.
- Practice educators can provide direction with regard to self-care practices students can adopt.
- How a social care worker can build a relationship with someone who does not one to engage is an area that warrants discussion. Involuntary service users and defensive relationships are a part of social care day to day practice. Support the student in acknowledging and understanding the presence of difficult emotions in the dynamics of hostile relationships.

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Chapter 71 – Padraig Ruane (D5SOP10)

Domain 5 Standard of Proficiency 10

Be able to identify, interpret, record and respond appropriately to patterns of behaviours displayed by service users in a variety of settings

KEY TERMS

Patterns of
behaviour
Identify
Interpr
et
Recor
d
Respond
appropriately

Social care is ... bringing it back to the person, remembering that they have the same rights as you and me. The person has dreams, desire and emotions like any human. In social care setting people are given many labels, e.g., a person with ... intellectual disability, Down syndrome, autism, mental health problems. These diagnoses are often necessary to ensure the person gets the support they require, but we must not forget that above all they are people. Social care is protecting the humanity of the people we work with.

Patterns of Behaviour

In the area of social care, in particular disability services, the term 'behaviour' is often associated with words such as 'challenging', 'concerning' and 'responsive'. Social care degrees offered by third-level institutions tend to have a module on 'challenging behaviour'. Multi-disciplinary teams often include a behavioural support specialist. Organisations such as Studio 3 and the Callan Institute provide training on managing challenging behaviour, multi-element behaviour support or positive behaviour supports. If you look at the policy section on the National Federation of Voluntary Bodies website you will come across a number of policies and guidance documents on the topic of behaviour, including

supporting people with challenging behaviour, guidelines on management of behaviour that challenges. The area of challenging behaviour is heavily researched, but it is worth noting that absent from a lot of the research is the voice of the person and their contributions in term of what they believe works and does not work. As social care workers, supporting people who have behaviours that challenge is a major part of our role. This chapter will focus on the intellectual disability setting.

TASK 1

When you read the phrase 'patterns of behaviour', what comes to mind? Is it negative or positive?

Historical Context

The literature offers numerous definitions of what 'challenging behaviour' means. A widely used definition by Emerson *et al.* (2011) describes challenging behaviour as:

'Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.'

In recent years, there has been a move away from using the term 'challenging behaviour'. Jeffrey Chan and colleagues, in their article 'Is it time to drop the term "challenging behaviour"?', argue that the term 'is associated with a crisis response approach to service delivery in which behaviours are assumed to be inherent in the people who exhibit them.' The most common alternatives are: behaviours of concern; responsive behaviours; behaviours that challenge. It is important to note that despite the move away from the term 'challenging behaviour', Emerson's definition is still widely accepted and can also be used for the alternative terms. The purpose of moving away from the term 'challenging behaviour' is to show that it is not inherent in the person or a diagnosis.

Challenging behaviour is not a diagnosis. It is important to note that 'challenging behaviour' is not a disorder that a person can be diagnosed with. When working in the area of social care you may hear phrases such as 'her challenging behaviour' or someone being described as 'having challenging behaviour'. This use of the pronouns and verbs implies that the issue is in the person. It is important to recognise that the behaviour is rather the result of an interaction between the person and their environment. Research has shown that there is higher incidence of 'behaviours that challenge' in people who communicate differently, have diagnosis of severe to profound intellectual disability, autism, mental health issues, visual impairment and hearing difficulties. This is often as a result of the setting or environment not being adapted to meet the person's needs.

Behaviour as Communication

Behaviours that challenge should be considered a means of communication. Read the following example:

Case Study 1

David is a young man with Down syndrome and he communicates differently. As part of his weekly schedule he goes for a walk in the local park on Tuesdays. Staff have noticed recently that David is reluctant to go on the walks. He has refused to put on his walking shoes. On occasion he becomes upset and has thrown his shoes, nearly hitting staff and fellow residents.

Take a moment to think about what David could be communicating with his behaviour.

Is he in pain? He could be communicating pain or discomfort. Are the walking shoes hurting him? Do they fit him properly?

Is the activity the problem? Is he communicating that he doesn't want to go on the walk? Perhaps he doesn't enjoy it? Perhaps the weather is getting colder?

Are the people he is going with a problem? Is he communicating that he doesn't want to go with the staff or residents? Does he refuse to put on his shoes every week or only with certain staff?

Is he communicating his frustration at a lack of choice? Does David want to go on the walk? Often exercise is recommended for people by their GP and a schedule is developed without the person being involved. Is there something else he would rather do?

Is David aware of the schedule? Does he know that he is due to go for a walk? Oftentimes someone's weekly schedule is placed in the personal file. Would David benefit from having a visual timetable? Do certain staff have a better way of communicating with David in advance?

As you can see, a simple behaviour such as a person refusing to put on his shoes

can be communicating a number of things. It takes keen observation skills and high level of awareness from the social care worker to identify and interpret the behaviours. This brings me on to the fact that behaviour that challenges can be subjective.

It is important to note that when a person communicates differently it is often the case that decisions are made on their behalf without proper involvement of the person. There can be a belief that a person would not understand and cannot make decisions. In line with the principles of the Assisted Decision-Making Act 2015, there should be the presumption of capacity. Information should be provided to the person in an accessible way and they should be supported to communicate their will and preference using any communication method required.

Staff Interpretation

Take the case study example. Imagine that there are two social care workers supporting David that day. They both witness the incident. Each social care worker may come away with different interpretations. Social care worker A may see the behaviour as a refusal to engage in the walk and that David has responded inappropriately. Worker A may suggest developing a support plan to help David engage in the activity. Social care worker B may feel that David's refusal to put on his shoes is a method of communication, and they may suggest developing a support plan to explore what is being communicated.

If the shoes were causing David pain, refusing to put them on would be an appropriate response and would show a level of insight. This behaviour is actually quite adaptive and functional from David's perspective. The reason the behaviour is challenging is because the service is not adapting to his needs. The person may require communication supports, e.g., Lámh, PECS or communication devices. The service may need to review the staff roster, schedules, etc.

When we talk about behaviours that challenge it is important to ask, 'Who does the behaviour challenge?' Take the following example:

Case Study 2

Carol has moderate disability with mobility issues. She lives at home with her parents. Carol frequently wakes up during the night and will sometimes go for a walk around the house. Her mother is concerned that she is at risk of falling down the stairs and injuring herself. Carol waking up early in the morning is challenging for her parents as they have to get up with her. There is no doubt that the consequences of this behaviour are challenging to the parents, but with the correct supports the behaviour would not be deemed challenging. If Carol was living in a bungalow with night staff, her waking up during the night would not be an issue.

Context

The context and setting where a behaviour occurs can influence whether or not it is deemed challenging (Emerson and Einfeld 2011).

TASK 2

Think about the following situations. Think about what behaviours are acceptable and unacceptable in each.

- Visiting a library
- Watching football match
- Attending a music concert
- Attending a religious service

Notice that behaviour that is acceptable in one setting, such as shouting and cheering at a football match, is unacceptable in another, such as visiting a library. Think about the music concert: depending on the genre of music and venue there may be major differences in what is acceptable. The crowd behaviour at an open-air rock concert may be very different from a seated audience at an orchestral recital. The behaviour appropriate at a religion service will depend on the particular religion and culture.

Having an understanding of patterns of behaviour is important in the area of social care. The role of the social care worker is to identify, interpret, record and respond appropriately to the person's behaviours. That is what we will discuss next.

Identify

Identifying the Behaviour

The first thing you must do is identify the specific behaviour or behaviours. What is the person doing? Rather than simply saying the person is displaying 'behaviours that challenge', identify the actions. Are they shouting, scratching their arm, pushing a fellow resident?

As social care workers we must be aware that people can become labelled as displaying 'behaviours that challenge'. This can result in an attitude among staff of 'That's just how he behaves', or 'That's just what she does.' This can lead to staff becoming immune to behaviour, for example 'Julie always shouts, it doesn't mean anything', or interpreting all behaviours as challenging.

It is important to take time to identify the behaviour and not jump straight into interpreting every behaviour as 'behaviours that challenge'.

Identifying the Setting Event

A setting event is anything that increases the person's anxiety or decreases their ability to tolerate a situation. The setting event can be something that happened in the past or in the build-up to the behaviour, for example not getting enough sleep the night before, an incident in day service, the person feeling sick. A setting event can be a one-off event such as a cancelled visit with family or a build-up of events over time that can lead to an increase in anxiety. Setting events happen to everybody, whether or not they have an intellectual disability. The social care worker plays an important role in identifying the setting events. Through building a relationship with the person, the social care worker will develop a deep understanding of them. The social care worker will be able to identify setting events that the person may not be aware of. This is particularly important where a person communicates differently.

Identifying the Trigger

A trigger is an event that occurred immediately before the behaviour that

'caused' it. Being aware of potential triggers can be the first step in developing a support plan to reduce behaviour. Some common examples of triggers are:

- Being asked to do something or being told not to do something
- A noisy or busy environment
- A particular individual or activity
- Being bored.

The knowledge and insight the social care worker has of the person will allow them to identify triggers.

TASK 3

Imagine you have just started a new job in a residential service for people with intellectual disability. During your induction you are told that one of the residents, James, 'has challenging behaviour' without any details about what the behaviour is, what the setting event or triggers are. Think about how ill- prepared you would be to support James. In situations like this it is important to ask for further information: What are the specific behaviours, setting event and triggers?

Interpret

When behaviours that challenge happen it may seem like there is no obvious reason, but there always is a reason and the challenge for services is to work out what the purpose of the behaviour is. The Challenging Behaviour Foundation has developed the following table, which outlines four areas to consider.

Social Attention: We have all heard the saying, 'It's just attention-seeking behaviour.' It isn't bad to want attention from others. However, for a variety of reasons (e.g., limited communication skills, boredom, or an inability to occupy themselves), some people may learn that behaving in a particular way is a reliable way of attracting others' attention, even if it is negative attention.

Tangibles: Here it is the desire for certain things (e.g., food, drink, objects or activities) which is providing the motivation for the behaviour. Again, it isn't bad to want these things. If you are hungry, it makes sense to try and get something to eat. If you see something in the shop that you like, it makes sense to try and get someone to buy it for you. However, it becomes a problem when the person learns to act inappropriately to get these things.

Escape: While some people like attention, others would prefer to be left alone. Rather than behave in a particular way to get people's attention, some people will behave in a way that helps them to avoid/escape situations or activities that they don't like, or don't find that rewarding.

Sensory: Sometimes behaviour is internally rewarding, or self-reinforcing, i.e., what is happening around the person (externally) is not as important as what is happening inside the person

Source: *Challenging Behaviour Foundation Information Sheet*
(www.challengingbehaviour.org.uk).

Record

Recording should be done in line with policy and best practice guidelines. (See Domain 3 Standard of Proficiency 2 for further information.) When recording an incident it is important to remember the following: be factual; describe specific behaviour (e.g., 'Colm bit his arm' rather than 'Colm engaged in challenging behaviour'); and note any setting events and triggers. It may take a long time to understand the reason behind a behaviour. Having accurate reports is vital in helping the service get a full picture of the behaviour. As a social care worker you may feel that it is a reflection of your skill as a professional if a person engages in behaviours that challenge when you are working with them. This may make you reluctant to report incidents. But it is important that you report all incidents; there are often multiple reasons for a person's behaviour, not solely their interaction with staff. If there is an area that you need to improve on, your manager and service should provide you with supervision, coaching and training to develop skills in this area.

Respond

A common method to support people with behaviours that challenge is by using positive behaviour support. It is an evidence-based approach with the primary aim of increasing the person's quality of life and the secondary benefit of decreasing the regularity and severity of their behaviours that challenge.

What is Positive Behaviour Support?

The key components of positive behaviour support are:

Person-centred	Inclusion of relevant
Support plans	Reduction in restr
Staff development	Environment ch

What does a Behaviour Support Plan Look Like?

Behaviour support plans include the following three areas:

- **Primary prevention:** This means putting in place supports to meet the person's unmet needs. Examples of such supports are making changes to the person's environment, improving communication, enhancing active engagement in meaningful activities.
- **Responding to early signs of behaviour:** This part of the behaviour support plan aims to find out what the person is communicating through their behaviour and provides a prompt for staff to respond effectively to the early behaviour before it escalates.
- **Reactive strategies:** How to effectively respond to the behaviour when it happens. The plan aims to ensure:
 - the safety of the person and others around them

- that the least restrictive practices are used
- that the person develops new skills and re-engages in positive behaviour and interactions as quickly as possible.

Social Care Worker Input into Multi-disciplinary Teams

It is common for behaviour support plans to be developed by a multi-disciplinary team (MDT). The social care worker has an important role here as they are the professional who knows the person best and witnesses first-hand the person's behaviours. The quality of the behavioural support plans developed by the MDT relies on the information they receive from social care workers working directly with person.

The success of the positive behaviour support approach is reliant on the skills and commitment of the social care workers implementing the plan. When it comes to reviewing the plan the social care worker plays an important role in providing feedback to the MDT team. The social care worker plays an important role in ensuring that the person is included in developing the plans as much as possible.



Tips for Practice Educators

- Move away from the term 'challenging behaviours' to 'behaviours that challenge', 'behaviours of concern', 'responsive behaviours'.
- The importance of behaviour as communication.
- Challenging behaviour is not a diagnosis.
- Importance of accurate recording. Having accurate reports is vital in helping the service get a full picture of the behaviour and developing supports.
- The important role social care workers play in MDTs as they work directly with the person, implement the plan and can give feedback on its effectiveness.
- There should be a focus on what students may see or experience. There should be an acknowledgement that they may be fearful initially, but seeing the behaviour as communication will help, and support will be provided.
- Supervision and promoting reflective practice is important.

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Chapter 72 – Denise Lyons (D5SOP11)

Domain 5 Standard of Proficiency 11

Be able to analyse activity and adapt environments to enhance participation and engagement in meaningful life experiences and positively influence the health, well-being and function of individuals, families, groups and communities in their everyday activities, roles and lives.

KEY TERMS

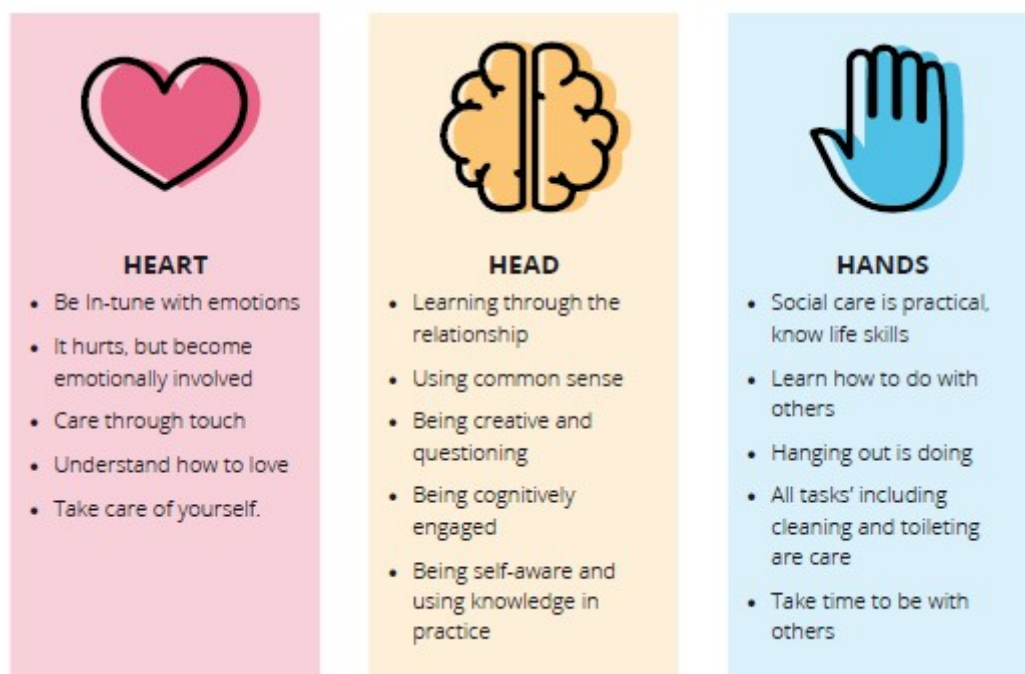
Heart, head and hands
Meaningful life experiences
Everyday activities
Participation and engagement
Environments and contexts of care

Social care is ... a relationship, a psychological space between people, where they can grow, have their needs met, can learn to trust, feel accepted and heard. It is a privilege to work with people, especially at a time in a person's life when they are defined by society as 'vulnerable'. It is our job to bring kindness and our humanity to our interactions with others, without judgement or bias. Social care is very challenging because of the daily demands to be both personal and professional, to reflect and be present and to bring love and kindness to the people we have the pleasure to encounter in our working lives.

Social care practice has developed from individual service provision to organisations providing care and support for families, groups and communities. This standard of proficiency highlights the core of social care practice; that workers can focus their practice and adapt the environment to promote a person's participation in meaningful moments and experiences. Creating environments that enhance participation and engagement requires us to adopt a holistic approach, which I have framed in a model for social care work entitled 'Heart, Head and Hands'. This model is based on the findings from my PhD research (Lyons 2017) illustrated below, which uses Johann Heinrich Pestalozzi's famous trinity of 'head, heart and hands' (Brühlmeier 2010) and incorporates ideas of contemporary theorists from practice in Ireland, Scotland and Canada

(Doyle & Lalor 2009, 2013; Smith 2009, 2012; Garfat 2008; Garfat & Fulcher 2012; Digney & Smart 2014). The 'heart, head and hands' approach to social care practice presents the heart first, emphasising that all practice is contained within the relationship between the worker and the other (Lyons 2017). The 'heart' of the model outlines the values and attitudes needed to focus your practice on enhancing the service user's participation and engagement in meaningful life experiences. The 'head' denotes all the knowledge underpinning this proficiency, including the key themes of this chapter, meaningful life experiences, everyday activities, participation and engagement, and contexts of care. 'Hands' relates to the practical activities and interventions that, when performed with care and respect, can 'positively influence the health, well-being and function of individuals, families, groups and communities in their everyday activities, roles and lives' (SCWRB 2017: 9).

Heart, Head and Hands – These are the main themes that emerged from my PhD research (Lyons 2017) on what social care workers 'do with others' in a variety of Irish social care settings.



Author-Created Diagram: Title: Heart, Head, and Hands: Core Themes of Social Care Practice based on: Lyons (2017) PhD Research on Social Care Work in Irish Contexts

TASK 1

Read Chapter 6 ('Doing Small Things with Great Kindness', by John Digney and Max Smart) in Howard and Lyons' *Social Care: Learning from Practice*. Compare Figure 6.1 on page 64 of the book with the themes in the illustration above.

The 'hands', or doing stage, reflects how care is viewed as a verb, an action word, and what we do with others. These hands-on activities include day-to-day tasks, 'direct care tasks' (Fulcher & Ainsworth 2012), rituals of everyday life (Smith *et al.* 2013), and everything we do with people. They all involve one person engaging with another while they are doing things together and being with each other. We engage in activities, provide care and meet needs through the relationship (McHugh & Meenan 2009, 2013; Burton 2015). The relationship between a worker and service user is meaningful (Digney & Smart 2014), and trusting (Ruch *et al.* 2010; Howard & Lyons 2014). The relationship is the 'core' of practice that enhances the service user's daily life experiences, supporting their increased participation in the community and enhanced health and wellbeing (Kennefick 2006; Lyons 2009). We cannot support a service user to engage in meaningful experiences and purposeful activities without first getting to know them, through being in a relationship. Garfat theorised this experience of being in a relationship with others through the terms 'hanging out' (spending time doing 'normal' things together), 'hanging in' and 'counselling on the go' (Garfat & Fulcher 2012).



Author created diagram that presents three core relational practices in social care—Hanging Out, Counseling on the Go, and Hanging In—which reflect the everyday, relational, and often informal ways social care workers build trust, offer support, and stay present with service users over time.

Through hanging in, hanging out and counselling on the go, social care workers learn the likes, dislikes and needs of the service user, in order to communicate, advocate and engage. Using the relationship in this way enables workers to act as a bridge between the service user, other professionals and the community, where social care workers can effectively advocate and communicate these needs. The relationship is what makes social care work distinctive; it is the most important learning space for practice. As discussed, engaging in activity with services users also includes daily tasks that can enhance their overall health and wellbeing, which includes physical and intimate care tasks.

Physical and Intimate Care Tasks for Health and Wellbeing

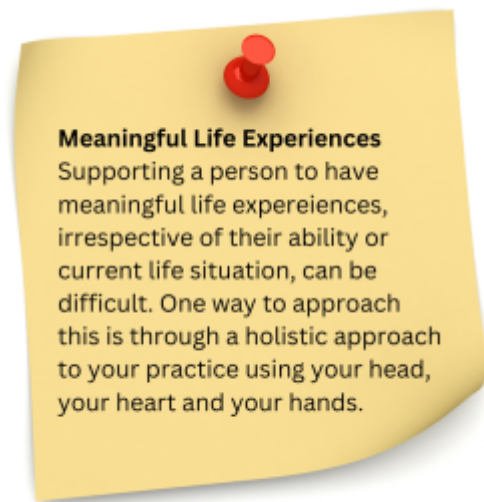
Social care workers engage in caring for the physical and intimate needs of others (Carnaby & Cambridge 2005), thus promoting and supporting the health and wellbeing of service users. This can include the manual handling tasks of lifting, using hoists, pushing wheelchairs, and moving furniture and aids. Many students find providing for the physical and intimate care needs of service users difficult, and this is viewed as one of the main deterrents to taking up a career

in the disability sector. Personal care tasks include shaving, skin care or applying external medication, hair care, help with feeding, teeth care, undressing and dressing, applying makeup and deodorant, and prompting to go to the toilet or bathroom (Twigg 2000). Intimate care duties, by virtue of the title, are more personal and include dressing and undressing (underwear), helping someone use the toilet, changing soiled incontinence pads, bathing and showering, washing intimate body parts, menstrual care, administering enemas, and administering rectal medication (Carnaby & Cambridge 2006). When providing intimate care, it is essential that the space is adapted to ensure that a person's dignity is protected (Twigg 2000). In all care duties, the social care worker is trying to ensure that intimate experiences feel respectful and private and are performed with dignity. There may be opportunities to provide meaningful moments while brushing someone's hair or while patiently supporting an individual to select what they want to wear that day. As social care workers, we use daily events within our planned practice to enhance a person's involvement in experiences that are beneficial and meaningful to them.

TASK 2

Describe a recent experience that was meaningful for you in your life. Why was this experience important?

Meaningful Life Experiences



Activities can provide opportunities to enhance the relationship and create meaningful moments within day-to-day shared life events. Having a meaningful experience is tied to having a sense of purpose, feeling productive and needed, having a satisfying social network, and a sense of belonging within close reciprocated relationships. We use the head when we are actively involved in the work of social care and facilitate meaning-making through mutual

engagement and doing things together within the relationship. This is purposeful practice, based on an integration of the theories that underpin the work and experiences that inform and shape it. When we have a relationship with another person, we work from the heart, showing care and kindness, unconditional positive regard and empathy.

Everyday Activities

Getting to know a person enables you to learn about their likes and dislikes, what activities they enjoy, who they like to spend time with and what experiences are meaningful for them. Engaging in different activities can play a significant role in relationship development and the creation of meaningful moments. Social care is viewed as a hands-on role, where workers 'do' with others, though being together (Digney & Smart 2014).

Participation and Engagement

Like us, the people in our care are social beings who need to be provided with opportunities for fully participating and having a meaningful engagement with the world around them. One place to start is within the local community.

Walking is an important activity for community engagement and social learning, where people can get to know others external to the service and find out what local services are available to them. Walking in the local neighbourhood is part of travel training for people with a disability, and in the HSE's *New Directions* report is viewed as one of the ways to achieve community engagement (HSE 2012). Getting out in the community emerged within the ethos of the normalisation of public and private spaces for the care of people, thus helping to recreate the space from the institution to the home. Social care workers do not always need to look beyond the service to promote participation and engagement; the service itself or 'context of care', with imagination and in collaboration with the service user, can also facilitate meaningful moments. The office can be viewed as a 'staff only' space, which can give the impression of spaces in a person's home that the service users are not permitted to enter. It is important to maintain a balance between the confidential storage of important information and the office documents and some space for the residents to sit and chat.

Adapting Environments – Creating a Home

Practice settings are the places and spaces that service users and workers inhabit which are flexible and adapted to meet diverse needs and practices. The question of 'where social care work happens' is complicated, as it includes the physical building or social care service and relevant social care spaces, which can include, but are not exclusive to, the kitchen, the office, the car, the coffee shop, the bathroom. Social care services are either a residential or day service, which is adapted to become an activity centre, a place for work and/or activity, treatment, care and love, and a person's home (Byrne 2016). Specific spaces are also purposefully used and adapted to enhance the service user's feeling of belonging and active participation.

TASK 3

This is the bedroom window sill in a residential home for adults. Who lives here? Why did you come to that conclusion?



*Author created
still-life drawing by
Denise Lyons.*

As well as being a practical base for the provision of care, spaces within the service can also evoke feelings of being welcome, or feeling at home. The service is the physical representation of how practice is influenced by policy, and valued by society.

Creating a Home: Social care workers often adapt a room or house as a space where meaningful life experiences happen on a daily basis in a place that is personalised, lived in and loved. Trying to recreate the experience of home in an unnatural setting is a difficult task, especially as there is limited scope within practice to discuss the meaning of home for both workers and service users. The idea of creating a homely space for people to live has become a national

standard in all government publications on residential care since 2004: 'it should be as much like an ordinary family home as possible' (DoHC 2004: 31). Cooper (1974: 131) described 'home' as a personal space where we have control over the 'few intimates that we invite into this, our house', especially the people we live with. In reality, service users have limited control over the people invited to live, to visit, or work, in the space (HSE 2011). The appropriate placement of residents together in the one house is paramount, as it can be very destructive to a resident's placement if they do not get along with the other residents (Reynolds 2014). Having your own bedroom in the house can also increase the sense of home. The physical house is also viewed as an expression of self: 'we project something of ourselves onto its physical fabric' (Cooper 1974: 131). The expression of self is manifest in the material culture of the space including furniture, the way it is placed around the room, the selection of photographs and images hung on the walls (Woodward 2007). In residential services, service users may have limited involvement in the purchasing and placement of furniture and personal items in the house other than in their own bedroom.



Author created pencil drawing of a house held by a rope in the air by Denise Lyons.

The desire to create a homely atmosphere is aided through rituals and social practices, for example making a cup of tea for people when they arrive at a day service or sharing a cup of coffee and a chat during the day in a residential house (Martin & Rogers 2004). Byrne (2016) discusses how staff used the cup of tea both as a way of engaging with the service users and also as a way of alleviating stress during the day; taking a break and having a cup of tea. This is most common for residential care staff who are not permitted to take a break away from the unit. Making tea is also a ritual between the staff members, where team meetings can evoke feelings of family and engagement, by starting with a cup of tea (Martin & Rogers 2004). Staff members can also feel more at home if the management creates a culture and atmosphere of

respect where individual opinions are heard (Martin & Rogers 2004), in the negotiation of practice (Wenger 2010). *(Drawing by Denise Lyons)*

The kitchen, the heart of most social care services, can become a space for meaningful connections and experiences. This room plays a central role in ordinary family life but also in the lives of service users and social care workers. As well as the place designated for eating, the kitchen is also the room where people gather to perform everyday activities and do one-to-one work. In the home, families eat around the kitchen table, and this practice is viewed as part of normalisation in service provision. The kitchen is also a space where gender roles are practised, learned and adopted (Byrne 2016). It is important for social care workers to examine what practices exist within their service to ensure that everyone has an equal opportunity to engage, when possible and appropriate, in the preparation of food.



Author owned photo: A monochrome image of a lived-in kitchen by Denise Lyons.

The kitchen is a place where service users can express personal choice by having some input and participation in the menu and the food that is prepared there. The kitchen table is also a place for communication and relationship development, providing a focal point for a relaxed and non-threatening discussion. As well as the place designated for eating, the kitchen is also the room where

people gather to perform activities, for example doing homework, playing board games and doing art. *(Photograph by Denise Lyons)*

The car: The car has become so necessary for social care work that many organisations list having a full driving licence as a prerequisite for employment (Ferguson 2009). The car can be an expression of care and humanity, through the act of collecting and bringing someone where they need to go (Miller 2001). As well as being used to bring people to their destination, for example to school or on an access visit, the car is also a space for purposeful relationship-based work. There are three factors that facilitate the role of the car for purposeful social care work.



Author created drawing: A drawing capturing a caregiver and child during a car journey. Drawing by Denise Lyons.

First, the reason for the journey (Ferguson 2009); second, being in the confined space of the car and moving between fixed spaces creates a pause in ordinary life; and finally, the arrangement of the car seats creates a physical space between the passengers, including the avoidance of direct eye-contact (Ferguson 2010). *(Drawing by Denise Lyons)*

Ross *et al.* (2009) explain how relationship-based social care work can become framed and bounded within the car. Sitting within the physical boundary of the car made young people feel safe, and this feeling encouraged them to share and have intimate 'car conversations' (Ferguson 2009). Ross *et al.* (2009: 612) described these 'car conversations' as free-flowing, 'offering a means through which young people could share past memories, associations, and future imaginings that the journey brought to mind'. The drawing above represents people engaged in a 'car conversation'. The worker is looking forward, and the lack of eye contact enables the young person to chat freely. The car can encourage the service user to leave the centre and get out into the community.

The community: Getting out and doing shared activities together outside is an important part of the shared experiences of social care work (Fulcher & Ainsworth 2012). Eating out in the community is an important social activity for people with an intellectual disability (Adolfsson *et al.* 2010). However, this activity may be limited based on multiple possible factors, for example: the unsuitability of the space for people with a disability; any behaviours of the service users that challenge; specific food allergies or requiring food liquidised or thickened (Adolfsson *et al.* 2010). Ross *et al.* (2009) mention the role of walking as an important activity for community engagement and social learning. Walking in the local neighbourhood is part of travel training for people with a disability, and is viewed a way of achieving community engagement (HSE 2012). Getting out in the community emerged within the ethos of the normalisation of public and private spaces for the care of people, from the institution to the home. Another way of getting out and about is through the use of the car, which, as we have seen, can also become a space for purposeful practice and meaningful experiences.

To understand social care is to acknowledge that the meaningful moments we achieve for individuals, groups and the community are shaped by the breadth, depth and complexity of practice. Of the many theoretical frameworks contained within this book, this chapter introduces the 'Heart, Head and Hands' model to capture an experience that is relational, emotional, caring, physical, and experienced within the physical environments or contexts of care.



Tips for Practice Educators

As discussed, meaningful moments can happen during the ordinary shared experiences between the service user and the student. Students need time with the service users to develop relationships and learn about the individual's or group members' likes and dislikes.

Beginning of placement: Where possible, give the student specific tasks in the commonly used rooms in your service, for example the kitchen. Loading and unloading the dishwasher enables the student to start casual conversations and observe service users' different drinks and food preferences. Encourage the student to invite service users for tea and a chat, when they can get to know each other better.

Middle of placement: This is the time for the student to introduce activities that will appeal to the service users and will offer them alternative experiences and opportunities. For ideas on creative activities, go to Chapter 75, but here are a few to get you started:

- a. Look at communal spaces – do they reflect the people living or working there? What about doing a photo collage of shared memories between the staff and the service users to hang on the wall?
- b. No place like home – show the service users and staff photographs of different rooms on Pinterest, and ask them to select the room that feels most like home. Look at simple ways you could use these ideas to make the communal spaces feel more like home to everyone who lives there.
- c. Create photo albums with individual service users of their likes and dislikes, meaningful people and places.
- d. Make individual 'memory maps' of all the local services that you can visit together. Make a space in the day for everyone to sit, drink tea and share their 'meaningful moment of the day' story.

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Chapter 73 – Paul Creaven (D5SOP12)

Domain 5 Standard of Proficiency 12

Demonstrate safe and effective implementation of a range of practical, technical and professional practice skills relating to the specific needs of the service user in a range of social care settings.

KEY TERMS
Professional
skills
Practical
skills
Technical
skills

Social care is ... an opportunity to support people and support them

TASK 1

List the professional, technical and practical skills that you think are the most important for a social care practitioner to have.

Professional Skills

Professional Skills	
Communication Adaptability Empathy	Initiative Team player Non-judgemental

Professional skills in any job or career are the skills that you, as an individual, bring to your practice. These skills include communication, adaptability, empathy, being non-judgemental, advocating, showing initiative, being a team player, self-care and self-reflection. While not explicitly presented as a module in some colleges, these skills are more evident to a student during college placement. If these skills were not obvious to the student on placement, this is where the responsibility of a supervisor comes in (Rochford 2007).

As well as exploring skills, this chapter introduces traits, which are more personal and involve the nature of the work. We are, as professionals within services, part of an individual's world, their life, goals and ambitions. The first professional skill this chapter focuses on is communication.

Communication

One of the most vital professional skills a social care worker can possess is the ability to communicate, whether with a service user, their support network, or when you are speaking on their behalf to your team. If a practitioner is not a good communicator, either a listener or speaker, the majority of other professional, practical and technical skills can become redundant. A good communicator in the field will be able to actively listen to a service user or group, adapt their own communication (tone of voice, how fast they speak, words they use to describe something) to suit the needs of a service user or group; they may even demonstrate negotiation skills (Shannon 1948). While the first two parts of this skill will be required every day in your role as a social care worker, the skill of negotiation will be required only every now and then; perhaps to convince a service user to come into a day service or even to support an individual in

residential care in getting out of bed in the morning. Communication is vital in supporting the service user in making informed decisions in their lives and it is central to our practice.

An example of adapting communication to suit the needs of a service user includes supporting an individual with difficulty in verbal communication. This may require having a pen or paper with you when talking to the individual, having pictures of general items, or even changing the environment you are in to suit their needs.

Empathy and being non-judgemental

Being able to communicate in a positive manner will enable a social care worker to develop empathy for a service user. Empathy is the ability to understand how someone feels (Statham 2007). With empathy, a practitioner in the field can support a service user through difficulties in their lives. In order for a social care worker to be able to develop empathy while supporting a service user, it is important to remain non-judgemental. There may be periods in our career when a service user's belief system or actions go against our own attitudes and values. It is extremely important that this is recognised by the practitioner; however, we must not let that cloud our own judgement while we provide support.

The difference between sympathy and empathy can be explained in the following example. If somebody is affected by an acquired brain injury, it may prevent them from working, driving or socialising. Showing sympathy is feeling sorry for the individual. Empathy is understanding the hurt felt by the loss of independence, understanding the grief somebody may feel by not being able to drive their children to events any more or relying on people to bring them to appointments. Being non-judgemental could be understanding the individual and their hurt, responding appropriately if there is a change of personality or decision-making due to the acquired brain injury, rather than directly pointing out the inappropriate behaviours that may be demonstrated. It is about separating our personal values and norms from our work and focusing on supporting the individual.

Advocacy, initiative and being a team player

With an understanding of how a service user (or group within a service) feels, a

social care worker can become an efficient advocate on their behalf if required. To advocate for someone is to support them with their needs within a service or externally within the community. To advocate for an individual or a group, a practitioner must first understand their need and how advocating can overcome it. The social care worker needs to ask questions such as to whom and how they should advocate (Inclusion Ireland 2020).

The most common example is supporting an individual in being accepted for Disability Allowance after an appeal. The process for the worker involves supporting the service user and their family; explaining what happened and the process that must now be followed; getting in contact with relevant external agencies; and even speaking on the day of the appeal. Group situations might involve supporting a group of service users in getting a bus stop closer to a day service or even advocating for a set-down area outside a day service. The impact these supports have on a service user (or their family) can be enormous. Quality of life, feeling safe and feeling listened to are just a few things that a service user may feel when someone listens and advocates for them.

It will quickly become apparent to a social care worker, no matter how much they use their own initiative while supporting a service user, that being able to engage in a team has a great impact on the quality of service a service user receives. Some of the work requires a multi-disciplinary approach, whether that is internally within a service or externally with social, community or medical agencies. When you work in a team, knowing who you are in it, the goal and responsibility you have for achieving that goal is vital.

A team working together within a service for the benefit of a service user might include the service user's key worker relaying information to other staff about the service user's person-centred plan or support plan. In a day service this may present itself in information being passed to other staff members. For example, the type of medication the service user is on or the risk assessment of a service user being updated and staff informed. A person-centred example is all staff members supporting a service user, not just the key worker involved in the service user's goals. Group facilitators and one-to-one support all support the service user in achieving their goals. Working productively in a team could open many opportunities to a service user that may not have been possible if they were only working with one social care worker. While we are working with the lives of vulnerable children or adults, we must acknowledge that we sometimes do not have the appropriate skill set or tools to support someone with a specific need. A multi-disciplinary approach to social care work enables the service user to access a variety of professionals, where appropriate; mental health (counselling, psychology), specialised rehabilitative support (speech and

language, occupational therapy), employment support (job coaches, guidance counsellors) and professionals to support physical health, from the doctor to the personal trainer.

Your role as a social care worker could be to sit down with specialists and the service user and then you all come together to create an action plan that allows the service user to make use of the skill set of external agencies. When advocating we are expressing the wishes of service users and supporting their right to choice. This is achieved by also ensuring that the service user is aware of and understands the information that they are receiving, whether oral or written.

Adaptability

As a social care worker, your role is about guidance, support and assistance. In a single day, a practitioner's role in one day could involve supporting the same individual with their personal needs, facilitating their workshop and then being the person they want to talk to because of the argument they had with a family member at the weekend. A social care worker may play a number of characters on the same day for the same person. Indirectly, you may also be speaking on behalf of a service user, receiving information on behalf of a service user or supporting a service user with referrals for health or welfare services.

A normal day for a social care worker may require them to change their approach with various individuals – service users, family members, other social care workers or professionals in other services. These changes could involve different uses of language or different types of support provided to a service user.

Self-care and self-reflection

TASK 1

List the things that you enjoy and that help you to switch off from work or college. What type of exercises do you do to help you self-reflect?

All the roles, attributes and styles that social care workers possess, however, mean that self-care is such an important skill. Without it, a social care worker

cannot protect themselves from the traumatic lives of service users. If they cannot support themselves, they will be unable to support a service user. Self-care for a practitioner involves being reflective, observing the worlds of service users, understanding if these worlds are going to impact on you personally and, most important of all, knowing your limits. Social care workers need to know when to switch off and, when they do clock off, to know how to look after themselves. It is a professional skill that can reap benefits for the practitioner, the service and, most important of all, the service user. It is an attribute that is personally and professionally an enormous asset to a social care worker, but it can be one of the most neglected. This is, ironically, due to our desire to help and support those who are entrusted to us as professionals in our own field.

Self-care from a work point of view is not being overworked and having appropriate supervision. Personally, it is all about what makes the social care worker step safely from the worlds of service users and into their own personal lives. It could be exercise, hobbies, keeping a journal or even having a check-in with a counsellor or supervisor external to work.

Practical Skills

Practical Skills	
Report writing IT skills Induction	Forma Know On t

Report writing, IT skills and induction

An organisation may have policies or procedures that then determine how they approach report writing, how service or goal plans are put together and how risk assessments are compiled.

Being IT efficient in a social care environment means being competent with emails, using applications such as Word and PowerPoint and whatever IT system an organisation uses to store service user information or statistics. This can even

extend to being an administrator for an organisation's website or social media accounts.

The service type may then determine if the ability to work in groups, one-to-one, in a training environment, in the community or within a home is appropriate. Is the goal of the service to support with community skills or independent living? Is it to support with developing vocational skills for work or rehabilitative skills to enable someone to cook and clean for themselves? The advantage of being able to describe what type of service an organisation provides is that it enables an organisation to state the type of professional they are looking for and to develop a training programme for staff that suits the service. For example, if a staff member is expected to run groups, training on workshops can be provided; residential staff may have training on supporting service users with taking their medication.

Formal training

Leading on from that, funders may have expectations about the type of formal training social care staff have when supporting service users within a service. Staff working on vocational programmes may need formal training in providing group training to service users. Formal training can also include manual handling, first aid, children first and safeguarding.

Knowledge of service users and being on the front line

Last but not least, the profile of service users who the service is geared towards must be taken into account. Then, a service needs to ask if it is the appropriate service for those needs and what skills are needed to ensure that a service user is safe. The practical skill set for physical needs may be support for eating, for personal needs such as toileting, or even something as simple as assisting someone to close their jacket. Knowledge on the service users profiled for a service is important. A service could, for example, be for individuals diagnosed with an acquired brain injury or an intellectual disability. A social care worker is not expected to be an expert on a diagnosis, but they should at the very least know how the symptoms of a diagnosis may have an impact on someone. Take an acquired brain injury, for example: a social care worker is not expected to know the brain like an expert in neurology; but they should at the very least

understand the possibility of memory difficulties and the affect on cognitive processing, and the impact such an injury can have personally on someone. A social care worker needs to have the skill of researching these impacts and how they might affect someone’s life.

The nature of social care and the services that are associated with the profession, being on the frontline can mean very different things to each individual social care worker. Within a vocational service it could mean providing support on IT or literacy skills. For a day service it might mean providing therapeutic groups and facilitating art groups, music groups and meditation groups. In a residential setting it could involve supporting a service user with personal skills such as washing, making breakfast and grocery shopping. For this author, while working in a training centre supporting individuals diagnosed with acquired brain injuries and strokes, front line meant supporting one-to-one in the community, facilitating brain injury education groups, maths groups and IT skills, and also facilitating walking soccer groups, mini tournaments for table tennis and even supporting an external facilitator for yoga. Supervising lunch breaks and providing support for personal needs can also be added to this list. It may be difficult to believe, but all this happened in one training centre for one staff member. This does not include the different responsibilities of other staff members.

Technical Skills

Technical Skills	
Risk assessment Positive risk assessment Support plan	Person-centred Service review Session notes

Technical skills involve putting professional and practical skills together, resulting in a service that is directly linked to a service user. Whether it is positive or negative depends on the ability of the social care worker. Technical skills include putting together an appropriate risk assessment, positive risk assessment, support plan, person-centred plan and service review, and compiling session notes. While a social care worker gets training in this from their service and is

aware of these concepts though academic learning, in practice it is now about the ability of the social care worker in using their own professional skills, the appropriate practical skills and tying them both together.

As mentioned at the start of this chapter, without being skilled in communication, it will be very hard for a social care worker to interact with a service user in a way that allows the successful implementation of these technical skills. Unfortunately, this skill set may at times involve the social care worker having to give a service user bad news. This could be due to a risk assessment or limited resources within a service or the community not allowing the completion of a goal in a person-centred plan; or having to record or write up session notes after a challenging incident with the service user.

While we do not like giving bad news to anybody, either personally or professionally, it is important that service users are informed, that they understand what is being said and that it is done in a non-judgmental environment.

Risk assessment

A risk assessment is about the social care worker assessing the needs of an individual or group, identifying the risks, understanding the severity of the risk and then identifying ways to reduce that risk. It must be understood that nobody expects a staff member to get rid of every possible risk – that would nearly stop a service from even happening! It is about figuring out risks, and preventing or minimising them. This applies as much to staff as it does to service users. It must be understood as well that it is not about stopping a service or activity. This is all about the skill the staff member has in creating a safe environment (as much as is reasonable) to allow something to proceed. For example, if there is a group activity out in the community for a day service and part of the plan is to walk to the activity, a risk assessment is completed for the group and individually. If there is a service user who has balance or co-ordination difficulties and issues with their peripheral vision, it does not automatically exclude them from the activity. A service can put a plan together that would allow that service user to have one-to-one support. The risk assessment would also look at the staff member/volunteer/student on placement supporting the individual by directing them away from the edge of a path on a main road or, if that is not possible, staying on the side that is most at risk of causing a fall/serious injury. Risk assessments need to be viewed as instruments that allow us to put in place procedures,

where possible, to allow an individual the same chance as everyone else, not as something that restricts the chances someone has to participate. It needs to be accepted, though, that occasionally a risk assessment will show that an activity cannot happen because the risk and likelihood of injury to the service user and/or staff members is too high.

Positive risk assessment

While the risk assessment takes a health and safety point of view, a positive risk assessment assesses the risks associated with the goals a service user may have and using the positives of that goal as a measure. This is a skill usually used when discussing goals with a service user's family members. They may be quite anxious about something going wrong with the goal. The aim of the social care worker is to ease those anxieties and prevent them having an impact on the service user. A perfect example of this is if a service user wanted to get gym membership or take part in an exercise group in the community. One of the most common fears family members have is that their son/ daughter/brother/ sister may get injured. The appropriate approach is to acknowledge that there is a chance that could happen but to point out that getting injured is the same for everybody who does this activity. The positive part of this assessment is to then point out the benefits, for example exercising, community participation and social interaction. The social care worker needs to show that the positives outweigh the negatives.

Support plan

Both these risk assessments will pull information from a support plan (which may have a different name, depending on the organisation). A support plan identifies the needs of the individual, which are then acted on to enable them to participate in a service. Again, this is not about the social care worker pointing out limitations to stop a service user participating in activities. It is about the social care worker putting things in place to make participation possible. This is part health and safety, part guide. The service user is also aware of the support plan. It is important that a key worker asks a service user what they feel should be on the support plan or let them know the reasons why something goes on it. A support plan may look at physical, mental, emotional, cognitive, living skills and

social needs. This all depends on the type of service. The support plan is vital, as it complements the person-centred plan that a service user has within a service.

Person-centred plan and service review

The person-centred plan (PCP) for a service user is the plan that directs an individual's service. A technically astute social care worker can support a service user in identifying goals they would like to achieve, ensure they are realistic for the service user, specify to the service user the steps involved in achieving the goal and support them in creating realistic deadlines for goals. A social care worker also needs to be able to come up with contingencies if steps need to be adjusted. One of the most important skills a social care worker can possess when supporting a service user, when putting together a PCP, is the ability to look long term at how goals can progress and benefit a service user. One example might be the benefits of upskilling on a computer. From a goal of being able to turn on a computer, a service user's PCP around technology could lead to using emails, online shopping, online learning and completing a part-time or full-time course. From those goals comes the added achievements of a new way to communicate, educational success, the opportunity to be part of a new community in a college, to potentially achieving a level of employment. A social care worker needs to be able to tie all this together while respecting the service user and the goals they would like to achieve. All of the above would then be transcribed into a service review: goals achieved; why certain goals were not achieved; and contingency plans that were put in place. This is completed, of course, with the input of the service review.

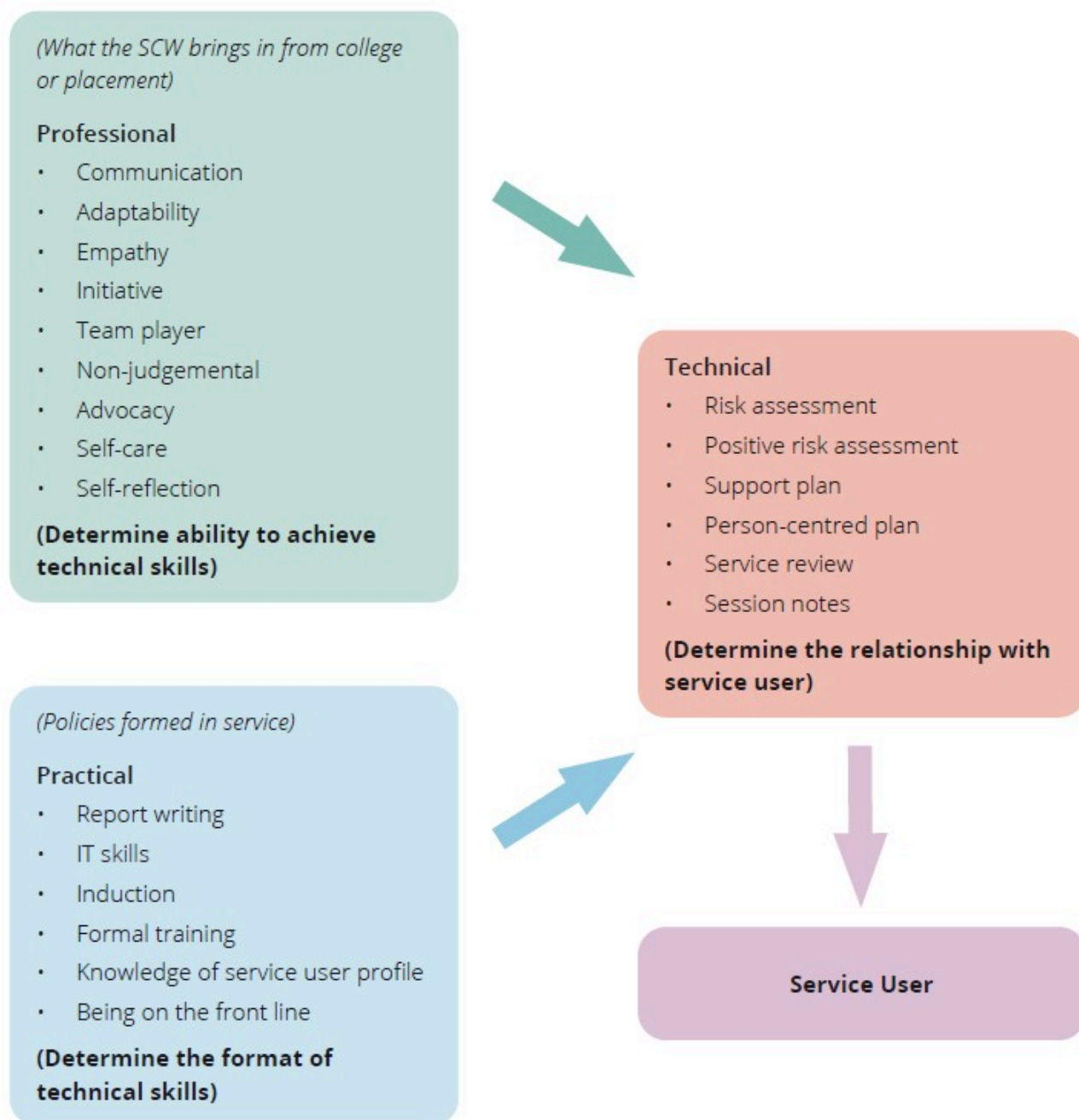
Session notes

Communication with the service user is transcribed into session notes. It is important for the social care worker to be objective but also empathic when writing session notes. While understanding the need to be factual, a social care worker must also make sure that they do not use personalised language or write their own views in session notes. A good exercise for a social care worker is to imagine that you are the individual the notes were being written about – how would you feel? Service users have a right to access their personal files, which include session notes. Session notes may also be required for legal reasons.

Good professional practice when writing session notes is to write objectively about the events of a meeting or session; notes should not read like the opinion of the social care worker. For example, writing in session notes that a service user cried when told something is appropriate; however, a social care worker cannot write that the service user got upset because the word 'upset' can mean any number of things.

Professional, Practical and Technical Skills Combined

Professional, Practical and Technical Skills in use



Author created diagram illustrates how social care workers integrate professional values, practical workplace knowledge, and technical skills to build meaningful, person-centred relationships with service users.

A blend of all three skills is required for the development of a service user's service in a social care setting. With that being said, communication is

paramount for all three to work together. This applies to how a social care worker communicates within the field and how they take in any interactions.

In order for a social care worker to stay focused, reflection and awareness are vital components in the social care toolkit. Without them, the skills a social care worker has acquired or naturally refined may become dull and in the long term possibly result in apathy and even burnout.

One of the most important things for a social care worker to realise is that there is no such thing as a perfect social care worker. This is not a criticism of professionals in the field, but an acknowledgement that social care is such a personalised field. There will be times we cannot bring our best selves to work, but it is how we respond that counts. We also need to understand that if we are working in a service that may have as many as fifty service users, we cannot be everything for everyone all the time, despite our best efforts.

Above all, we need to accept that the environment we work in can be quite fluid, due to policy changes, new research on best practice, and legislation. It is our ability to adapt to these changes while ensuring the safety and quality of service to service users that enables social care workers to support individuals, groups and their goals.

TASK 3

1. Make a list of professional, practical and technical skills that are your strengths and the type of impact they can have on a service user.
2. Make a list of professional, practical and technical skills that you feel you could improve on and how they could benefit you professionally.
3. What strengths do you have that have not been included in this list?



Tips for Practice Educators

The stand-out words in this proficiency are safe, effective, skills. It is not just about knowing what the skills are but whether a student already has them, needs to work on them or has the skills to investigate how to increase their knowledge.

Professional skills or knowledge of professional skills can be explored through personal development or self-reflection exercises. A student can be asked to explain or describe how they believe these skills can support them in being a competent social care worker and provide a safe

environment or atmosphere for service users. It is important that a student can not just list the strengths but also explain why they are strengths. While we point out their strengths, there is nothing wrong with asking a student where they feel they themselves can improve and how they can achieve that. As mentioned, self-reflection is something that a social care worker needs in their own toolkit. It will allow a student to self-analyse but allow them the opportunity to come up with solutions. In a way, it is their very own support plan when in the professional field.

From a practical point of view, before students become social care workers it would be a massive benefit to have some form of knowledge around the legislation that moulds the social care profession and also be aware of the areas of social care and the similarities and differences between them.

Exercises might involve:

- Giving students the legislation and asking how they feel it could impact their work and when it may become relevant.
- When looking at services, a great exercise would be to research services in the locality, ask to speak to staff and then compare and contrast with other students. Questions to ask would be: the role of a social care worker; the goals of the service; and how a service decides if the service is relevant to an individual.
- A simple exercise for a student to complete when considering the technical skills is to ask them to imagine being a service user in a service. What would they feel is important or relevant? This exercise could be completed in two stages: before a student goes on placement; and when placement has been completed. Compare and contrast the answers – what was different? The skills listed can be used as bullet points. What do they mean for the student? What do they think they mean for a service user? What type of communication is important to ensure a constructive outcome and positive relationship between the service user and the social care worker?

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Chapter 74 – Victoria Mc Donagh (D5SOP13)

Domain 5 Standard of Proficiency 13

Be able to integrate self-awareness, communication, working in partnership and professional judgement into professional practice to meet the need of the service user and empower them to meet their full potential.

KEYTERMS

Empowerment
Partnership
advocacy
Relationship
building
Self-awareness
Reflection
Professional
judgement
Supervision

Social care is ... about supporting people who need different supports at different stages of their lives. As a social care worker, I feel it is about being a guide to an individual who is the expert in their own lives, ensuring they are making informed choices and engaging in opportunities for their own wellbeing. As a service user once explained to me during our time together, 'You were the angel on my shoulder, helping me to guide my own life.'

Empowerment and Partnership in Social Care Work

In social care work there are many different settings and many different people a social care worker might work with. However, regardless of the setting or the service user in front of you, a social care worker should always work from a place of empowerment and partnership with the service user/s. Partnership and empowerment are two key concepts in social care, whatever setting you are working in. Partnership is about working *with* the person. Whether the service user is a child, an adult with a disability or an elderly adult, you work alongside that individual. The social care worker should be able to act as a guide and

facilitate individuals to make informed choices, being experts in their own lives and their own support needs. This is what working in partnership looks like in practice. In this instance the role of the social care worker is to listen and learn the story and journey of the service user/s. Then the social care worker works alongside them, provides support and encouragement to make positive decisions and choices in their own lives. Working from a partnership approach ensures that the service user is at the centre of the work.

This links with the concept of empowerment. In social care work we talk about the service user being the experts in their lives. When we work in partnership with them we can help them to achieve their goals and meet their individual needs. If as a social care worker we work from this perspective, this empowers the service user to be the leader in their story and situation. The social care worker is encouraging and trusting the service user to take control over their lives, promoting choice and decision-making. This is a powerful tool. Empowering someone can encourage that person to feel supported but also to continue on their journey. In particular, in social care work, when we talk about promoting and encouraging change, the best and most long-lasting change comes from within that individual person. This is empowerment. Empowering a person to make change to contribute to their lives in a positive manner can be the most important step in supporting a service user.

Consider This

In my early years of practice, fresh from my studies and working in the area of adults with a disability, a colleague explained to me that sometimes as staff and in the daily support needs of the service users, we can get busy and might want to hurry things along. That it could be quicker for us to make the service user a cup of tea instead of supporting them to make it for themselves. This colleague explained to me how this was the opposite of empowerment and partnership. That making this cup of tea could, for the service user, be the mountain they chose to climb; and what a difference it could make to them when they are supported to achieve this. While making a cup of tea for one person might be part of everyday living, almost second nature, to another person it could represent independence and progress. When I hear the words 'partnership' and 'encouragement', they still remind me of that time and how important those concepts are in social care work.

Self-Awareness and Communication in Social Care Work

As described above, the social care worker should be able to act as a guide and facilitate individuals to make informed choices, being experts in their own lives and their own support needs. This represents the concepts of partnership and empowerment in social care. How a social care worker works within this aspect of practice can be both rewarding and also present challenges in practice. Challenges may arise from the service user and their actions and behaviours; but it can also arise from the skills and abilities of the social care worker. A social care worker's self-awareness, communication skills and professional judgement are important elements here. Professional judgement is our education, training, knowledge and skills all used together in practice to make decisions and judgements about our work every day when working with service users. Therefore, it is extremely important for any social care worker to continuously work on their self-awareness and communication skills, to be able to work in partnership with service users, but to also to have an awareness of their own judgements, values and attitudes that could present as potential barriers to their practice.

I have worked with children from as young as three up to adults in their elderly years. While each individual had different needs at different stages of their lives, I always strived to work 'with' them. Working with the person includes working in partnership and putting them at the centre of their support and care. This approach also includes being able to adapt and put aside the time needed to build a relationship. Sometimes it may take longer, depending on the complexity of need and the situation of each person. However, I found when I took this approach that it helped to build a genuine and trusting relationship. Working in social care is also about creating this support as part of a team. How social care workers interact and communicate with each other can also impact upon their relationship and work with the service user/s.

TASK 1

Reflect on how two workers, for example, may communicate to one another in the presence of service users.

Is the language that both workers use appropriate, not only to the setting but to that particular service user?

Does this language reflect the needs of the service user but also respect and empower them?

Does the service user understand the language being used? Do the workers check in with them, using the service user's language of how they describe their needs and story?

This can be a powerful tool in social care work, when striving to build a relationship and empower a service user. For example, think about a service user sitting in a case conference about their support needs and care. Imagine if that individual did not understand what was being said about them and their disability because the language being used was not their language. That they do not understand, but they are too frightened to say otherwise. This is an isolating place for a service user, a disempowering place. A social care worker must check in with the service user that they understand, but also is their voice and view truly being heard and represented. This is working in partnership and working from a place of empowerment.

TASK 2

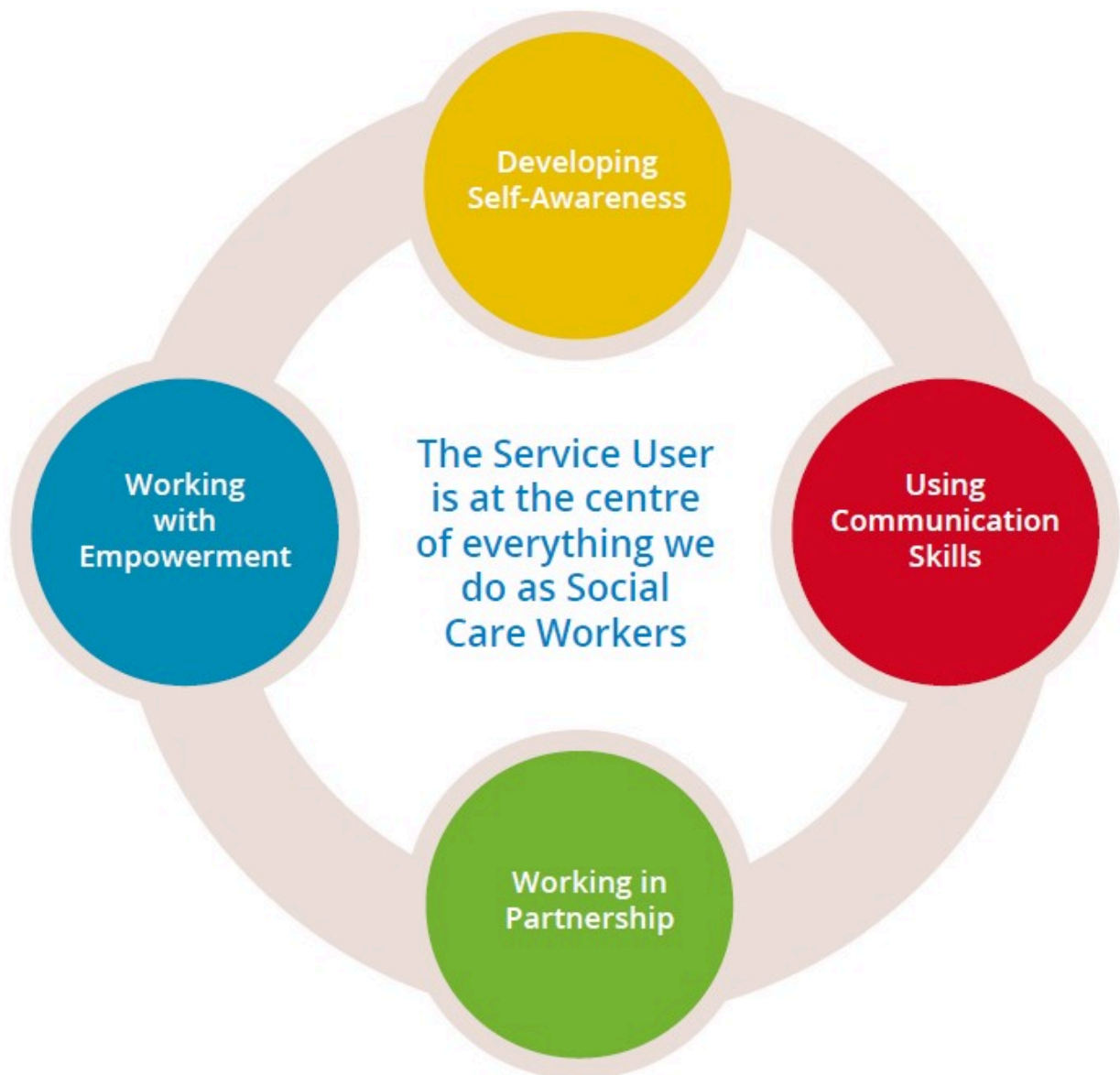
Think for a moment about your own communication style. Do you really listen?

Do you adapt your communication style when needed?

Developing skills such as self-awareness is not about being tough on yourself; it is about developing the ability to reflect on your practice. Examine your own values, beliefs and attitudes and their interaction with your practice. Being honest with yourself, do you let any of your own attitudes, values or beliefs get in the way in working with service users? How do you use these values, attitudes and beliefs in a positive way to enhance your practice? This is not about being a negative cheerleader for your work – it is the opposite. It is a healthy process in a safe and comfortable environment for social care workers to check in with themselves. Within the practice setting it may be about using formal supervision to engage in this process, or having an informal discussion with a colleague. Developing your own self-awareness is about seeking out a time and place where you can do this. Spending time developing your self-awareness will enhance your skills and abilities to work in partnership with and empower service users.

The concepts of partnership, empowerment, communication and self-awareness are connected with each other in social care work. It is important to

work on each of these in order to truly work with the service user/s and their support needs. This is represented in the diagram below.



Author created diagram that highlights the core pillars of professional social care practice: self-awareness, communication, partnership, and empowerment. All revolving around the central commitment to place the service user at the heart of every interaction and decision.

The Social Care Worker's Toolkit

It was once explained to me that social care workers carry with them their own toolkit, just as a mechanic would carry a toolkit. Our tools are the skills, abilities, values, attitudes and professional knowledge required for practice. Just

as a mechanic would look after their tools, social care workers need to do the same. Doing this not only contributes to good practice with service user/s, it also develops and maintains the wellbeing of the worker. When a social care worker is looking after themselves in this way, it heightens their self-awareness, develops their communication skills and makes a positive contribution to their role in a social care team (Sanderson & Lepkowsky 2014).

- What is in your toolkit? Can you identify some skills, knowledge, attitudes and values that you use in your own practice?
- Why are these particular tools important to you?
- How well do you care for your tools? How well do you look after your own wellbeing? Are there any areas you would like to improve upon?

This may also be used in supervision with a social care worker or student.

The social care worker's toolkit requires continual care. This is the work achieved through reflective practice, supervision and continued personal and professional development opportunities.

A Helpful Resource

This five-minute video looks at person-centred care in social care work and the impact of partnership and empowerment for service users:
<https://www.scie.org.uk/providing-care/personalised-and-person-centred-care/>

Summary

This particular proficiency examines how you work in partnership and empower those you work with in social care. It goes further, exploring what skills and abilities are required by a social care worker in order to achieve this. It explores the social care worker's sense of self-awareness, their communication skills and how they use their professional knowledge to achieve this. This proficiency is explored by looking at how social care workers can strive to work in partnership and empower service users to reach their full potential. All those you work with in social care have unique needs and lives and this must be at the centre of everything you do.



Tips for Practice Educators

This reflective activity may assist both placement supervisors and social care educators to explore this proficiency with students. Within the classroom it may be appropriate for students to explore these questions in small groups.

- Can you think of a time where you felt empowered?
- Can you reflect on how you felt and what thoughts you had at the time?
- What made you feel empowered? For example, was it something somebody said or someone's actions?
- Why does this feel important for you? Or why does this particular experience stand out?

This task can help to develop self-awareness and empathy for the social care worker/student. It can also be used in a supervision session, where appropriate.

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Image Credit: St Patrick's Mental Health Services. Available at <<https://www.stpatricks.ie>> [accessed 28 May 2020].

Chapter 75 – Teresa Brown and David Power (D5SOP14)

Domain 5 Standard of Proficiency 14

Be able to identify and understand the impact of social care history, organisational, community and societal structures, systems and culture on social care provision.

KEY TERMS

Institutionalisation and seclusion
Professionalisation and deinstitutionalisation
Secularisation, specialisation and accountability
Crisis and change

Social care is ... in its simplest form, supporting, protecting and helping vulnerable people to maximise their potential. However, social care is not simple. It is a journey of growth and learning. A way of providing resilience, but also being resilient. It is a way to promote change in people's lives. It encourages people to be real. It is caring and kind when things become difficult and teaches by example with patience, trust, care, self-love and courage. It is unconditional to the needs of others. It is holding the dreams and hopes of traumatised young people. Social care feels pain and understands the lasting hurt from childhood experiences, and from the past, both theirs and ours.

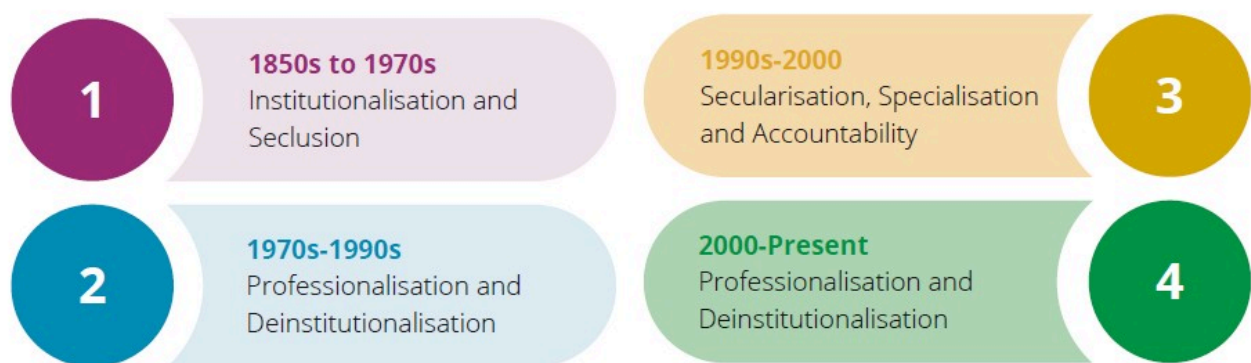
Introduction

A complex interplay of socio-political and economic factors has impacted on the wider context within which social care provision has emerged and has been shaped and delivered. At the current time, there is a concerted effort to professionalise, specialise and regulate the sector with the aim of improving outcomes for children, young people and families. Central to this reform is the need to *understand the impact of social care history, organisational, community and societal structures, systems and culture on social care provision*. There is no doubt that there is a tendency to distance ourselves from our history,

such was the scale of physical, sexual and emotional abuse suffered by children in institutions run by a range of religious orders which were funded and inspected by the Department of Education. However, as McGregor (2014) argues, we must move beyond feelings of shock and shame at the failings that have been exposed and learn from the problems of the past and from their specific contexts.

This chapter provides a brief history of the key developments in our social care history. While locating the discussion within this wider context, the primary focus will be on the history of care for children. Changing ideologies and discourses and their consequent positive and negative impacts on social care provision and policy are highlighted. The catalysts and constraints which have shaped social care provision will be discussed.

The emergence and development of residential childcare has been chronicled by Gilligan (2009) into three periods of development: institutionalisation and seclusion (1850s to 1970s); professionalisation and deinstitutionalisation (1970s to 1990s); and secularisation, specialisation and accountability (1990s-2000). To this, we have added a fourth category to denote developments from 2000 up to the present day. We have entitled this ‘crisis and change’, given the dominance of historical institutional abuse inquiries over this period, the challenges that have arisen and the changes that are emerging.



Author created timeline diagram that outlines the historical evolution of social care, tracing shifts from institutionalisation and seclusion toward a more professionalised, accountable, and person-centred approach—highlighting the ongoing journey of deinstitutionalisation and empowerment from the 1850s to the present.

Institutionalisation and Seclusion

The first phase, from the 1850s to the 1970s, demonstrates Ireland’s unique socio-

cultural composition. The development of policy was shaped by the influence of the Roman Catholic Church and the State remained at the periphery in all areas of residential care provision. Historical literature paints a picture of residential childcare as both positive and negative. On the one hand, thousands of destitute, orphaned and/or abandoned children received care, often for many years, and they were supported into adulthood (Barnes 1989). Thus residential child care played a pivotal role during a time of enormous hardship in Ireland.

On the other hand, writers also depict the geographical seclusion of these large institutions, isolated from the outside world, where contact with families was actively discouraged and, in some cases, prohibited (Barnes 1989). These practices were not criticised at the time because provision of residential childcare was underpinned by a 'rescue model' (Gilligan 1991) of childcare provision, where children were saved from unsavoury conditions. O'Sullivan (1979) depicts this model in his references to the Lord Chancellor's speech in 1870 where childcare provision is described as 'giving so many useful citizens to the State, so many immortal souls to heaven and rescuing thousands from lives of penury and sin who would have lived and died in crime and misery' (O'Sullivan 1979: 211).

Reformatory schools were established by statute in 1858 for young offenders over the age of 12, in order to end the practice of sending young people to jail. Subsequently, the need for a different type of institution to cater for young people in need of care, and who were not offenders, was recognised. Ten years later the institution of the industrial school, first established in Scotland, Wales and then England, was extended to Ireland in 1868 after Irish parliamentarians advocated for its introduction (Craig *et al.* 1998). Industrial schools were described as schools 'for the industrial training of children, in which children are lodged, clothed and fed, as well as taught' (Children's Act 1908, Section 44). Reformatory schools were defined in the same terms, but with the substitution of 'youthful offenders' for 'children' (Robins 1980). Despite being largely state-funded, these institutions were managed by religious orders (Raftery & O'Sullivan 1999), with the state adopting a subsidiary role in their management (Robins 1980), thereby allowing religious organisations to run the institutions without state interference.

The rescue model underpinned provision. It was informed by a social risk model of care, in which children were perceived as a social risk and a threat to society (O'Sullivan 1979) and the aim was therefore to mould males into hard-working working-class adults (Raftery & O'Sullivan 1999) and females into 'the living embodiment of Our Lady – humble, pious, celibate' (Inglis 1998: 248-9). Children were viewed as moral subjects, with the emphasis being on conformity

(Smith 2007). Consequently, industrial and reformatory school systems were harsh regimes. However, it was only years later that it was realised just how harsh and cruel they were. The Church-State relationship constructed what Smith (2007: 45) terms 'Ireland's architecture of containment', a term explained below. In addition to industrial and reformatory schools, there were other interdependent institutions, such as mother and baby homes and Magdalene laundries. Behind the walls of these institutions were members of society marginalised by a number of interrelated social phenomena including illegitimacy, incest and infanticide (Smith 2007).

In the mid-1850s, as an alternative to the state-owned, religious-managed facilities, voluntary organisations became involved in the provision of care for children. One such organisation was Mrs Smyly Homes. The founder of the organisation, Ellen Smyly, stated that in the 1850s it was nearly impossible to walk the streets of Dublin without being chased by children begging for pennies to buy food. Her first school opened in 1852 in Townsend Street. Smyly Homes began by providing education and accommodation for deprived children of Dublin, and it has maintained this value and approach to care.

TASK 1

Watch the YouTube clip 'Courageous Campaigner – a tribute to Christine Buckley'.



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://tus.pressbooks.pub/standardsofproficiencysocialcareworker/?p=368#oembed-1>

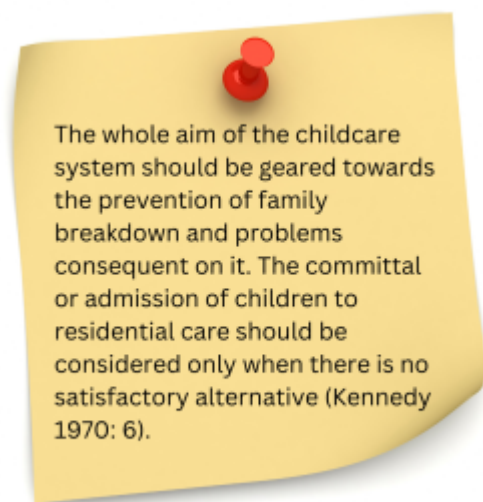
Professionalisation and Deinstitutionalisation 1970-1990s

In 1970, the Report of the Committee of Inquiry into Reformatory and Industrial Schools' Systems (which became known as the Kennedy Report) was published. It was generally viewed as a pivotal moment in childcare history. It set the course for the future development of childcare provision while also reflecting changes

that were already afoot under several broad themes: deinstitutionalisation; diversification; regulation and professionalisation of the workforce.

With regard to deinstitutionalisation, by the time the report was published in 1970, the residential childcare system had greatly declined. Between 1964 and 1969, fourteen industrial schools were closed at the request of the religious orders. The decrease in the number of children in residential care and the increase in the use of foster care reflected both international trends and particular features of Irish society; fewer people were entering religious orders, and state finance to support voluntary and Church-based providers of residential childcare had been reduced (Buckley *et al.* 1997).

Although the process of the closure of industrial schools had already begun, the Kennedy Report reiterated the necessity of this, with Justice Kennedy being 'appalled' by their 'Dickensian and deplorable state'.

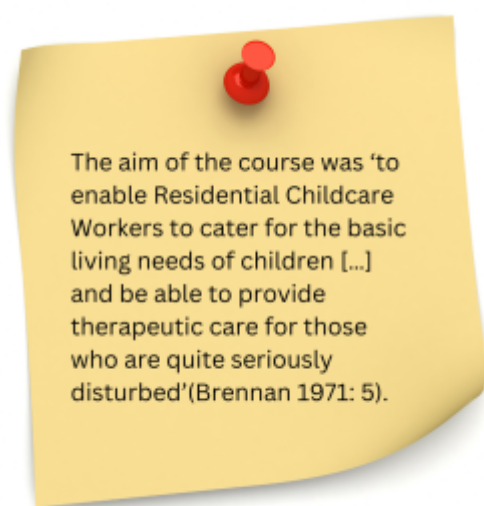


Reiterating the recommendation of the Tuairim Report (1966) that staff should be fully trained in the various aspects of childcare, the Kennedy Report (1970: 13-14) also stated that the provision of trained staff should take precedence over any other recommendation and highlighted that 'neither affection nor common sense is sufficient by themselves'. However, despite the positive support for the findings of the Kennedy Report, the Association of Workers with Children in Care expressed

some reservations that a group model of care 'could not provide for the majority now in need of care, the children with problems' (1974, cited in O'Sullivan 1979: 45).

After the publication of the Kennedy Report in 1970, there were major changes in both child policy and practice. Subsequent policies and reports reflected and reiterated the view that residential care should be used only when no satisfactory alternative was available. Social workers were given primary responsibility for supporting families in need and placing children into care. This move was reflected in the Boarding Out Regulations (1983) which formally required a Health Board to place a child in residential care only where it was not possible to place him/her in foster care. Arising from the Kennedy Report, it could be argued that the positioning of residential childcare as an intervention of last resort was sanctioned and reinforced. On the other hand, the residential childcare sector

continued to provide care for children and it was positively impacted by the growing emphasis placed on: understanding children's needs; the workforce; and delivering care in a context where roles, responsibilities and regulatory frameworks were clear. For example, in relation to conceptualising and understanding children's needs, the Kennedy Report depicted a shift in the discourse of the child. Smith (2007) highlights how these shifts in constructions of childhood were informed by scientifically informed conceptions of childhood, such as developmental psychology. A more positive view of childhood emerged during this era with developments depicting the recognition of a developmental model of care, replacing the 'social risk' model of childcare, whereby the child was seen as a potential threat to society rather than someone with needs and rights (O'Sullivan 1979).



With regard to the workforce, the infrastructure of the residential care system was radically changed, with religious orders retreating from provision as a result of shrinking recruitment and an ageing profile in their congregations (Barnes 1989; Gilligan 2009a). As a result of this decline, lay personnel were employed in residential care centres. The decision to recruit lay staff effectively introduced the discipline of social care childcare in Ireland. Residential childcare workers employed in industrial schools

were seen as purveyors of Church values and were expected to support the young people in their care to develop these values (Doyle & Gallagher 1996).

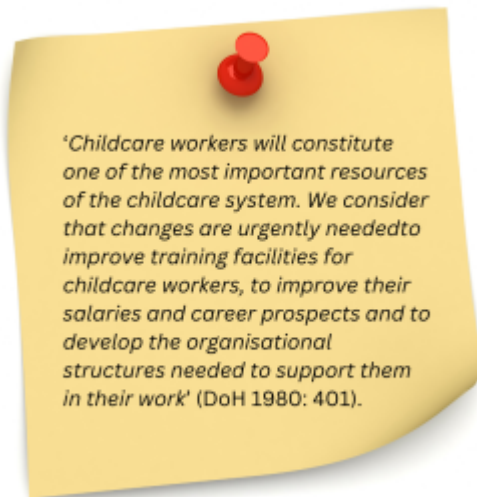
This strategy resulted in the continuation of an untrained workforce, as noted by the Kennedy Committee, which stated that there was 'a tendency to staff the schools in part at least, with those who were no longer required in other work rather than with those specially chosen for childcare work' (Kennedy 1970: 15). However, it is also within this context that positive moves towards professionalisation of the workforce also emerged. The first residential training course in childcare was initiated in 1971 in the School of Social Education, Kilkenny, signalling the start of the journey to professionalise residential childcare.

The significance of the move to professionalise the workforce, which gained further traction later, was that it signified an acknowledgement of the particular needs of children in residential childcare and challenged the view that children

need only to be '*lodged, clothed and fed as well as taught*' (Children's Act 1908, Section 44). 'House Parents' was a title ascribed to the residential worker (Joint Committee on Social Care Professionals 2002) to reflect 'normal' family structures.

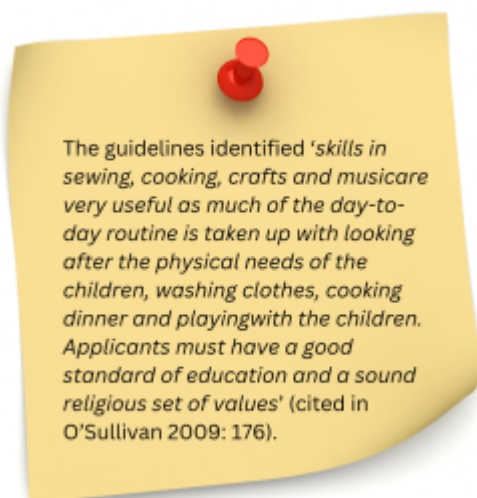
These positive outcomes of the Kennedy Report (1970) and reports from voluntary advocacy groups, including the Tuairim Report (1966), and *Children Deprived: The Memorandum on Deprived Children and Children's Services in Ireland* (CARE 1972) were indicative of the move of the state from a peripheral position to centre stage in the delivery and organisation of residential care provision. Although positive developments were being made, challenges were still evident; for example, residential care was managed by three separate government departments until 2007, and there were concerns regarding broader governance arrangements as no single department had overall authority over or responsibility for children in care.

A further positive change was the establishment of the Task Force on Childcare Services in 1974. A year later it submitted its Interim Report, the recommendations of which focused primarily on the provision of additional residential services for Travelling children, young children, residential facilities for boys and residential facilities for girls. One section of the report was dedicated to setting up on a pilot basis 'Neighbour Youth Projects' for children at risk. The common theme in the recommendations centred on residential services for young people who were described as 'severely disturbed' or young people 'too difficult or disruptive for existing facilities' (Task Force 1975: 9). In addition, identifying the training needs of residential childcare staff was considered a matter of urgency. Five years later the task force's final report was published, as was a minority report reflecting the alternative views of two of its members (O'Cinneide & O'Dalaigh 1980).



Despite this progress, many subsequent developments reinforced the pervading discourse of residential childcare as a 'last resort'. For example, the broader-based recommendations of the Task Force strongly favoured foster care and it emphasised the importance of prevention and community-based family services programmes. Furthermore, the report identified how this process could be achieved, suggesting that a specially trained worker could be instrumental in

enabling some deprived children to continue living at home (DoH 1980: 21). Hence, in the early 1990s, this recommendation afforded opportunities for many residential workers to be appointed on multi-disciplinary teams in statutory services as community childcare workers, a title still used today. The importance of supporting residential workers was a dominant theme in the report.



The Association of Workers with Children in Care, commenting in 1982 on the report's recommendations, stated that 'we plead loudly for our inclusion within a comprehensive plan' (O'Sullivan 2009: 403). (Interestingly, this theme of seeking inclusiveness in policy formation is echoed today by Social Care Ireland.) Workforce issues continued to dominate this period. In November 1979, for example, guidelines on the recruitment of childcare workers were issued by the Resident Managers' Association, the

Department of Health and the Department of Education.

TASK 2

While the history of the children's experiences is now on record, it must also be acknowledged that many carers had given great commitment, care, concern and warmth, mostly at great cost to themselves -unsupported, unacknowledged and in pretty impoverished conditions. There was

no thirty-nine hour week, no salary scales and always a dearth of staff, especially men (Pat Brennan Director of first training course for social care workers).

Q. Reflect on what it was like to be a social care worker at this time.

Secularisation, Specialisation and Accountability 1990-2000

Developments during this period are best understood in the context of changing ideological, political and economic factors. As indicated earlier in this chapter, the development of childcare services up to this point reflected the positive and increasing recognition of the needs and rights of children, the need for specialist provision and the requirement for service delivery to be underpinned by a trained workforce. However, this was coupled with ongoing concern about the quality of day-to-day service delivery. In the 1990s, with the growing influence of neo-liberalism, the effect on the residential childcare sector was an increased emphasis on accountability, managerialism and bureaucratisation. These developments ran concurrently with an increased emphasis on the rights of the child.

Turning first to the rights of the child, from the early 1990s recognition of the need for changes in policy and practice in relation to children gained impetus (Nolan & Farrell 1990). In 1992, Ireland ratified the UN Convention on the Rights of the Child (UNCRC), which provides a framework within which to develop and critique policies related to children. The conceptual paradigms of childhood were changing, with children's needs beginning to be constructed more within a discourse of rights (Smith 2007). Developments in our legal framework provided further evidence of changing attitudes towards children. The Childcare Act 1991 replaced the Children's Act 1908 after a gestation period of 25 years (Gilligan 1993), arguably indicative of society's complacent attitude towards the welfare of children.

Specific changes in the Act included: extending the legal definition of a 'child' from the age of 16 to the age of 18, thereby prolonging the period of childhood; the introduction of a range of new orders, such as the emergency care order, which authorised the removal of a child or the retention of a child in the custody of the Health Board for a maximum period of eight days. Furthermore, an interim care order was introduced, this being a new short-term provision which could be

made where an application for a care order was likely or pending. The care order committed a child to the care of a Health Board until their eighteenth birthday or for a shorter period. The Act also placed a statutory duty on Health Boards to provide family support, and set out the powers and duties of Health Boards with regard to children who were in their care. In addition, provisions under the Act required that consideration be given to the wishes of the child, having regard to the age and understanding of the child (Ferguson & Kenny 1995).

Monitoring compliance with the regulations was carried out by the Health Boards until 1999, at which time the Social Services Inspectorate (HIQA) was established on a statutory basis. The key area of change, as noted by Richardson (2005), following the passing of the Childcare Act 1991, was that there were increasing efforts to regulate and standardise procedures and practices in child welfare services.

Turning to neo-liberalism and the combined influence of discourses regarding accountability, managerialism and bureaucratisation, evidence of their hold on residential childcare provision can be seen in relation to the identification and management of risk (Webb 2006), with discussions 'dominated by emotions of fear, an undermining of trust and the wish to control' (Parton 2001: 69). This became evident in the broadening of the residential care landscape to meet the needs of young people considered 'at risk' or 'a risk'. Consistent with previous studies, the overall picture that emerges from much of the research (Focus Ireland 1996; Craig *et al.* 1998; during this period centred on the difficulties of the residential care system in dealing with the 'risk' or the presenting problems of young people in their care. Arguably, insufficient attention was given to these challenges, which were repeatedly highlighted by residential workers over the years.

This situation escalated to the point that in order to secure a young person's safety, applications were made to the High Court as a means of accessing placements. The High Court observed that Health Boards could not detain a young person for their own care and protection under the legislative provisions of the Childcare Act 1991 and therefore had to fill this legislative void (Carr 2007). With limited options available to the High Court, non-offending children were being routinely detained under court orders in Children Detention Schools, police stations, hotels, adult prisons, adult psychiatric hospitals and care institutions outside the state (Seymour 2006).

This response placed the Irish state in violation of its obligations under both domestic and international law and attracted much media attention and widespread criticism. However, it was the government's inaction that provoked much critical commentary from the judicial system. The state's lack of

accountability to young people and families was the source of much criticism. The High Court repeatedly castigated the state for its failure to protect the constitutional rights of young people who came before the court (Whyte 2002). Commenting on the Health Board's delay in providing secure accommodation, Justice Peter Kelly, in particular, gained national prominence for his criticisms of the system.

While these observations and concerns, cloaked in the discourse of risk, cast another shadow over the residential child care sector, revealing gaps in service provision, positive developments did emerge in the form of the establishment of special care and high support units. In general, the young people who came before the courts had been known to the Health Boards for several years. For some of these young people their histories highlighted a series of failed care placements, missed opportunities for professional interventions, and multi-disciplinary contact with families that had spanned a number of years. The extension and specialisation of the residential system to include high support and special care provoked much discussion and debate, with some favouring the development of a specialist resource and others querying the effectiveness of secure care in meeting the needs of young people and criticising the failure of the state to provide appropriate services and facilities to children with severe behavioural problems.

As a result, and in a context in which Ireland, from the mid-1990s onwards, was experiencing sudden economic success (the 'Celtic Tiger'), various layers of accountability, managerialism and bureaucracy in residential childcare and in the form of policy and practice initiatives began to emerge. *Delivering Better Government* (DoHC 1996) outlined the government's commitment to providing services that were accountable and transparent. There was a political view circulating that services would be more effective if managed like the private sector (Harvey 2011). Consequently, one of the central mechanisms of the Strategic Management Initiative (SMI) was the devolution of accountability and responsibility from the centre to executive agencies. The aim was to improve financial accountability and new systems obliged Health Boards to produce an annual service plan as well as to secure the 'most beneficial, effective and efficient use of resources' (DoHC 1996: 26).

At this time there were concerns about the number of social workers 'leaving at an alarming rate due to high levels of stress and lack of appreciation of their role' (McGrath 2000: 3). There was a sense that the budgetary framework was the primary focus of the accountability mechanisms in service management (O'Toole 2009). There were further calls for greater accountability and managerialism following the publication of the first major child abuse inquiry in

Ireland, the Kilkenny Incest Investigation (McGuinness 1993). The report revealed the inadequacy of the Irish child protection system (Ferguson 1993) and has been described as catalyst for significant reform (Buckley & Nolan 2013). The report significantly changed the context in which policy and practice developed (Ferguson 1993). This report centred on a case of incest in which a young woman had been abused by her father over a 16-year period, during which time the Health Board had continued to be in regular contact with the family. In addition to expediting the implementation of the Childcare Act 1991, the report recommended the recognition of the rights of the child and the primacy of prevention and it called for constitutional reform so that the rights of the child were foregrounded and not subsumed within the marital family. This led to the subsequent constitutional amendment in 2012.

Three years later the first inquiry into residential care practice was published amidst legal discussions, with sections of the report omitted. This inquiry was established by the Sisters of Charity with the assistance of the Department of Health to review the operation of Madonna House, a residential centre in Dublin, in response to allegations of misconduct made against certain members of staff. It was suggested that 'this report had brought residential care to its knees and to the forefront of the public domain' (Dolan 1995:11), leaving a number of care workers from Madonna House 'under a cloud of suspicion by association' (O'Sullivan 2009). Then in 1999 an inquiry was called into Newtown House (SSI 2001), a residential centre that offered a high level of support in a secure setting, after a 16-year-old resident who had been absent without leave was subsequently found dead from a drug overdose. The report noted that there was a small number of trained staff, with high levels of sick leave due to stress and assaults, and a notable absence of professional supervision. The report concluded that staff were 'working in an atmosphere of stress, fatigue and crises without adequate supports to guide their work' (SSI 2001: 89).

As the impact of these reports was being processed, revelations of the ill-treatment and abuse suffered by children between the 1930s and 1970s in the reformatory and industrial schools system were highlighted in a three-part television documentary entitled *States of Fear*. Smith (2001: 23) describes how Raftery's documentaries 'excavated Ireland's architecture of containment by focusing on the very people the structure was erected to deny'. Practices associated with the institutionalisation of children were now being exposed and the historical journey was being viewed through a different lens. It was inevitable that the *States of Fear* documentary, coupled with the Madonna House and Newtown House inquiries would create a sense of mistrust amongst the public regarding residential childcare provision.

The public were now more finely attuned to the sense that children were constantly in danger and as a result policies and guidelines were developed to reduce risk (Walsh 2013). The foundations, such as the introduction of the Child Abuse Guidelines in 1987, had been laid over the previous period (1970- 1980) for a professional system to respond to child abuse in the 1990s (Buckley & O’Nolan 2013). In 1999 the Children First Guidelines were published, but the application of these guidelines provoked much critical commentary, primarily due to a failure to impose them on a statutory basis, thus leading to inconsistency in their application (OMCYA 2008; Shannon 2009).

Crisis and Change – 2000 to the Present

By the year 2000, the conceptualisation of the child as a ‘rights bearer’ had gained much impetus and was articulated with the publication of the National Children’s Strategy (2000). This positive development marked a focus on rights-based language in policy development.

The National Children’s Strategy recommended an approach based on an ecological system practice orientation. In 2003, the first Ombudsman for Children, whose overall statutory mandate is to promote and monitor the rights and welfare of children, was appointed, and in 2005 of the Office of the Minister for Children (OMC) was established.

In this era, the Children Act 2001 was enacted, underpinned by the principle that detention should only be used as a last resort and that the focus should be on preventing criminal behaviour (O’Sullivan 2000). However, contradictions to the family support rhetoric were evident in the basic philosophy underpinning the Act that parents must be made responsible for the offences of their children (O’Sullivan 2000).

In general, the Children Act 2001 was viewed as a positive development, informed by the principle that detention should only be used as a last resort. The implications of increasing the age of criminal responsibility from 7 to 12 (subsequently amended to create two ages of criminal responsibility – 10 for most serious offences (murder, rape) and 12 for all others), meant that the Health Boards had responsibility for all children aged under 12 who came to the attention of the Gardaí. Practice was now located in the broader context of family support, and the importance of supporting families was a consistent theme in policy and reports, including the Agenda for Children’s Services (OMC 2007) . Arguably, the view that children’s welfare was generally best secured within the

family setting was further consolidated by the public's mistrust of residential care provision as a result of highly publicised inquiry reports.

In 2008, as a decade of prosperity ended abruptly, the government introduced a series of austerity budgets, which impacted on vulnerable Celtic Tiger populations (O'Toole 2009). This coincided with the Report of the Task Force on the Public Services, which recommended that publicly funded services needed to operate more efficiently and effectively, with more attention given to performance and delivery. Following a ten-year inquiry, the final report of the Commission to Inquire into Child Abuse, commonly known as the Ryan Report, was published on 20 May 2009. The report contains harrowing accounts of the lives of children in institutions and details incidences of neglect and abuse – physical, sexual and emotional. Findings indicated that a climate of fear, created by pervasive, excessive and arbitrary punishment, permeated most of the institutions (CICA 2009).

The Ryan Report received international attention. The revelations of the nature and scale of abuse was particularly distressing; however, the cover-up by Church and state increased public indignation and provoked much critical commentary (Ferguson 2007, Stein 2008, Lee 2009, Ferriter 2010, Keenan 2011). The view that 'children in care were from a lower strata and therefore unequal and less deserving' (Lee 2009: 45) was evident in the commission's quest to uncover the truth. It was often reliant on the efforts of survivors of child abuse and advocates to support it in the process.

The same year the government introduced the Ryan Report Implementation Plan (DoHC 2009), to which it allocated a budget of €15m. This positive development was quickly overshadowed by debates regarding the exact number of cases of children who had died in the care of the state between 2000 and 2010 being played out in the media.

TASK 3

Read the following article by Noel Howard: 'The Ryan Report (2009): A practitioner's perspective on implications for residential child care', *Irish Journal of Applied Social Studies* 12(1), available at: <http://arrow.dit.ie/ijass/vol12/iss1/4>

The Report of the Independent Child Death Review Group (Shannon & Gibbons 2012) highlighted the deaths of children in care and identified missed opportunities where interventions, if available, could have made a difference to outcomes for young persons. They noted the most concerning finding from a

public point of view when they concluded 'that the majority of the children who are the subject of this review did not receive an adequate child protection service' (Shannon & Gibbons 2012: 4).

In 2010, findings from the inquiry into the Roscommon case (Gibbons 2010) highlighted systemic failures that had been identified in earlier inquiry reports. Despite the endorsement since the 1990s of seeking the view of the child in all welfare policies and guidelines, the inquiry report (Gibbons 2010: 69) noted that the voice of the child in Roscommon case was 'virtually silent'.

It is argued that these recent reports highlight the inadequacy of statutory services and demonstrate the continuities between historical practices and current responses to children in need. It was the impact of the successive inquiry reports, coupled with increasing calls from various groups (Constitution Review Group 1996, Children's Rights Alliance 1997) advocating for the constitutionalisation of children's rights, that eventually led to a referendum to insert a clause in the Constitution dealing with children's rights.

Following an audit of existing aftercare services and consultations, the HSE introduced a national policy on leaving and aftercare services (HSE 2011). To ensure a co-ordinated approach in the delivery of services under the Childcare Act (1991) and the Children Act (2001) and in line with international developments, there was a concerted effort to involve young people in processes and procedures on decisions affecting their lives, coupled with support from advocacy groups such as Empowering Young People in Care.

The Ryan Report Implementation Plan (2009) stated that lines of responsibility and accountability for services delivered to children at risk were unclear, evidenced by the fact that there is no national out-of-hours social work service for children at risk or for children in care or their families. In 2011, there was a 50% cut in HSE staff training, despite the increase in caseloads and complex cases (Burns & MacCarthy 2012). At this time, the management structure of child protection and welfare services had been a source of consistent criticism.

Commentaries highlighted the dichotomy between 'protection' and 'welfare' and between 'welfare' and 'justice' (Smith 2005), which had been a recurrent concern in the literature. In addition to this orientation in practice, there were worryingly high thresholds for admission to the child protection system (Shannon & Gibbons 2012), which often delayed the provision of care for young people who needed it. Failures of multi-disciplinary communications (Duggan & Corrigan 2009) and increasing workloads were making it more difficult to engage with children in care (Lynch & Burns 2012).

In this context, change was eventually proposed in 2012 when a task force was established to advise on the preparations for the establishment of a child

and family support agency on a statutory basis (DCYA 2012). Tulsa, the Child and Family Agency, is now the dedicated state agency responsible for improving wellbeing and outcomes for children.

Challenges continue to exist at the coalface of practice, with greater scrutiny, accountability for service delivery, and fear of litigation shaping the way services are delivered (Buckley & O'Sullivan 2007). These developments have led to a stronger emphasis on policies relating to accountability and performance. Accountability was further consolidated in 2012 with the publication of HIQA standards for statutory child protection social work departments. HIQA's remit was now extended to the inspection of family and childcare services and to the development of standards.

This chapter concludes that despite efforts to rectify historical deficits, and despite positive developments in that direction, challenges remain. A common theme emerges that is a clear constant across each period of our history: the government's attitude. This attitude is manifested in piecemeal reform, inaction and reactive responses to inquiry reports/controversies, which leads to policies being developed in times of crisis with fragmented solutions. Challenges articulated by advocacy groups, social care workers and cumulative committee recommendations have received limited attention. Consequently, knowledge has not been accumulated and there have been limited responses to challenges as they presented. There is clear evidence that demonstrates social care workers' concern around the inadequacies of the system; however, it appears that change only occurs when situations are at crisis point or when there is a threat of litigation. Despite the evidence of discursive shift and consequent changes in service provision, gaps are still evident. One notable absence in the development of social care provision is the voice of the social care worker. The culture of accountability, although welcome, needs to be monitored in relation to its impact on day-to-day practice. The legal and risk management responsibilities of child welfare systems have shaped the overall orientation of our social care sector, this is an area that warrants attention in terms of the impact on relationship-based practice.

We need to continue to highlight gaps in service provision and endeavour to be part of a collective voice for social care reform. We must, however, remember that there are parts of our history we can be proud of; we need to learn from the important continuities of best practice and expertise built up over decades and recognise the commitment and dedication of past social care workers. To ensure the next chapter in our social care history is one to be proud of, we suggest the following areas need to be addressed.

Moving Forward to the Future of Social Care

- 1 There is a need for the voice and experience of service users to be visible in policy formation and service delivery. These voices need to be not only heard but encouraged and fostered.
- 2 Although the legal and risk management responsibilities of child welfare systems shape the overall orientation of our social care sector, we need to ensure that organisational structures and culture facilitate, rather than impede, positive outcomes for service users.
- 3 Social care education and practice need to focus on the structural and institutional nature of oppression.



Tips for Practice Educators

- Discuss with the student the historical development of your agency. Set a task that supports the student in identifying the wider socio-economic and cultural contexts of social care practice.
- Support the student in documenting their views and understanding of social care history in their reflective diaries.

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Chapter 76 – Niamh Delany (D5SOP15)

Domain 5 Standard of Proficiency 15

Recognise the role of advocacy in promoting the needs and interests of service users, and understand the influence of system-level change to improve outcomes, access to care, and delivery of services, particularly for marginalised groups.

KEY
TERMS
Advocacy
Needs
and
interests
of service
users
System-
level
change
Outcomes

Social Care is ... respecting, listening and building relationships. From those foundations a path can always be found. The pace of progress is different for everyone; sometimes you need to go backwards to ensure that the person is still with you in the relationship.

TASK 1

Describe a time in your life when somebody helped you to speak up for yourself or spoke up for you. How did it feel? Did you learn and grow from this experience? Did you feel that you could have been a bigger part of the process?

Advocacy

Advocacy is an inseparable part of the fabric of our daily working lives. Supporting service users to access and realise their rights is often a large part of the job description. We advocate to meet the needs of individual service users and for system changes when they are needed to improve the outcomes for both individuals and groups. Advocacy, when practised effectively, enables somebody to speak up for themselves through increased education and accessible communication tools. It can also mean speaking with a person, for example attending a meeting with them and providing support or advice if required. Even when a social care worker needs to speak for and on behalf of a service user to effectively advocate for them, any actions should be based on the service user's needs, interests, will and preferences.



Author created diagram that represents three key approaches to advocacy in social care: speaking up, speaking with and speaking for.

'Advocacy can be a difficult concept to grasp ... Some people only equate it with legal representation ... Some believe it is simply about speaking up and out, on behalf of oneself and others. Advocacy is all of these things, but it is more. It is about a process; how one speaks or represents another, whether the principle person is involved, how people are involved, and the accountability we

have to those we represent' (Birmingham 2001:4).

There are four different types of advocacy: self-advocacy; representative advocacy; peer advocacy; and group advocacy. Each type includes the values of **independence, autonomy, empowerment, equality** and **citizen engagement**. Advocacy occurs in all social care settings and the type of advocacy will be determined by the underpinning values of both advocacy and social care.

Independence: The concept of independence in relation to the type of day-to-day advocacy that social care workers provide will almost always feature some level of tension between those on whose behalf they are advocating and external forces, including access to funding, legislation and policies (Drage 2013). Social care workers are rarely independent in relation to the funding systems they work within. However, the commitment to advocacy, social justice and equality as the founding values of their profession means that social care workers are duty bound to advocate against social injustice and inequality.

Autonomy: This can be described as self-directed decision-making. When

working as an advocate in social care work, we must remain faithful to the autonomy of the person/people we are working with. How are they directing this advocacy process? Have we checked in with them at every stage of this process? How can we empower the person throughout this process? Some people may need support in relation to equal legal recognition of their autonomy.

Equality: It is part of a social care worker's duty to establish what, if any, extra support is needed in order for equality to be realised. Equality and social justice are inextricably linked. Our primary role in relation to equality in social care settings involves ensuring that the people we work with can realise their human rights on an equal basis with their peers. Some people do not have access to adequate employment support due to a lack of accessible communication. Some residential settings may have 'one size fits all' policies, perhaps with regard to individual finances or visiting rules. This may not respect the value of equality. Our work in relation to equality begins with identifying systemic barriers to equality. The Irish Human Rights and Equality Commission website (www.ihrec.ie) provides information on human rights and equality.

Citizenship: Social conditions can lead people to be proactive and engaged or passive and alienated (Ryan & Deci 2000). Effective advocacy promotes the development of active citizenship. In order to promote active citizenship, social care workers may engage in supporting and facilitating self-advocacy groups; individual self-advocacy; and peer-based advocacy groups. In residential services, regular 'house meetings' are often facilitated in order to allow service users to give feedback in relation to the service provided.

TASK 2

Discuss the following question.

Are service users encouraged and supported to engage in the democratic process? Is voting information accessible?

Policy and Legislative Background

The code of ethics and conduct provided by Social Care Ireland describes the primary goal of social care work as 'advocating for and with, supporting, enabling and empowering individuals, families and groups'. The values underpinning the code of ethics are described as 'respect for dignity, the promotion of social

justice and equality, honesty and integrity, and the recognition that human potential is most often realised within the interplay between the independence and interdependency' (SCI 2021). CORU's code of ethics and conduct for social care workers also refers to the responsibility to advocate for social justice under Section 31 of the Health and Social Care Professionals Act 2005 (SCWRB 2019).

The Jigsaw of Advocacy policy document was published in 2003. It describes advocacy as 'the key which will unlock entitlement to services for those who are often bewildered by the bureaucratic complexity of access to social and other state services' (Weafer 2003: 4). Our domestic legislation refers to advocacy in the Citizens Information Act 2007. Social care workers will often incorporate these supports into their day-to-day working life. The National Advocacy Service (NAS), established in 2011 by the Citizens Information Act 2007, provides issue-based representative advocacy to marginalised groups, particularly people with disabilities. A referral to NAS services can be made by or on behalf of anyone fearful that they are not receiving services on an equal basis with others or are being denied their rights. Often social care workers will facilitate advocacy in relation to these issues and, if necessary, escalate a referral to NAS. This is a nationwide service with regional offices. More information about NAS and making a referral can be found at <https://advocacy.ie/>.

Autonomy, Person-centred Planning and Assisted Decision-making

The people we work with often need support in recognition of their decisions. This is particularly relevant to those with an intellectual disability, psychosocial disability or different communication needs. One of the most significant changes in relation to social care work practice in this area is the principle of respecting the will and preference of the person, which replaced the 'acting in the best interests' approach. This means that we now act on the evidence of what choices people want to make. We do not assume that we know what will be best for the person. Social care workers, with our relationship-led approach, are uniquely placed to effectively explore, discover and document the will and preference of the people we work with.

Recognition of legal capacity has traditionally worked on the premise that the self-contained person will make reasoned decisions to protect his own interests. Where someone was not considered capable of reason, they were considered no longer equal in the eyes of the law. The poet John Donne wrote, 'No man is an

island entire of itself; every man is a piece of the continent, a part of the main.' Relational autonomy is an approach that takes account of the different social systems and supports that influence decision-making.

Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), is concerned with equal recognition before the law. In a commentary on Article 12 of the UNCRPD, Arstein-Kerslake and Flynn state that this Article has been identified as the catalyst for change in this area (Arstein-Kerslake & Flynn 2016). A focus on providing appropriate support rather than placing the onus of change on people with disability is consistent with the social model of disability, a key driver of the UNCRPD.

Ireland is poised to implement an Act loosely based on relational autonomy theory. This Act came about as Ireland was preparing the groundwork for ratification of the UNCRPD. We have, as Moira Jenkins explains, entered a 'new ecology for the exercise of rights' (2018). She was referring to the new legal framework around decision-making in Ireland. The Assisted Decision-Making Capacity Act 2015 is a phenomenally important piece of legislation for the exercise of autonomy for people who struggle to be recognised as equal in the eyes of the law, such as people who have an intellectual disability or psychosocial disability.

Jo-Anne Watson, an academic in Australia, completed research in 2016 on the role that frontline support workers can play in recognising decision-making capacity through facilitating person-centred planning when providing support to people with very complex communication needs (Watson 2016). Her empirical study of five people with severe or profound intellectual disability provides an insight into what supported decision-making through person-centred planning can look like. It also highlights the effect of supporters having positive assumptions of decision-making capacity as a factor in supported decision-making. The study aims to influence practice and policy efforts to ensure that people with severe or profound cognitive disability receive appropriate support in decision-making.

Social care workers often practise the support of relational autonomy in their working day. 'Through hanging in and hanging out social care workers learn the likes, dislikes and needs of the service user' (Lyons 2017: 89). They may participate in an organisational person-centred planning programme. Many of these programmes exist; however, it is the relationship between the social care worker and the person they are planning with that determines the quality of the plan. If the plan is documented and progressed in a meaningful way, it can assist people in realising the right to autonomy and equal recognition before the law. These

programmes can be used to establish will and preference in relation to finances, medical support, services offered, places to live and much more.

A Decision Support Service (DSS) is planned to assist in promoting the rights and interests of people who may need support with decision-making. The DSS is not operational yet. There is a plan to commence the service in mid-2022. Information on this service can be found at www.decisionsupportservice.ie.

Advocacy in Practice

The examples included here are an amalgamation of events experienced over the course of sixteen years of social care work in intellectual disability services. No example represents an actual event.

Case Study 1

Local level self-advocacy made effective through appropriate systems.

Tom, Brosna and Jack live in a residential house run by an intellectual disability service. They have a house meeting every week. Everyone must be there for the meeting to go ahead. Two staff members must be there too, and everything that is said is written down. Last week Brosna and Jack said that they were disappointed that they could not bring their friend on a daytrip with them even though there was room on the bus. This was because their friend has epilepsy and the staff in their house are not trained to give him his medicine. When the social care leader read the minutes, she put in a request for the team to receive training for administering medication to Jack and Brosna's friend. This will happen in two months' time, when their friend's team will also be receiving training. Jack and Brosna are told that in the summer they will be able to organise daytrips with their friend.

Case Study 2

Engaging in or identifying opportunities for equality and human rights training/ education and training/education on the democratic process for the people we work with.

Marian has been an advocate for the people who share services with her for many years. Her social care worker key worker has identified a class in the community on equality and rights. Marian is looking forward to learning more about 'standing up' for herself and others.

Case Study 3

Identify opportunities for stakeholder involvement in consultations.

The government is looking for people who have lived experience of intellectual disability services to participate in a consultation group. Yetunde is a social care worker working in the area. She reads about it on social media and encourages Aoife to apply. Aoife is passionate about improving the services that she and her peers receive. She wants a job, but she needs someone to help her. The HSE has recently cut employment support funding because it says it is not its role to support employment. When Aoife went to the new employment support service, they didn't know how to talk to her, never mind help get her a job! Yetunde requests that she is on shift on the day of the consultation. She reads through the information with Aoife and helps her to prepare what she would like to say. They research the bus route together. On the day Yetunde politely asks the chair to give Aoife a little more time to speak as she can see that Aoife has more to say.

Case Study 4

Collect data on rights realisation within the area they are working in.

Claire works in a large day service for people with intellectual disabilities. She is passionate about rights realisation for people with disabilities. Claire develops a rights checklist and asks people using the service if they would like to fill it out with her. When the checklists are filled out, Claire establishes that 85% of the 50 people using the service have not chosen where they live; 65% of the people using the service want a job but have no access to employment supports; and 70% of people using the service have no respite support. When a local politician calls to the service in the run-up to a local election the self-advocates use these statistics to guide their conversation.

Being an Advocate

Social care work is a focus on individual relationships. We work with service users and discover what system change can help them. We build relationships with the people we support through the 'doing' (Lyons 2017: 307) of shared experiences, 'hanging out and hanging in' (Garfat & Fulcher 2011). The relationships that are built during this work enable empowerment and advocacy. Unlike other allied health care professionals, social care workers do not learn how

to master our craft in one fell swoop. Our job changes with every individual and set of circumstances we meet. It is shaped by the relationship with the person who is being supported and their desires and needs. We master ourselves; we channel our skills, listen, adapt and empower. The outcomes achieved by people we work with are not our professional victories; they are the victories of a service user empowered to overcome barriers and achieve meaningful outcomes.

Social care workers need to think on their feet every day in order to react appropriately (Lyons 2017: 288, 387). Some days we will arrive at work to find the atmosphere chilled out and benign. We will adjust our energy to complement this atmosphere and will find opportunities to progress advocacy for desired outcomes and to develop the relationship. On other days we will need to use the relationship to ask the person to trust us enough to remain calm. Advocacy is an integral part of the everyday work of social care workers. Advocating through relationships and empowerment results in meaningful outcomes for the people we support. We may use the relationship to realise the function of a behaviour and in partnership with the person advocate change in the systems in place to support them.

TASK 3

Please read Claire Leonard's chapter 'Supporting a Team to Direct and Lead Change in Social Care' (see References) as an example of how a system-level change was successfully introduced to change a sheltered occupation service into a training and activation service.

System-level Change

As well as recognising the role of advocacy in promoting the needs and interests of service users, this proficiency acknowledges the importance of understanding how system-level changes in your social care service can also improve outcomes, including access to care delivery, especially for marginalised groups. According to the World Health Organisation (WHO 2017), 'people with disabilities are among the most marginalised groups in the world'. System change is the introduction of new practices or structure which are aimed to improve the performance of the service (Birney 2015). This proficiency draws our attention to the importance of change within organisations and how, if managed correctly, it can have a positive impact on outcomes for service users. According to Burnes

(2004), organisation change is influenced by both internal or external forces. Leonard (2014) provides an example of how her organisation implemented the New Directions Policy (external force) to change a 'sheltered occupation service' into a 'training and activation service'.

One example of an internally motivated change is based on my own experience. I worked on a Self Advocate and Family Forum in my service, which lobbied the management for a system-level change that would make easy-read appointment letters the norm for correspondence given to service users. This system-level change was driven by the need to empower service users to have easy access to information that was relevant to their care. Making system-level changes can be difficult, especially if the change has an impact on the culture and practice norms of the organisation. Leonard (2014) demonstrates that giving staff time, having lots of meetings focused on the proposed change and the possible impact on each individual, and providing training when needed, helped with the introduction of new practices. This chapter concludes with some tips for practice educators on how to help students understand the important role of advocacy in social care practice.



Tips for Practice Educators

Practice educators could consider how they might enable the student to build an awareness of how the values of advocacy can guide system-level change. Through focusing on the needs and interests of service users, students will find a path to flexing their advocacy muscles. The following reflections may be useful to encourage a more robust understanding of the values.

Reflection in relation to independence for the student on placement:

- What are the power structures in the organisation?
- How would I voice concerns?
- What is the funding structure for the organisation? An organisation that receives funding for providing a rights-based service will have a vested interest in making advocacy for human rights a priority.

Reflection in relation to autonomy:

- Can I further empower and promote autonomy within this placement?
- Can everyone communicate effectively and are communication tools consistently used?

Reflection in relation to equality:

- Can the person I work with exercise their rights on an equal basis with their peers?

- If not, what supports do they need?

What barriers are present?

Reflection in relation to citizenship:

- If there are house meetings, do they work for the residents; can the residents put forward their own agenda?
- Have the house meetings been effective in changing practice in the service in accordance with issues identified?
- Are feedback mechanisms such as complaints policies in place, accessible and advertised?

Practice educators could encourage students to complete these reflections in relation to their placements. Even the smallest issue will require deep reflection. Often students have fresh eyes and can critically evaluate practice in a way that can have a lasting positive effect on the service.

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Chapter 77 – Denise Lyons (D5SOP16)

Domain 5 Standard of Proficiency 16

Understand the role of, and be able to demonstrate skills in the use of creative and recreational interventions in social care work to meet the needs of the service user in a variety of contexts.

KEY TERMS

Defining recreation
Defining creativity
Recreation and creativity as interventions in social care practice

Social care is ... planned practice. In the day-to-day lived experience of practice, social care work appears 'in the moment'. However, the worker's response is a planned approach to meet needs, uphold rights and enhance the potential for meaningful and creative shared experiences.

Despite the importance of creative and recreational interventions in social care practice, there is only one standard of proficiency that references the terms 'creativity' and 'recreation'. Chapter 72, which describes 'activity' as opportunities for meaning-making, increased participation and engagement, should be read in conjunction with this chapter. 'Intervention(s)' are discussed widely: as requiring consent (Chapter 15); as part of the care plan developed in partnership with the service user (Chapter 35), which needs to be evaluated and revised (Chapter 48) in terms of risk (Chapter 50). These key terms are addressed here in this chapter, but also included is a discussion of the importance for the student of engaging in creative and recreational activities during their formal training, as well as the benefits for the service user, which are broader than identifying needs. This proficiency requires an understanding of the role of creativity and recreation as an intervention within social care to meet needs in a variety of contexts, and also requires that the student be able to demonstrate skills in using

these interventions. This is a challenging task; therefore, I have drawn on the expertise and knowledge of my colleagues in the Creativity and Innovation in Social Care (CISC) network to support this discussion (Jackson 2021; Mac Giolla Rí 2020).

Defining Recreation

Recreation is a term used to define the active participation in variety of pursuits for fun, education, socialising, exercise and sport (Kraus 1998; Benatuil 2018; Rodriguez de la Vega & Toscano 2018). Recreational activities are ‘undertaken by choice during free time, with the aim of experiencing the pleasure derived from the activity itself and finding in it intimate satisfaction and an opportunity for recreation’ (Benatuil 2018: 52). Recreation is deemed separate from leisure, which is viewed as a passive experience during your free time (Klaus 1998). Benatuil (2018: 53) states that although both leisure and recreation relate to pleasure and enjoyment, they are distinct in the following ways:

Recreation	Leisure
Organised and directed activities.	Enter
Planned – can be engaged in as an individual or a group.	Rand
Active – associated with participation and engagement with a planned activity.	Passi
Emphasis on doing , outcomes or challenges and goals.	Little

People choose to engage in recreational activities to enhance their creativity and as an outlet for their personal expression and interest (Klaus 1998; Benatuil 2018). The types of recreational activities used as interventions in social care settings are physical (sport activities, including the Special Olympics, active games, fitness and exercise classes, swimming and walking), social (participation in non-sporting clubs and societies, parties and trips out as a group) and creative (art, drama, singing and music) to name a few. Engaging in recreational activities enables service users to become active participants in their community, to become healthier, to maintain friendships, have fun, increase their overall wellbeing and exercise choice.

TASK 1

Read Chapter 72 and create examples of recreational interventions that involve the head (planned practice to meet needs), the heart (relationship development) and the hands (doing with others – community engagement).

Defining Creativity

Creativity is defined by Benatuil (2018) as a form of recreation and by Mac Giolla Rí (2020: 86) as ‘an ordinary human ability’ that can be experienced and practised by all. Understanding creativity includes a knowledge of the theoretical perspectives that underpin creative practice. Kaufman and Beghetto (2009) make a distinction between big ‘C’ creativity, or the activities we associate with professional artists, musicians and thespians, and little ‘c’, which includes the everyday creative pursuits of planting a garden, decorating a cake, or styling your external identity through your clothes or hair colour. The perception that big C creativity is only experienced by individuals with an enhanced ability or talent has been challenged (Runco 2007). Over time, with prolonged engagement in the creative activity, and a little luck (Runco 2014), ordinary people can explore new ideas (Boden 2009) and ways of working and self-expression to create at a big C level. For Runco, everyday creativity involves the same processes as big C: *‘after the creative idea is produced, expertise may add to it, persistence may allow a refinement of it, impression management may couch it so it is accepted, and so on, but the creative part of the process (e.g., the construction of an original interpretation of experience) is the same as the creativity of little c creativity’* (2014: 132). Thus, creativity is not defined by an outcome or product that is deemed of value; it is about the dynamic process and the changes or benefits experienced from engaging in the creative act (Walia 2019). Runco (2007) redefined creativity as a hierarchical framework, building on his original theory of the 4 Ps (person, product, process and place). This framework makes a distinction between **creative potential** (person = your personality, process = cognitive and social, place = access and environment) and **creative performance** (products of creativity). Here creativity is affected by the individual, their ideas and motivation, and the external environment. This theory is relevant to social care work as the environment, including the service and the staff members, has a role to play in the service user’s ability to engage in creativity.

TASK 2

Understanding Creativity

For a greater understanding of creativity, read the journal article by Denise Mac Giolla Rí (2020), 'Learning to put everyday creativity, semiotics and critical visual, semiotics and critical visual literacy using inquiry graphics (IG) visual analysis to work in social care' in the Irish Journal of Applied Social Studies, Vol. 20, Issue 2, available at <https://arrow.tudublin.ie/ijass/vol20/iss2/>.

TASK 3

Questions about Your Creativity

How do you express your creativity? Do you define yourself as a creative person? If yes, in what way? What are your fears around engaging in creative activities during your studies or practice?

Interventions in Social Care Practice

Evident from the multiple workplaces of the chapter authors in this text, social care is practised in a variety of different settings, with a shared aim; to provide care and support for children or adults. Irrespective of the setting, social care workers are directly involved with people, using assessment and planned interventions to provide for the holistic needs of diverse and vulnerable populations (Lalor & Share 2013). The Standards of Proficiency for Social Care Workers (SCWRB 2017) state that interventions are only provided when consent is granted and documented (D1 SOP 15 – see Chapter 15) and are created in partnership with the service user and his or her family, when appropriate (D2 SOP 12 – see Chapter 35). SCWRB (2017) also references the importance of reviewing the intervention based on the service user's feedback and of ensuring that this is documented and included in all future plans (D3 SOP 8 – see Chapter 49). Students become familiar with the term 'intervention' from their placement portfolio, used as an opportunity for students to demonstrate initiative and planned practice and integrated knowledge (IASCE 2009). Students, under the supervision of their practice educator, and with consent from and in collaboration with the service user, plan an intervention to meet the needs of service users, and demonstrate the practical skills learned through creative studies modules (Graham & Megarry 2003). The creative studies text *Creative*

Studies for the Caring Professions (Lyons 2010) includes multiple creative interventions (in each chapter and in the appendix) that can be adapted and used with service users from a variety of social care settings. Facilitating creative and recreational interventions with service users enables you, the worker, to have an active role in their engagement in creativity and an opportunity to demonstrate your skills. Creative and recreational interventions have multiple roles in social care practice and education, which include, but are not limited to, social development, increased cognitive engagement, fun, relaxation, self-expression, movement, imagination, promoting resilience, freedom, choice and meaning-making (Lyons 2010; Mac Giolla Rí 2010, 2020), and this chapter focuses on the following roles: relationship development; to meet needs; for community engagement; and for self-awareness and facilitation skill development.

Relationship Development

Social care work is experienced through the relationship between the worker and the service user and engaging in recreational and creative activities can facilitate this process. Creativity in practice is reliant on your ability as a social care worker to facilitate a psychologically and physically safe space for personal expression and play. This begins with the relationship between you and the service user, inspired by your own courage to take risks, by being less self-conscious of your image-making or creative expression. This process starts with the relationship as you learn the likes and dislikes of your service user(s) and the types of activities they may be interested in.

One example of how creativity in social care education can support the relationship development of students and service users is evident in a joint initiative between the Daughters of Charity Disability Support Services and TU Dublin Blanchardstown Campus that began in 2009. 'Learners', adults with an intellectual disability from the daughters of Charity Service, became full-time students in the creative studies module on the social care programme in TU Dublin. As well as studying in the classroom together and developing relationships as student peers, this project provided opportunities for people with an intellectual disability to actively participate in the college community. This also created an informal space for social care students to learn the fundamentals of how to communicate and develop relationships with people with diverse needs. As the lecturer, I noticed how the 'learners', through their creative freedom of self-expression, encouraged the social care students to play,

have fun and fully engage in the creative activities. Relationships formed naturally and social care students became both learner and teacher as they sat together doing the shared activities.



Caption 1 (Author-Owned Photo): An inclusive arts and crafts session where individuals of all abilities engage creatively, showcasing the power of shared making as a form of expression, connection, and care. Photo by author, published with permission. Caption 2 (Author-Owned Photo): A social care practitioner supports a participant in a hands-on activity, reflecting the importance of patience, presence, and relational practice in nurturing confidence and creativity. Photo by author, published with permission.

To Meet Needs

Meeting the needs of service users is a core threshold in the Standards of Proficiency for Social Care Workers (SCWRB 2017). Students must demonstrate that they ‘understand the role and impact of effective interdisciplinary team working’ in meeting needs (Chapter 37), ‘gather all appropriate background information relevant’ to the service user’s needs (Chapter 41), ‘demonstrate an evidence-informed approach’ and adapt practice to meet needs (Chapter 46), ‘identify and document ... unmet needs’ (Chapter 55), ‘demonstrate safe and effective implementation of a range of practical, technical and professional practice skills relating to ... specific needs’ (Chapter 73) and ‘recognise the role of advocacy in promoting needs’ (Chapter 76). The Freda principles of fairness, respect, equity, dignity and autonomy (HIQA 2019) is an excellent framework to support the application of creative and recreational activities to meet needs in a human rights-based approach to practice.

Principle	Role of Creative and Recreational Interventions
Fairness	Listen to the service user and seek out their likes and dislikes. Ensure that they have all the information needed to make a decision on what intervention they would like to engage in. Receive consent before beginning your creative or recreational intervention.
Respect	Spend time with the service user before engaging in creative or recreational activities with them. Work at their pace and be courteous in your manner and how you communicate. Listen without judgement and respect their likes, dislikes and interests.
Equity	Support your service user to have equal opportunities and to fully engage in activities of their choosing. You may need to adapt the intervention to ensure that people of mixed ability can engage fully in the intervention. Always assume that the service user has the capacity to engage, first, before you exclude an experience or activity from them.
Dignity	You can demonstrate dignity to the service user in the way you communicate the stages of an activity or intervention. Risk assess all interventions to ensure that the service user is not physically or psychologically harmed based on their participation.
Autonomy	Service users express their autonomy in getting to choose the activities and interventions they want to experience. It is important to support the autonomy of the service user to refuse to engage in your intervention or plan.

TASK 4

Apply the FREDA principles to this case study and note the important steps Sharon needs to take to ensure that the intervention applies the principles of fairness, respect, equity, dignity and autonomy.

Case Study 1

The following practice example was shared with me by one of my past students, who is now a social care leader in a residential service for adults with an intellectual disability. Sharon (not her real name) used an activity she had learned in her first-year creative skills module in her work with one service user preparing for his person-centred plan presentation day (PCP day). Paul (not his real name) is non-verbal, so Sharon used the 'clay world' workshop to support Paul to visually express his plan for the coming year. Using clay, Paul carved out his dream of going on holiday, through the shape of a plane, his plan to learn how to travel independently to the day service, evident from his happy face on the bus and the importance of family and friends, illustrated through heart and star

shapes. Creating the clay world together enabled Sharon to learn about Paul's desires for his future and the activity produced a tangible object that he could bring to his PCP day to share these ideas with his friends and family. This clay world activity was used to meet Paul's need to communicate using tools that related to his ability, will and preference.

The clay world intervention that Sharon used is available to view on YouTube. The video is a recorded workshop (poorly edited and filmed by myself), but offered as an sample activity for social care students in IT Carlow. The three participants, IT Carlow lecturer Caroline French, jewellery maker Tracey Weir and myself, made three clay tiles to represent our life and interests through clay.

TASK 5

Watch the Clay World Workshop and make your own clay world to represent you and your current needs or desires. The full workshop is available to watch on YouTube with permission to share granted by the three participants.



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Community Engagement

Recreational and creative activities play an important role in increased community participation. Walking around the community and visiting the local amenities, like the post office, library and coffee shop, are planned activities for increased community engagement and social learning (Ross *et al.* 2009; HSE 2012). The New Directions Report (HSE 2012) noted the importance of leaving the centre and getting out into community spaces, becoming members of local recreational clubs and societies and taking part in activities as examples of the normalisation of care (Gilbert 2009). Getting to and from the activity enables the worker to spend quality time with the service user, and use the time to chat and learn more about their interests and potential new hobbies. Ferguson (2009)

discussed the importance of the 'car conversations', as being in the car supports open, free conversation and a sharing of stories about the activity experienced.

Case Study 2

Scott (not his real name) is a 30-year-old man with a mild intellectual disability who lives in a community house with three other males, all over 60 years old. Although Scott communicated to staff that he was lonely and wanted to make new friends, he was reluctant to join any of the groups in the local community where he lived. Scott was interested in taking photographs and I asked him would he like to participate in creating a photographic collage made from images of his world and all the people and places he loved. So, with consent from Scott and the support of the team, we began to plan the project, beginning with the purchase of a disposable camera.

On one of our 'photographic walks' through the village, Scott stopped to take a shot of the street we had just walked up. He was outside a Men's Shed and one of the participants came out to say hello and asked Scott about the project. Scott was invited to visit the Men's Shed to talk to the other members about his photographic collage. Walking past the Men's Shed became part of the photographic walks and Scott eventually gained the courage to drop in and say hello and chat to the men about what they were making. The photographic project and his meeting the members of the Men's Shed was the beginning of his increased participation in the community.

TASK 6

Think of a new creative or recreational intervention that could support a service user to actively engage in the community.

Read Chapter 72 for more information on community engagement, the use of spaces within the service and the role of car conversations for meaningful moments in your practice.

Self-awareness and Facilitation Skill Development

Engaging in recreational and creative activities with your service user 'fosters hidden potential, growth and actualisation ... encourages playful and imaginative engagement with processes and critical reflection, within a safe space, so new ideas and practices can emerge' (Mac Giolla Rí 2020: 86). Social care workers need to experience creativity to help them to develop empathy, to become sensitive to the emotions of others, to learn how to adapt and change in order to meet the diverse needs of service users (Jackson 2021). Encouraging creativity in

others begins with the development of your own skills, which can be based on your own participation in recreational and creative activities, or during the time spent on the creative modules in your formal social care education. Central to creative skill development is the ability to facilitate activities that are strengths-based, timed in a way that reflects the ability and pace of the service user, and based on their choice and interest and/or need.

TASK 7

Understanding Facilitation For a greater understanding of how to facilitate creative and or recreational activities, read the chapter by Paul Timoney (2010) 'Creative Group Facilitation' in Lyons, D. (ed.), *Creative Studies for the Caring Professions*

Use the template in that chapter to design a creative activity for your service user.

Creative modules are viewed as an important part of social care education, in part for the development of facilitation and creative skills, but also to offer students experiential creative experiences for their own self-expression, reflection, self-awareness and relationship development (Lyons 2010). Some programmes may include recreational activities as part of the suite of experiences offered to students. Recreational activities may be more accessible to students from their own life experiences outside college, experienced through their membership of sports groups and clubs, and social outings in the community. Therefore, many social care programmes focus on the development of the students' creative and facilitation skills. The creative modules are important for skill development and through practical experience students learn about the different materials and types of activities they can use and adapt to the different people they will encounter in practice. Students do not need any prior knowledge or experience in the arts to actively engage in the workshops and this will help students understand that creativity is for all, irrespective of ability. The classroom becomes a safe space for the student to practise their creative and facilitation skills without the pressure of producing a finished product. The importance of the process, messing with the materials, learning by doing, sharing personal information, being encouraged by others, helps students understand how to create with others. Over time students develop a 'tool-box' of creative activities they can use as interventions in practice.

Practice placement is the space where students experience the value of recreational and creative activities in terms of seeing how engaging in creative activities can enhance relationships, demonstrate facilitation skills and meet

needs. Students on placement have more time to spend with service users and creative and recreational activities form an important part of their time together. By applying the FRED A principles (HIQA 2019), students can facilitate activities that meet needs, promote fairness, respect and autonomy and enable service users to be seen in ways that promote their abilities, strengths and capacity. Creativity can also challenge the student's preconceived ideas about the service user by providing opportunities to see them in a new way. My first social care placement in the early 1990s was a sheltered workshop for adults with a physical disability and the following case study is an example of one service user's capacity to engage in creative interventions.

Case Study 3

One day a dance teacher came to the centre to facilitate a workshop with the service users and students on placement. One of the service users, Tom (not his real name), was in an electric wheelchair and I noticed that he was also attending the session. I did not know Tom well at this stage and I wondered how he was going to actively participate in the workshop. Music filled the large hall, and the facilitator told all participants (service users and social care students) to create shapes with their body as they moved in time with the melody. At first, I was very self-conscious of 'dancing' until I noticed that everyone else had become lost in the music and their own movements. Tom started to move his chair in a figure of eight shape, in time with the music. The dance teacher, seeing this, responded to Tom's movements and began to dance with him. At one point, she was sitting on the side of the wheelchair as they moved around the hall creating beautiful shapes as one unit. This was a key learning moment for me, in realising how I had underestimated Tom's ability to actively engage, based on my preconceived and inaccurate ideas about him. In that moment, Tom was not defined by his wheelchair or disability – Tom was a dancer.

TASK 8

Watch the video from 'Gravity' Wheelchair Dance by Marisa Hamamoto and Piotr Iwanicki, available on YouTube:



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Depending on the setting and the interests and needs of the service user, creative and recreational interventions may form part of the day-to-day lived experience of practice. Social care workers can use activities within practice as opportunities for self-expression, for imagination, to illustrate person-centred plans, and to have fun. It is important for social care workers to ignore the internal critic, lead by example, and play freely with their own creative expression, without fear of producing an end product which will be judged by others as either 'good' or 'bad'. Some settings provide more opportunity to engage in creativity than others, but there are many ways to use recreational and creative interventions to meet the needs of all our service users. The social care worker plays an important role in supporting the service user to engage in activities and this time spent together helps to enhance your relationship as well as provide opportunities to assess and meet needs.



Tips for Practice Educators

Creativity for self-expression – Ask the student to work directly with one service user on a creative activity that is fun and enables the service user to share something about themselves.

Use of materials – Encourage the student to look at past activities completed by the service users and create a new activity using the same materials.

Recreational activities – Ask the student to focus on one service user and through communication and based on their needs, interests and choice, to support them to join a new group or plan a social outing.

FREDA principles – Ask the student to apply the FREDA principles to the creative and/or recreational activities they have planned for placement.

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Chapter 78 – Francis Gahan (D5SOP17)

Domain 5 Standard of Proficiency 17

Demonstrate ability to participate in or lead clinical, academic or practice-based research.

KEY TERMS

Participate
Lead
Practice-based research
Clinical and academic research

Social care is ... a bridge to equality, human-rights, personal fulfilment and happiness. Social care workers form that bridge in the care, support, advocacy and inspiration that they provide. It is on the foundations of a trusting and empowering relationship that the bridge is built.

TASK 1

Consider how social care workers can use research in practice to improve the quality of their work and outcomes for service users

Introduction

The terms 'clinical', 'academic' and even 'practice-based' research might conjure up notions of rigour, procedure, strict protocol and strategy that one may need to adhere to in the pursuit of knowledge or to provide solutions to social problems. And in certain contexts this can be the case: research often strives for objectivity and applies procedures or tests to validate a hypothesis or develop an understanding about a particular issue. As a student setting out on a career in

social care, one might easily consider the worlds of ‘research’ and ‘practice’ to be two very distinct concepts, each adhering to their own set of rules and following their own protocol. Research might be thought of as something separate from the world of social care and a job that can only be carried out by people who are highly skilled or professionally trained in its application.

However, through the academic and practice experiences of social care training, it becomes possible to apply the principles and philosophies that underpin ‘research’ both to the research task itself and also to the work that happens in social care. In fact, it could be argued that the social care worker, rather than the academic researcher, is better placed to undertake practice research. This type of research can subsequently influence the standards of practice itself. This can be due to our need for ‘intimate’ knowledge of the lives of service users and of the processes involved in social care work, allowing the social care worker to apply a more collaborative approach at all stages of the research.

Research and Social Care Education

As part of academic training, students may undertake a ‘research methods’ module to give them the skills and knowledge required to undertake meaningful research. It can also provide them with a foundation on which to write a final-year or postgraduate research dissertation. This may involve learning about which methodology is appropriate to carry out a research project. They will learn about whether a qualitative or quantitative methodology is the most suitable approach to answer their research question or to test their hypothesis. They will also likely to learn whether their research is best suited to a mixed methods approach. Subsequently, they will learn which method of data collection is best to use in certain research situations.

They will learn sampling procedures (how to choose participants), how to create a survey or interview schedule and the relevant interviewing and data management techniques required to produce valid and reliable research. Another important aspect of research is the fair and ethical treatment of participants of the research, so students will develop knowledge of ‘research ethics’: how to manage information appropriately and confidentially and ensure that the risk of harm to participants in the research is minimised.

With reflection, it becomes apparent that, while learning the appropriate knowledge and skills to carry out both quantitative and qualitative social research, there is far more to researching than just knowing and applying the

appropriate strategies or methods to a particular research project or problem. The principles of research are not solely for the purposes of the 'strategy' or the 'method'. Rather, they can also be construed as attitudes and values that are inherent to us as social care workers, due to the nature of our daily work. Research values and attitudes are based on a desire to garner information and to use such information for a purpose. Thus, it can be contended that the work of the social care practitioner and the values of research itself are inextricably intertwined. This is due to the often inquisitive or investigative nature of the work we do. In practice, there is the need to be ever-inquiring. There must also exist a perpetual pursuit of knowledge to enable us to work more effectively and for the betterment of the individual(s) we are caring for or supporting. This can be something that occurs not only in macro-level practice – in which we might, for example, be researching methods and models of best practice – but also at the 'micro' and 'relational' levels with those we work with. Thus, the importance of being able to participate in and lead research becomes obvious in the work we do.

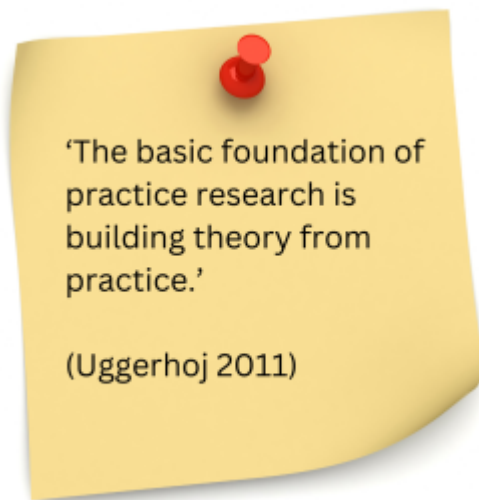
Research Principles and Social Care Practice

In order to support a service user in their situation, during a particular stage of their life or within whatever social care context we are involved, social care workers must continuously engage with research. Inherent in the work is that we must find out about service users, their likes, their fears, their past, their hopes and dreams for the future, their medical, social and family histories, their dietary requirements, behavioural supports and so on. This process of finding out is arguably research in and of itself and crucial to the support of individuals in our care. This information provides the basis on which we, in partnership with service users, help them to make decisions about supports or about interventions required in certain situations.

The inquiry that we engage in as social care workers usually begins with us meeting the service user(s) for the first time. This, for the student on practice placement, can be a good time to consider how principles of research can be used to influence practice.

In this initial process of relationship-building, we may begin to ask questions of the service user about their life, their likes, dislikes and other questions that may help us to build a trusting, respectful relationship on which our support of the individual can be based and from which it can grow. It is important that, based

on principles of consent, we seek permission to read any relevant files or care plans belonging to the service user. Information such as this can provide the data required to work more effectively, carefully and respectfully with the individual or group. This type of information-seeking is not fundamentally reliant on a specific process or framework of research.



It does, however, espouse the same attitudes, values, ethical principles and the desire to discover information that will inform the judgements and decisions that are made in the support of and in the collaboration with those that we support.

A practitioner or group of practitioners may carry out enquiry in order to better understand their own practice and client groups and to improve service effectiveness. These typically small and localised studies have the potential to

be shared with colleagues working in similar environments.

The initial stage of developing a strong relationship with and a good understanding of the skills, desires and needs of the individual or group is crucial to the ongoing support of the service user. However, our inquiring, questioning or curious attitude does not end there. Social care work is such that we must constantly be aware of the changing needs of individuals and groups. In practice, this occurs through an ongoing awareness of the individual's progress, requests, behaviours and emotions. This information can be seen as the data that we gather from our observations and questions. Changes to any of these can be recorded in daily logs and filed as part of an information system. Furthermore, these changes may be discussed at team meetings, key working sessions, quarterly or annual reviews, safeguarding meetings, family or case conferences, and sometimes these discussions will be in consultation with multi-disciplinary professionals.

Practice-Based Research

TABLE

As a process, evidence-based practice involves:

1. Having a research question (i.e., a question that is driven by client need)
2. Engaging in a systematic review of existing evidence and search databases
3. Assessing evidence
4. Considering the results with a client
5. Drawing conclusions and intervening appropriately

It can be contended that practice-based research is highly compatible with social care work as a means of producing an evidence base to inform practice. Practice research is considered a 'bottom up' approach to research and it occurs as part of our everyday work. Flyvberg (2001) suggests that no one person can provide the answers or true insights into a particular phenomenon, thus practice research emphasises the input of all stakeholders in the research process. One of the central tenets of practice research is the concept of 'evidence based practice'. Summerskill (2005) suggests that evidence-based practice requires that decisions about care are based on the best available current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources. Practice research can take the form of action research, community-based research, small-scale research projects and case studies, for example. These forms of research rely heavily on the principles of involvement of all stakeholders, as outlined earlier, and the social care work is central to facilitating this type of research.to implement changes in the programme if necessary.

Case Study 1

Practice research might take the form of a group of social care workers coming together within their organisation to conduct a study to better understand a particular issue/phenomenon in the organisation. For example, if there is a pattern of service users being dissatisfied with a particular educational programme in the service, practitioners may engage in a practice-based, small-scale study to identify the underlying causes of service users' dissatisfaction. This might involve a focus group or individual discussions with relevant stakeholders in order to ascertain the facts about the problem, the findings of which can be used to implement changes in the programme if necessary.

Clinical and Academic Research

It is unlikely that social care workers, by the nature of their professional role, will participate in or lead clinical research per se. However, some social care workers may decide to further their study in related disciplines such as psychology or psychiatric-based practices, taking their knowledge-hungry and inquisitive attitudes with them. Clinical psychology and psychiatry, for example, integrate scientific enquiry, knowledge and theory as a basis for understanding and are heavily dependent on research. They involve rigid research methods and research is carried out 'on' people with the focus of understanding more about health, disease or dysfunction, for example, and can strive towards finding or improving new treatments or increasing levels of a person's care.

Social care workers will have an understanding of the application of clinical research, as training often provides modules in clinical and abnormal psychology as part of professional qualification. These modules give learners an understanding of psychological and psychiatric disorders and the current means of diagnosing these disorders, which is important where service users in their care present with such issues. Students are made aware of the role of research in informing both theory and practice in abnormal and clinical psychology and the ethical considerations employed within related research practices. Social care workers will often find themselves working in multi-disciplinary teams alongside medical professionals, psychologists and psychiatrists. These disciplines, the knowledge and theory on which they base their practice, are heavily reliant on clinical research to inform their diagnosis, interventions and the care of individuals. Therefore, social care workers must have knowledge of the type of research on which such disciplines rely.

It is imperative that social care workers engage in academic research in their training and education. Social care workers can immerse themselves in this type

of research throughout their practice careers. Academic research, as a way of learning about individuals, groups and societies, begins with a student's search for relevant literature, articles and research papers to inform them in their essay assignments and other college tasks. Writing a literature review of a particular social phenomenon, for example, involves following the steps that guide planning, organising, information gathering and writing. There will also be a guide in relation to referencing (e.g., the Harvard system) and/or creating a bibliography. Academic research is not confined to college learning. It is something that social care workers can involve themselves in throughout their careers, whether they work in practice or elsewhere.

Influencing Practice through Research

There are numerous ways in which social care workers can influence their own practice and the general practice of social care. For example, they could disseminate a piece of work by submitting their research or academic paper to relevant social care journals in Ireland or internationally. They might also present their work at social care and/or related conferences such as the annual Social Care Ireland conference. They can influence the practice of their organisation by engaging in practice-based research and by encouraging others to engage with this philosophy.

Whatever the topic of interest, the type of research or the methodology involved, the research process involves similar steps. It is important that those undertaking a degree in social care develop the necessary knowledge, skills and attitudes required to participate in, develop and lead research for their own continuous professional development, to inform and improve the work they are involved in.

Participating in or Leading Research

As outlined above, a positive attitude to research in practice and an understanding of its benefits is an important aspect of what it means to be a social care worker. Social care workers must also be willing to participate as 'research subjects' where others are carrying out research that may be used to inform practice for the betterment of all stakeholders. Some of the skills that need to be developed in order to carry out, participate in or lead research

are those associated with communication, motivation, organisation and management, relationship-building, delegation and motivation. As a student, you will hone your academic, writing and project management skills throughout your education and these skills will be useful in carrying out research throughout your career.



Tips for Practice Educators

Practice educators should consider how they might enable the student to develop their academic and practice research skills and to meet this proficiency during the student's placement. Practice educators might provide the opportunity for the student to discuss how practice-based, clinical or academic research could be useful in informing either a piece of work with a service user or group and to discuss the implications of such research for the individual, group and organisation. This could occur during a supervision meeting. The practice educator may identify the need for a small-scale piece of research within the agency and thereafter support the student to design the study, to do some reading which might inform the research and guide the student in carrying out the data collection process. Following this, the practice educator may assist the student in writing up their findings and collaborate with the student in deciding how to implement these findings if necessary.

Such a piece of work can also provide the opportunity for the student to develop many other proficiencies. These include working autonomously and accountably throughout the research process, being able to manage the project/workload and adhering to the ethical principles involved in the research. It might also be an opportunity to develop communication, collaborative practice and relationship-building skills. The student should apply the knowledge acquired during their college course to the research task and develop new knowledge through any reading that might be necessary to inform the research.

It is important to include opportunities to reflect on the process of carrying out the piece of research, both during and after. This can provide the space for the student to identify and consolidate any learning that may have occurred during the process. It also gives the student the opportunity to consider what they did well and what skills/proficiencies they need to develop as their education progresses.

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Chapter 79 – Gillian Larkin (D5SOP18)

Domain 5 Standard of Proficiency 18

Know the basic principles of effective teaching and learning, mentoring and supervision

KEY TERMS

Teaching
Supporting
On-going learning
Continuous professional
development

Social care is ... about working with people with various difficulties and issues in partnership to find the right support so they can live empowering independent lives.

According to McSweeney and Williams (2018), social care practice encompasses knowledge from disciplines such as psychology, sociology, human rights in addition to the use of evidence-based practice. As well as an extensive knowledge base, social care workers require an array of skills including communication, active listening, boundary management, assessments, interventions (Allen & Langford 2008), while values of human rights, anti-discrimination, anti-oppression, empowerment, social justice, and equality provide the context in which we work (Lalor & Share 2013). In practice, this could mean working with several service users at the one time, all with different needs, utilising a range of skills and knowledge specific to each person so that their care is person-centred to them. In addition, social care workers need to work in and understand the legislative and policy framework of the organisation in an often changing environment. In my experience, social care professionals work under conditions of complexity and uncertainty and require a combination of theory and skills to deliver safe, effective, and efficient person-centred care (Turpin, Lynch & Spearmon 2015; Lalor & Share 2013).

Developing and maintaining these skills, values and knowledge is challenging

due to the evolving nature of social care development, the ever-expanding evidence base, and caring for service users with often-complex social and emotional needs. Consequently, social care staff, whether in the learning, graduate or experienced phase of their career, are all learners.

TASK 1

Think about...We can all remember those times when we experienced being new to a situation: first day at school, first day on placement, and the first week of taking up a new post in a social care setting.

Take a moment to think back to how it actually felt to be a student on placement/a new member of staff.

- *What are some of the main issues you think your students/graduate staff members/new experienced staff might be facing being in a new work environment?*
- *What might you as a social care worker do to help them?*

The Multiple Roles of a Social Care Worker

A social care worker does not focus on just the service user, but on students who are undergoing their placement, on graduate social care workers, on peers and on the self. This means a social care worker could be supporting a student on placement, mentoring a colleague, acting as a supervisor to colleagues and engaging as a student as they continue in their professional development. Therefore, social care workers are teaching others and learning through their interactions with students and staff, through supervision, mentoring and personal development.

An On-Going Learning Journey

Social care students receive training to prepare them to work in such a diverse field, both in the classroom and out in the practice environment through student placements. Within the education setting syllabi, student handbooks, assessments, evaluations and tests provided to the student ascertain their understanding and development. This learning process provides various guidelines and clear expectations, and when a student struggles to meet

expectations there are supportive steps and interventions. Students receive a continuation of their social care education in practice placement. It is here where students apply theoretical knowledge and proficiencies, develop their practice skills and professional values, understand the working of a social care organisation and become more aware of themselves and their learning needs, through supervised participation in the work of a social care agency (IASCE 2009).

Once qualified, social care workers engage in Continual Professional Development (CPD). The Health and Social Care Council define CPD as “the means by which health and social care professionals maintain and improve their knowledge, skills and competence, and develop professional qualities required throughout their professional life” (CORU 2013). CPD can include different activities; *Mary has recently trained as a Practice Educator while Lukas has attended a conference on Resilience in Children, and Francis is undergoing Key Worker training.*

Teaching and Learning

Teaching is an important part of the professional’s role and members of the social care profession teach students and other staff at some point in their career. Teaching involves setting appropriate learning experiences and includes activities/opportunities or kinds of interactions that lead to learning new information, skills and ways of thinking and being (Taylor & Hamdy 2013).



*Author created diagram illustrates the three domains of learning—**affective**, **cognitive**, and **psychomotor**—emphasising that meaningful education and practice emerge from the integration of emotional engagement, intellectual understanding, and physical action.*

Within social care, learning can occur in many ways. Jarvis (1983 cited in Hand 2006: 3) suggests learning can occur “...via the acquisition of knowledge, skills or attitude by study (course, training), experience (applying the theory/working with service users) or teaching (practice educator/supervisor/mentor)”. Reece and Walker (2007) note there are three domains of learning: cognitive, affective and psychomotor (behaviour), and learning can occur from teaching, study or the assimilation of information and skills from experience.

The three domains of learning take place along a continuum and the more learning, practice and experience a student/worker has the higher levels of learning that occurs (see table below).

Cognitive Domain – think	Examples from Social Care Practice
Learning takes place across the six levels – knowledge, comprehension, application, analysis, synthesis, evaluation	A student has knowledge of Children's First Guidance (2017) prior to going on placement. In placement the student is asked to apply the legislation to a situation; a student may be asked to evaluate the effectiveness of the legislation.
Affective Domain – feelings/emotions	Examples from Social Care Practice
Concerned with attitudes, values, beliefs, opinions, interests and motivations Learning takes place across the six levels – receiving phenomena, responding to phenomena, valuing, organisation, internalising value	Learning activities aim to develop students'/ workers affective skills. For example – learning about discrimination helps students challenge existing views and opinions and incorporate new values within their existing value base. Students move from learning about a new concept to internalising it into their behaviour through practice, experience and further opportunities for learning.
Psychomotor/Behavioural Domain – doing	Examples from Social Care Practice
Psychomotor skills relate to the ability to convert the basic skills of knowledge and attitude into physical skills and hands-on applied and technical proficiencies related to movement, coordination and practices. Learning takes place across six levels – perception, set, guided response, mechanism, complex overt response, adaptation, origination.	Learning activities aim to develop students'/ workers behavioural skills through observing and copying to develop skills. For example, students become aware of the importance of body language as a form of communication and develop through imitation/ practice skills in identifying eye contact, body posture, gestures and facial expressions and learn until the skill is automatic, integrated into practice and adapted to different service users/ situations.

Source (Randall 2011)¹

While learning is often associated predominately with cognitive learning, practice educators and mentors however must teach more than just knowledge and should guide students toward development within the affective and

1. The following resources provide in-depth explanation of the three learning domains: Randall, V. R. (2011) Learning Domains or Blooms Taxonomy. Available from: <https://academic.udayton.edu/health/syllabi/health/unit01/lesson01b.htm> Hoque, Md. (2017) 'Three Domains of Learning: Cognitive, Affective and Psychomotor', The Journal of EFL Education and Research, 2. 45-51.

psychomotor domains, and in essence, the domains are often interrelated (Hoque 2017). Some examples may help in understanding how the learning occurs.

Case Study 1

As an academic tutor I was on a placement visit and a student was telling me about her interaction with a service user who was attending a course in parenting support. The service user was not engaging with the student and her body language was closed off. The student remarked she found the service user challenging due to the lack of engagement and was quite impatient with her. In discussion the student demonstrated her understanding of the theory (cognitive domain) and her skills in reading body language (psychomotor domain) however the student had not demonstrated an unconditional regard (Rogers 1957) for the service user and was judgemental in the lack of engagement by the service user. The student did not demonstrate the correct attitude or professional manner (affective domain), so this proficiency was not met.

Case Study 2

Student Princess was working with a young woman, Clare, who was seeking a job and had sought help to do up her CV. Clare had Spina bifida and experienced some paralysis in the lower part of her body so used a wheelchair. Princess was delighted to help her and typed up the CV. At supervision Jackie (practice educator) asked Princess to reflect on how the activity went. Princess felt it went very well as the task was completed. Jackie asked Princess if she could explain (**cognitive domain**) the ethos of the service. Princess was able to explain that the service was underpinned by an empowerment model. When asked to apply it to practice, she said it was empowering service users to do things and make choices for themselves (**cognitive domain**). Princess was asked did she empower Clare and she said yes. However, Jackie asked Princess to delve deeper into her practice and asked her “Did you asked Clare what help she needed?” “Did you let Clare take the lead in the task?” In discussion Princess learned that while her intentions were good, she had not valued Clare as an independent woman but rather her engagement with her was based on her belief (**affective domain**) people with disabilities cannot do or think for themselves. This supervision session enabled Jackie to teach Princess about her knowledge and beliefs via cognitive and affection domain learning.

Types of Learning

The European Commission (2001, cited in UNESCO 2009) has drawn attention to different kinds of learning, and have identified a typology of learning. This is of

relevance to all social care students and professionals as it offers a lens through which we can determine what way we are learning.

Rogers (2014) considers the notion of **formal learning**, which is intentional, structured, occurs in an education institution and leads to certification. This type of learning mirrors the educative and practice placement opportunities students engage in, and the CPD activities the professionals undertake.

Non-formal learning is also organised, intentional, certified and can include first aid training, SAMS training, report writing training and so on. A third type is **Informal learning** and results from daily life activities related to work, family or leisure. In most cases, it is non-intentional and frequently unconscious (UNESCO 2009: 27). Tannenbaum *et al.* (2013, 2010 cited in Cerasoli *et al.* 2017) believes once formal training has finished employees are provided with the potential for informal learning from their working environment. For example, I learned about Transactional Analysis (TA) and developed the skill of negotiation while working in practice.

Think about...

Have you learned a new theory, piece of legislation, model of practice while on placement or in work?

What new skills have you learned as a result of your placement or work?

Did you require support with your new learning?

Who offered you support?

Student-Centred Learning (SCL)

The notion of teaching and learning has moved from a teacher led style to a more student-centred approach. Harden and Crosby (2000: 335 cited O' Neill & McMahon 2005) describe teacher-centred learning strategies as the focus on the teacher transmitting knowledge, from the expert to the novice. In other words, the teacher is the driver of learning, and does not provide choice to the student in terms of what or how they want to learn. Conversely, a student-centred approach focuses on the principles outlined below and promotes a more collaborative process between the teacher and learner and one that is used within the social care environment:

Figure 1.2: Principles of Student-Centred Learning (O'Neill & McMahon 2005)

- The learner has full responsibility for her/his learning
- Involvement and participation are necessary for learning
- The relationship between learners is more equal promoting growth and development
- The teacher becomes a facilitator and resource person
- The learner sees him/herself differently because of the learning experience.
- The learner experiences confluence in his education (affective and cognitive domains flow together)

Exploring the Multiple Roles of a Social Care Worker

Practice Educator

The Practice Educator is a member of the social care team who works with a student to maximise learning on practice placement. This includes identifying learning objectives, monitoring their learning, engaging in supervision sessions and assessing student development in conjunction with the student's education provider. Through participation in this learning environment, students integrate theory based learning with the realities of practice and through which professional competence is achieved (Alsop & Ryan 1996). In effect, Davys and Beddoe (2000) note the role essentially involves managing, assessing, monitoring, teaching, challenging and supporting the student. What a hugely important role practice educators provide to the social care sector. As articulated by McSweeney (2016), practice educators are essential in the education of social care workers.

Stop!

Are you a Practice Educator?

If yes, give yourself a huge clap. You are an essential part of social care learning and development.

Do you work with a colleague who is a Practice Educator? Shout out well done, give them a clap, buy them a coffee and a scone – you choose!

Are you thinking of becoming a Practice Educator? Thank you!

We can all remember the time of being a student – the not knowing, of being unsure, of being afraid, of not being sure if we would make it! To my practice educators, to the practice educators of today and tomorrow – keep up the good work!

Bastable (2014) argues it is essential for a practice educator to have knowledge (of the material to be learned, the learner, the social context), and be competent (be imaginative, flexible, and able to employ teaching methods, display solid communication skills; and have the ability to motivate others) to facilitate effective learning with students. Thus, it is necessary for social care workers who take on the role of a practice educator to engage in ongoing professional development.

Learners as a Resource

A key learning opportunity is when students are on placement. Students bring new ideas and knowledge, can challenge practices for both the practice educator and other staff and prompt increases in the practice educator's reflection (Mc Sweeney 2016). McAllister and Lincoln (2005: 1) found that practice education and the experience of having students offered "opportunities to both educators and students for professional growth" and that this professional growth and development implied a "movement along a continuum of professional skills and competencies".

Examples from Student Placements

Student Fiona noted that first thing in the morning on placement, a staff member was tasked with waking up each service user at 8am regardless of

whether they were going to school or Youthreach, which led to difficulties when the young people would not get up. Fiona asked if those not getting up for education could be left until those going to education had gone? In the team meeting, the staff remarked they had been doing the routine for so long, it was no longer fit for purpose, but no one thought to change it.

In a supervision session, a student explained the Social Role Valourisation Theory (Wolfensberger 1983) to the practice educator, who was engaging in such practice, but did not know the evidence base behind it. Another student provided a presentation on New Directions as the staff team were unfamiliar with the guidelines.

Supervision and Mentoring

To ensure a supportive teaching and learning environment, the 'teacher' needs to demonstrate a genuine non-threatening relationship with the 'student'.

Bernard and Goodyear (2013: 7) define **supervision** as “an intervention provided by a more senior member of a profession to a more junior member or members of that same profession”, or in the case of a student placement, is provided by the practice educator to the student. Morrison (2003) proposes that the purpose of supervision is to enhance the social care worker's/students professional skills, knowledge, and attitudes in order to achieve competency in providing quality care. Supervision is documented and thus is an evaluative process (Saliba 2013). The follow example demonstrates how supervision prevented a student from leaving her placement.

*“It was my first week in placement and I was struggling. I had never worked with people with disabilities before and found I could not understand when they spoke to me, and one service user threw her bag at me because I kept saying ‘pardon, sorry, pardon’. At my first supervision I told my practice educator I was leaving as the service users did not like me and I cannot understand what they are saying. I was crying as I always wanted to be a social care worker but was rubbish! My practice educator was amazing. She let me say how I was feeling (**affective domain**) and then asked me to tell her all the interactions I had with service users that were positive. I struggled but named two. She explained to me that all*

students experience difficulty with service users initially and communication is a skill (**psychomotor domain**) I will develop during placement through practice. We discussed theory that would help me (**cognitive domain**), and we explored other reasons why the service user may have been cross (**cognitive domain**), and I identified 2 skills (**psychomotor domain**) that I wanted to achieve around communication before my next supervision session. We then discussed my feelings in regard to the service user being cross with me and how I attributed my inability in understanding the communication to being 'stupid' and my subsequent reaction. Through the discussion I learned that I had no awareness that I was valuing myself against my engagements with the service users, and when I perceived that things had not gone well, it was an indication of my lack of ability, which led to an overload of emotion. To try to increase my awareness around my feelings (**affective domain**) and what were triggers to feeling good, bad, confident etc. my practice educator asked me to journal my feelings on a daily basis with a view to helping me making connections between feelings and behaviour (Year 2 Social Care Student)².

Similar to supervision, **Mentoring** also involves two parties (a mentor and a mentee), a relationship (formal or informal), and the transfer of skills, knowledge and attitude with the objective of development growth of the mentee (Bilesamni 2011). Megginson and Clutterbuck (1995: 13) define Mentoring as "offline help by one person or another in making significant transitions in knowledge, work or thinking". Unlike supervision, informal mentoring is not an evaluative process (Inzer & Crawford 2005).

Within social care mentors can be a peer or a senior member of staff who offer informal support to new graduates as they can experience a variety of developing challenges that may impact on competent practice, may feel inadequately prepared to practice independently, or navigate the complex responsibilities required. Taherian and Shekarchian (2008) note engaging with a mentor can help increase a mentee's motivation and empower and encourage them which can raise the performance bar, while as a result of nurturing self-confidence, teaching by example and offering wise counsel mentors can experience higher levels of well-being and work satisfaction (Morgan & Rochford 2017).

The following examples demonstrate the difference between mentorship and supervision, and the role of evaluation.

Supervision Example

Martha is a supervisor for Anthony, a social care worker who has been on the team for three years. This is a very structured relationship. There are regular meetings that support Anthony around the three supervisory functions of education, support and accountability (Kardushian, 1992). During the most recent supervision session, Anthony talked about finding it difficult to work with one young person in the unit, as this young person's behaviour had escalated and there is limited interaction with the staff team. As his key worker, Anthony felt he was not able to help the young person. He was feeling very low and a little angry as he had worked hard with the young person and felt the lack of engagement was a reflection on him, and really felt the young person ungrateful.

*During this session, Martha asked Anthony to evaluate the young person's behaviour from a theoretical basis (**educative function**) and reflect on why he was taking the young person's actions personally. Martha acknowledged the anger he is feeling and while supporting Anthony with his feelings (**supportive function**), highlighted this anger could seep out into his practice with the young person, which would be a boundary violation (Davidson 2005) (**accountability function**). Through discussion, Anthony said he was not sleeping well due to a new baby at home, and this was affecting his work. Martha spoke to Anthony around different options of self-care and invited Anthony to a further supervision meeting if needed. In line with regulations, Martha documents the supervision meeting.*

Mentoring Example

Josephine has been mentoring new staff in the team for the last five years. She has fifteen years of social care experience and has worked in a variety of services before taking up her role in this service nine years ago. Josephine works informally with the new staff for a period of six months depending on the needs of the staff member. During this time, Josephine supports the new staff member to settle into the staff team, build

relationships with all the stakeholders, offers feedback and provides new learning strategies, based on her knowledge and experience, to help the staff member become competent and confident in their practice. Josephine really enjoys this role as it allows the new staff to be open about their practice and seek support without being concerned of evaluation, as can be the case in a supervision meeting.

Tips for all Learners – What Helps Learning?

Roger's (1957) discusses three core principles to facilitate a therapeutic change, that of congruence, empathy and unconditional positive regard. As learning is also about change, the right environment is essential to ensuring optimal development. Hand (2006) has outlined some characteristics as essential to supporting learning which fit nicely in our roles of teacher and learner:

- Listening and responding consistently
- Helping the 'student' to identify feelings and personal knowledge
- Sharing of self with the student
- Being sensitive to the students' needs
- Valuing the learner as a person respecting and caring for his/her feelings and opinions
- Showing empathetic understanding
- Being aware of personal strengths and weaknesses and their effect on others

TASK 2

Activity:

Identify an element of your practice that you need support with and look around your staff team and select someone who you think may be able to help you.

Explain your issue and seek their help.

- How does it feel being the learner?
- Ask your colleague how it feels teaching you something new?

Case Study 3

Philip has recently graduated and is three months into his job as a social care worker and is finding things difficult. He loves the work and is really enjoying working with the young people but is not sure if he is doing the work 'right'! All of the other staff seem so sure of themselves and know how to deal with all situations with the young people. Philip thinks he has made the wrong career choice. Philip has spoken to his mum and she has suggested he talks to his supervisor however, Philip was adamant he would say nothing as it would look like he was rubbish at his job, and he is on probation.

- What are the benefits of providing Philip with a mentor?
- What will be the mentor's role?

Case Study 4

Sonia has been working in Cedar Family Support Services for three years and is struggling in her role. She has been working with the Byrne family for three months and is finding it difficult to separate her feelings to the mother Denise from her own personal experiences. On a number of occasions, she was quite judgemental towards Denise, and could not accept how she could forget to feed her children, and send them to school with no coat, to the point that five-year-old Sadie was hospitalised with a severe chest infection. Sonia could not contain her displeasure at those poor children experiencing neglect so asked a colleague to work with Denise last week; Sonia knows this is not a long-term option. Sonia's supervisor has noticed she

is not engaging with her service user as she normally would and has asked to have a supervision session with her.

- What do you see as the issues Sonia is experiencing?
- In your opinion, does Sonia need a supervision or mentoring session? Please explain your choice.

Case Study 5

Sunita is preparing the schedule for her new social care student. Sunita has been a social care worker for six years and has extensive experience in supervising students. This is her fourth year as a Practice Educator. Sunita likes to engage in weekly supervision sessions with the student as this

allows her to keep a check on student development, complete the college supervision logs and assess how the student is progressing in meeting the relevant proficiencies.

In preparing the schedule, Sunita provides opportunities that allows the student to develop in all areas including knowledge, legislation, models of care and application to practice. Both Sunita and the staff-team demonstrate ethical practice, skills in how to engage, communicate and work with service users, and develop reflection skills. Students are taught to be responsible and accountable for their decisions and actions through the allocation of roles and duties.

Supervision allows students to reflect on their practice and discuss areas that are going well for them and challenges that need support. In this space, students are given the time to talk about their emotions and feelings, their judgements and biases. In her role, Sunita offers the student constructive feedback on what has been observed by herself and colleagues in practice and this creates awareness and opportunities to enhance practice, feelings, emotions and skill development.

A key part of the practice educator role is to support the student to think critically and Sunita does this through asking questions and supporting the students to draw on many theories and skills to search for the most appropriate approach. Sunita also provides access to training such as report writing, Manual Handling, First Aid, SAMS and MAPPA.

- *In your opinion, what other opportunities are there for Sunita to teach her student?*
- *Can you think of any opportunities where the student may be able to teach Sunita?*

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Chapter 80 – Christina Sieber (D5SOP19)

Domain 5 Standard of Proficiency 19

Demonstrate an understanding of the importance of one's own personal growth and development in order to engage in effective professional practice whilst developing the personal skills of self-care and self-awareness in the role.

KEY TERMS

Personal growth and development
Self-awareness
Self-care
Reflective practice
Reflective writing/journaling

Social care is ... about relationship developing, building, nurturing, self-care, awareness and reflection. It is impossible to care for others if you do not care for yourself.

TASK 1

Reflecting on Practice

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

The Importance of Personal Growth and Development

An understanding and engagement in personal growth and development is an essential tool in the training of social care workers and in the practice of social care work. The use of self-care, self-awareness and reflection can help a social care worker engage in effective professional practice and explore aspects of themselves that may make them vulnerable. Using these tools in supervision can help to guide a supervisor and supervisee through difficult events and situations.

What is Self-awareness?

Awareness is about what you notice in life and in the world. It involves paying attention to what is happening around you. Forms of awareness are different for everyone and there is no right or wrong way of being aware. It is about how you experience life. So, if awareness is about noticing what is going on in the world, self-awareness is about focusing what you notice and your awareness of yourself.

While there is no correct or incorrect way to be self-aware it is important to be able to focus on your feelings, your reactions, your behaviours and your thoughts. One way of becoming self-aware is to practise self-care.

What is Self-care?



Author created personalised self-care plan that highlights Christina's holistic approach to wellbeing, balancing emotional, mental, and physical strategies.

Self-care is something you give yourself. It is any task that helps our mental, physical, and emotional health. Taking care of our wellbeing through self-awareness and self-care is a vital component in engaging in personal growth and development as a social care student or social care worker. There are many tools that can aid in this task. One way of becoming self-aware is to have a self-care plan. Constructing a self-care plan when times are good can help to focus you when life and/or work gets hard and you need a reminder of how to get back on track.

TASK 2

How do you self-care? What self-care techniques work for you?

Write down a couple of ways in which you engage in self-care in your life. Use these to create a self-care plan to look after yourself.

Another way of engaging in self-care and effective professional practice is to become reflective and to keep a reflective journal. This should be encouraged throughout social care training and when in practice.

Reflective Practice

Reflection can be defined as how a person perceives an experience, thinks and reflects on that experience and then uses their reflection to learn from that experience (Kolb 1984). **It is the learning gained that is important.** 'Wellbeing' is a term used frequently when discussing people's mental health; similarly, the term 'reflection' is important when talking about well-being in personal and professional life.

Dewey, quoted in Carlile and Jordan (2007: 27) suggested that reflection can be defined as 'turning a subject over in the mind and giving it serious and consecutive consideration'. Kolb (1984: 38) spoke of learning being 'the process whereby knowledge is created through the transformation of experience'. Gibbs (1988) added that it is not enough to have an experience; the important part is the process of thinking about it, and this new learning shapes how we react to similar situations.

Moon (2004: 82) defined reflection as:

A form of mental processing – like a form of thinking – that we may use to fulfil a purpose or to achieve some anticipated outcome or we may simply 'be reflective' and then the outcome can be unexpected. Reflection is applied to relatively complicated, ill-structured ideas for which there is not an obvious solution and is largely based on the further processing of knowledge and understanding that we already possess.

Reflective Writing/Journalling

The act of reflective writing/journalling can provide individuals with the opportunity to make meaning of their past experiences. They can then relate those experiences to present circumstances or their current opinions and evaluate how they might influence the way they approach new circumstances. The act of reflective writing/journalling can help individuals consider experiences and connect them in a way they may not have done before.

Reflection and reflective learning have also been compared to a toolbox (Lyons 2010). Like a physical toolbox, the reflective toolbox is a go-to place where individuals can draw on past experiences and reflections which can help in current situations. Reflection is a skill that can be learned and it can aid in personal development. Reflecting on a situation and analysing it can help one learn from experiences and can also help one be prepared to deal with situations in the future. At a personal level, perspective on situations and better decision-making can also be gained.

Case Study 1

You are a new member of staff in a social care setting. An incident occurred during your first shift and the way it was dealt with by an experienced social care worker is playing on your mind. While the incident was resolved positively you have many questions as to the practice of the social care worker in question.

Your monthly supervision meeting with your supervisor is in a few days and you are unsure whether or not to raise the issue.

TASK 3

Reflect on this case study.

Thinking about the case highlighted above, how might reflective practice before and during supervision support you if you encountered a similar case in the future?



Author created diagram that illustrates the multifaceted nature of reflection, connecting key theorists, tools, and outcomes that support personal growth, professional development, and effective practice, positioning reflection as a dynamic core of lifelong learning in social care.

Engaging in Effective Professional Practice: Reflection and Professional Growth and Development

At a professional level, the skill of reflection is a vital aspect in evaluating situations (at times dangerous) and making decisions about these situations. This skill is essential in the social care sector, where registration and competence practice will be a requirement. One of the prerequisites of registration is the completion of and submission of a portfolio of continuous professional development (CPD) to the registration board (CORU) and four reflective pieces about practice must be submitted as part of this portfolio. The skill of reflection is essential in putting an individual's knowledge to good use (McCann *et al.* 2009) and in taking responsibility for one's actions and values where one lives and works (Bolton 2010). The aim of this is to evaluate the effect of their own characteristics, values and practices on interactions with service users and to be able to critically reflect on this to improve practice (SCWRB 2017: 5).

Conclusion

An understanding of personal growth and development is an essential tool in the training of social care workers and in the practice of social care work. Self-

awareness and self-care are critical components in developing as an effective professional. Reflection is vital in ensuring that the practice of social care work is one that is fulfilling to the worker but also beneficial to the people we care for. It is through this awareness and reflection of the self that we can truly care for and engage with the most vulnerable members of our society – our service users.



Tips for Practice Educators

- Encourage your students to keep a free-flowing narrative journal (this can help to guide supervision).
- Encourage them to write in this journal at least once a week.
- The purpose of keeping a journal is to support the student in developing the skills necessary to become a professional social care worker.
- The process of writing forces us to deal with our ideas in a concrete form, and undoubtedly leads us to a deeper examination of what we are thinking.
- It helps us to clarify our thoughts and identify gaps in our understanding.
- Written accounts allow us to see our progress as our learning expands.
- A written record is also useful in our continued reflection and revision of what we have learned and experienced.

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Updated Revisions from PDF Booklets

Type of Alteration	Orginial	Change
Book restructure	Five PDFs with separate downloads are currently hosted on https://socialcareireland.ie/guide-to-the-standards-of-proficiency-for-social-care-workers/	Each published PDF book is now under 'Domain 1', 'Domain 2', etc. in the eBook.
Chapters	Sections are duplicated in each of the PDFs: Acknowledgments, Foreword, Table of contents and the Introduction.	Only one Acknowledgments, Foreword, Table of contents and the introduction were moved to 'Preliminary Sections' at the start of the eBook.
Heading	List of Contributors	Domain 1: List of Contributors

Colour change	Domain 3 – light yellow	Changed yellow heading to darker yellow – RGB (191, 153, 0) in Domain 3	26th Feb 2025 finished 11/3/25
Title of Chapters	Name of author	Change – Added the (D3SOP4) for example into every title	26th Feb 2025 – finished 27th March
Chapter 30 – Ailish Jameson (D2SOP7)	Links – https://mindofmyown.org.uk/ and YouTube video	Links were broken. Now updated and text added.	13th March 25
Domains 1-5	None	Each section is named after the Domain. For example ‘Domain 5 – Professional Knowledge and Skills’ for clarity	21 March 2025
Overview of eBook instead of table of contents	None	An overview of the eBook was added instead of the table of contents. the table of contents was no longer required as Pressbook created this in the web version.	21 March 2025