



**PERson CENTred Training; AGE care planning**

# **Course Planner**

A learning framework designed by  
partners across Europe

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# INTRODUCTION

The Percentage training programme was devised as a European Projected under the Leonardo Programme as a partnership between social care organisations in: Helsinki, Finland; Surrey, United Kingdom; Tartu, Estonia; Uppsala, Sweden; and Veneto, Italy.

This course planner will help you as a trainer to implement the training contained in the Percentage Programme. For each of the learning units, ideas are provided about techniques and material that can be used to deliver each part of the course. There are also details of how the training was delivered during the piloting process across Europe.

Additionally Percentage has produced: the Percentage Learning Units which gives details of coverage of each unit and the skills outcomes; the Percentage Learners' Guide to help learners prepare for each learning unit and the Trainers' Guide providing further information for trainers. Further information is available on our website : [percentageproject.com](http://percentageproject.com)

## **The Percentage Learning Programme**

Percentage is designed to equip frontline care workers with the skills and knowledge to work with their service users and their families. It helps them to explore their care needs, to devise and evaluate options for the delivery of care and to design, implement and evaluate a care plan for an individual service user.

## **Care Plans by Frontline Care Workers**

Care plans are often devised by supervisory staff or care managers. However, it is the frontline staff who have the closest contact with each service user. They know them well and they can understand their needs. They are also well placed to know what care tasks are needed and how best to deliver them. The Percentage Programme helps frontline care workers translate this knowledge into devising care plans.

## **Delivering Training for Frontline Care Workers**

Frontline care workers are skilled in delivering care to service users. They are well equipped to carry out care tasks effectively, safely and sensitively. However, many care staff have less experience of formalised learning and the use of written material. They can also be working in their second language so the design of the delivery of the Percentage Programme needs to reduce reliance on reading and writing. It needs to emphasise experimental visual techniques such as role play, demonstration, video etc. It needs to take full advantage of the practitioner focus of the learners, e.g. user examples, talks by users, talks by experienced practitioners.

## **Delivering the Learning Programme**

The results of the piloting of each learning unit by our European Partners are summarised. This should help you as a trainer to tailor each learning unit to meet the needs of your learners.

# LEARNING UNIT 1

## USER/FAMILY ENGAGEMENT

The aim of this learning unit is to enable the learner to work with the user and the people significant to the user to discuss the care needs of the user and their ability to help themselves and their wishes about their care. This unit was piloted in Estonia and in Italy.

### Pilot Training in Tartu, Estonia

This unit was tested in April 2008 in Tartu, Estonia with the help of eight learners and two trainers.

The training was split up into five sessions.

#### ***Introductions***

The trainers introduced themselves and invited the learners to introduce themselves. The trainers then outlined the aims of this learning unit and the design of the training.

#### ***Lecture***

The trainer gave an outline talk on the aims of care planning, the assessment of care needs and the purpose of involving users and family.

#### ***Group Exercise on Needs Assessment***

One of the learners presented a real life example of a user living at home. The group worked together to examine the possible types and the extent of care needed. The perception of need differed between the user, the family and the staff leading the assessment. The group work enabled the learners to reach an agreement on the care that should be offered.

#### ***Lecture on User Focussed Needs Assessment and User involvement***

The trainer outlined the philosophy of home care, users' rights and the limitations on them. The trainer then presented details of the hierarchy of human needs and how this related to the need for care services. The talk then focussed on empathy, communication and involvement of the family. The talk ended with an overview of social policy and the family, common family problems and how to raise awareness of them.

#### ***Role Play***

The learners took turns to play parts in a role play of the involvement of users and family members in making a care plan.

#### ***Lecture on Teamwork***

The trainer gave a talk on the role and effectiveness of team work

#### ***Evaluation of the Tartu training session***

The learners and trainers then discussed the value and effectiveness of the learning unit. The learners and the trainers were very positive about the training. They felt that the lecture could have included more information on behaviour models and advice about how to start a relationship with a user. The group work enabled learners to share ideas and resolve conflicting views. The role play allowed learners to experience different perspectives of care needs and to test their ability to make care plans. In general, this

learning unit (user/family engagement) pre-supposes some prior knowledge of needs assessments and care planning, so learners without this need some prior introduction. Among the conclusions reached were:

- It is important to introduce the overall concept of care planning and to give real examples of what goes wrong if there is no care plan.
- It is important to show people the outline of the whole process of care planning.
- Equally positive examples of care planning should be used.
- The learners valued group discussions, especially where these were handled in a stress free style.
- The role plays were a useful way to learn but it must be remembered that resources are sometimes limited so the solution must be realistic.
- This learning unit needs to be delivered in conjunction with aspects of Learning Unit 4 (Care Plan Recording) and Learning Unit 5 (Care Plan Implementation).

### **Pilot in Florence, Italy**

This learning unit was also piloted in Firenze (Florence), Italy by Obbiettivo Formazione, a specialist training organisation in February 2008. The training was given in Italian to eight staff who were not native Italian speakers. The session ran for four hours and was held in a training room in a residential care home. It was delivered by a trainer and a support tutor and the learners had met each other the day before.

The training was delivered in the following ways:

#### ***Introduction***

The trainer introduced herself and allowed the learners to meet each other. She then went through with them the learning outcomes desired from the training and asked them to consider their current levels of skills.

#### ***Written handouts***

The trainer then gave out written material on care planning and the background to it. These were then discussed in the full group.

#### ***Role play***

The trainer then split the learners into three groups to go through a role play to practice working with a user to encourage them to talk about their care needs and how they could receive the help they wanted.

#### ***Evaluation of the training***

The learners were asked to comment on the usefulness of the training and were given questionnaires to complete.

#### ***Conclusions***

It was felt that the practical approach was more successful in engaging the learners and they were more comfortable with informal styles. As staff who were used to the Italian systems and language, it was not easy to convey the underpinning knowledge within the session itself, so it would have been more useful to provide the learners with some written material to read as homework before or after the session.

## LEARNING UNIT 2

### PROACTIVE CARE PLANNING

The aim of this learning unit is to enable the learner to include in a care plan not just the needs described by the user but also those needs that are not easy to see or easy to talk about. The learner needs to know the range of issues to explore and how to deal with painful subjects.

This unit was piloted in three partner countries: Finland, Italy and Sweden

#### Pilot in Helsinki, Finland

The training was delivered in three parts:

- a pre-training written task
- theoretical training
- practical training

#### ***Pre-training task***

About one week before the training, the learners were asked to identify the other staff in their care team, their education and their occupation. They were also asked to identify other care professions within their team and what support services were offered to users.

#### ***Theoretical training***

The theoretical element of the training was split into two sessions each lasting for four hours and delivered three days apart. The training began with introductions of the trainers and learners and was followed by an overview of the Percentage Programme and the learning to be covered in the sessions.

The theoretical training then involved:-

- A presentation about assessing needs and making care plans including respecting users, meeting with users, observing users and their environment, identifying changes in users and making care plans.
- Providing learners with key care planning tools such as an “Album of Home Care” and an “Activities of Daily Living” form.
- A group discussion on the pre-training task prepared by the learners.
- A role play by two trainers of a needs assessment meeting between an older woman user and a care needs assessor.
- A role play of a care planning meeting between an older woman user and a member of staff. The roles were played by two trainers and observed by the learners. It was followed by a group discussion.
- A case study focussing on maximising independence, which was discussed by the learners in pairs and then followed up by a whole group discussion.
- The learners were also given time to practice completion of the daily activities forms and care plans.

#### ***Practical training***

In the practical training, the learners accompanied experienced staff on home visits and were required to observe users’ needs, the living environment and the effectiveness of the current care services in meeting care needs.

#### **Evaluation of the training in Helsinki**

The learners in Helsinki did not have previous experience and training in delivering care services at home. It was therefore important to recognise this in designing the training.

Combining the learning units 2, 7 and 9 was successful, although not all the material could be covered, so it would be necessary to follow up the training when the learners had more experience.

### **Pilot in Florence, Italy**

This unit was piloted by a specialist training organisation in Florence in February 2008. The eight learners were care workers who were not native Italian speaking and were not fully familiar with the Italian culture.

The trainer began by outlining the learning unit and testing out how much the learners already knew. Following feedback from Learning Unit 1, the training was more focused on interactive techniques. The trainer gave out written material to the learners. Then the trainer introduced a family member as a witness to talk with the learners about what the family expected from a care manager who was supposed to arrange care for their mother. This was followed by questions so the witness session lasted for 45 minutes. Then the trainer divided the eight learners into four groups to do some practical exercises. This was followed by a full group feedback session.

### **Pilot in Uppsala, Sweden**

This learning unit was piloted in Uppsala, Sweden in February 2008 with six care staff and two trainers. The training was delivered in conjunction with learning units 3, 4, 5 and 6 because the learners and trainers felt that the learning units flowed well together.

As the care plan documentation is already available in Uppsala, this was used as part of the training. Firstly, the learners took a real life example and mapped this against the existing documentation process. Then the learners were split into two groups, each with a trainer. The learner did a real life care plan with a service user and this was observed by the trainer. Afterwards, there was a feedback session.

The trainer would also consider using videos of real life cases and get staff to develop care plans from them.

## LEARNING UNIT 3

### CARE PLAN PRODUCTION

The aim of this learning unit is to enable the learner to draw up a care plan by working with the user and their family. Through this unit the learner will be able to explore what help the user needs and the best way of meeting them. Some users will not be able to easily explain their needs, so the learner will need to carefully assess them. This unit was piloted in three partner countries: UK, Italy and Sweden.

#### Pilot in Surrey, U.K.

When this learning unit was piloted in Surrey, U.K. in May 2008, it was delivered to six staff from two residential care homes for older people. The training was led by two senior staff from the home and it was combined with Learning Unit 4 (Care Plan Recording). It was run in a single day in a training room in the care home. The training was split up into several sessions:

#### **Introduction** (10 minutes)

The learners and trainers were introduced to each other and the programme for the training was outlined.

#### **Questionnaire** (80 minutes)

The learners were given 30 minutes to complete a written questionnaire with a set of 10 questions about the purpose, production and recording of care plans (see Appendix LU3A). Their written answers were discussed as a group and they were given a written copy of model answers to each of the questions (see Appendix LU3 B).

#### **Role Play 1** (75 minutes)

The trainers led a role play in which staff were trying to work out a care plan for an older person with dementia living in a care home. One of the trainers acted the role of the older person and one of the learners acted the part of her daughter. The interview with the user and daughter was led by the other trainer with the help of one of the learners. The other four learners observed the interview.

The role play ran for 45 minutes and was followed by 30 minutes of whole group discussion.

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#### **Role Play 2** (75 minutes)

The same role play was then re-run with the learners taking a more active role in working out the care needs of the user and producing this in written form. Again, after the end of the role play there was a group discussion including items about the different ways that the care plan could be written up.

#### **Mop up sessions** (30 minutes)

The trainers then led a group discussion on what the learners found difficult about care planning. The learners said that it was sometimes difficult for them to know what to include in a care plan and to find the work time to do care planning. They also sometimes found that the written format for care planning that is used in Surrey includes some words that are difficult to understand and it could be generally made easier to use.

#### **Reflective Account** (30 minutes)

The learners and trainers were asked to write down their thoughts about this learning unit. The conclusions reached were:

- It is useful to combine this learning unit with Learning Unit 4 (Care Plan Recording) when doing the training. This is because it is easy to record the care plan on the second running of the role play.
- Care staff enjoy doing the questionnaire because it allows them to work on their own ideas and improve them. It is better than being lectured to.
- Similarly, the role plays allowed staff to see and experience the working out of a care plan. The group discussions allow everybody to contribute ideas and to talk about previous difficulties they have had in care planning. The combination of trainers and learners in the role play helped to make the learning more inclusive.
- Everybody thought that the training should be given to all staff, not just new starters.
- There are detailed changes needed to the format currently used for recording care plans in Surrey.

### **Evaluation**

The learners really enjoyed working out care plans and the training validated their importance in knowing about the needs of users and making sure that all staff worked to the same plan.

The use of interactive techniques helped staff whose work is practically focused to think through how to work out care plans.

<b>Pilot in Florence, Italy</b>
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This learning unit was piloted by a special training co-operative in Florence, Italy in February 2008. The learners were eight care workers from outside Italy who were not native speakers and not familiar with Italian systems.

The trainer began by explaining the outline of the learning unit and to test out their previous experience. She then gave a talk with slides about what should be included in a care plan. There was also a discussion with the learners about what they thought should be included. The trainer then split the learners into three groups to carry out a practical exercise in developing a care plan from information provided in writing. After 30 minutes the trainer asked for a spokesperson to present the work of the group but they asked for more time and this was agreed.

Finally, the trainer provided the learners with a written care plan and helped them to understand the language used.

<b>Pilot in Uppsala, Sweden</b>
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This unit was piloted in Uppsala in February 2008 as part of a programme covering learning units 2, 3, 4, 5 & 6.

The system for delivering the training started with a discussion of the pre-existing care plan documentation in use in Uppsala. Then the trainer helped the learner to plan a meeting with a service user. The learner then did a live interview with the user to draw up the care plan in the existing documentation. The trainer directly observed this interview and fed back to the learner.

The pilot showed that the learning unit fitted in well with the care plan documentation in Uppsala and was an excellent introduction to Learning Unit 6 (Sensitive Communication).

**Questionnaire**  
**Units 3, 4**  
**Care Plan Production / Care Plan Recording**

1.	What is a care plan?
2.	Who is involved in care planning?
3.	Who is responsible for documenting the information?
4.	What needs to be considered for care planning?
5.	Why do we do care planning?
6.	How and where is the information kept?
7.	When should care planning be done?
8.	How is the care planning done?
9.	What support is available to the key worker?
10.	What if I make a mistake?

**Answers**  
**Care Plan Production / Care Plan Recording**

1.	A record of client's history, assessment of social, physical, emotional and spiritual needs.
2.	Client Family/friends Care manager Other professionals Key worker Senior care officers
3.	The key worker, monitored by the senior care officer and agreed and signed off by the client or representative.
4.	Wishes Choices Needs Preferences History Medical conditions Intervention Family support Environment Limitations Awareness of risk
5.	To enable the client to live: <ul style="list-style-type: none"> <li>• as full a life as possible</li> <li>• as safe a life as possible</li> </ul> Client's needs are met Support is available and provided Respected in their own right Continuity of care
6.	Confidential Appropriate locked place Documents can only be shared with the client's permission <ul style="list-style-type: none"> <li>• Or we can show the documentation to next of kin if they have enduring power of attorney</li> </ul> Any discussions must be in a safe place
7.	On the client's initial assessment Developed further during their stay Reviewed in an agreed time frame
8.	As much information given by client/representative You will have basic information on assessment You can get the information from observations and getting to know the client
9.	All key workers have access to a senior care officer 24 hours a day. The senior care officer's role is to support and guide you.
10.	It cannot be removed. If errors occur, then a line should be put through it and an explanation recorded, and the error should be initialled by the author, client/representative.

## **LEARNING UNIT 4 CARE PLAN RECORDING**

The aim of this learning unit is to enable the learners to accurately record the details of a care plan so that, as a written document, it can be used by the user, family and care staff as a programme for meeting the care needs.

In most cases the formats for the written care plans will already be set out by the organisation arranging the user's care services.

The key point of this learning unit is that the learners should be able to set out the care plan in such a way that it can be understood and used by others.

This unit was piloted in three European countries: UK, Italy, and Sweden

### **Pilot in Surrey, U.K.**

When this learning unit was piloted by Surrey in May 2008 the delivery of the training was combined with Learning Unit 3 (Care Plan Production). This meant that the learners could work out what the contents of the care plan should be (Learning Unit 3) and then how they should be written down (Learning Unit 4).

The recording of the care plan can be challenging for frontline care staff who sometimes have limited experience of lengthy form filling. The combining of learning units 3 and 4 gave them increased confidence. However, it was clear that the format used to record care plans in Surrey could be simplified.

The contents of the pilot training in Surrey are set out in detail in learning unit 3.

The learners enjoyed writing down the care plans that they had worked out in the role plays in Learning Unit 3. Previously, the task of writing care plans had been given to more senior staff. The training enabled staff who had direct experience of working with the user to make sure the care plans were better. It also enabled staff to feel more validated in their work.

### **Pilot in Florence, Italy**

The training was piloted in Florence in February 2008 with a group of eight learners who were inexperienced in care services, not native Italian speakers and unfamiliar with Italian formalities in care services. The trainer began by outlining the skills outcomes of the learning unit to the learners. Many of the learners were nervous about using the electronic version of the care plan used in Florence. The trainer explained the importance of care planning. This was reinforced by a group question/answer session led by a practising social worker who was able to explain in detail how care plans are used and the importance of not making mistakes. The trainer then split the group into pairs ensuring that one person in each pair was confident in using IT. Then each pair recorded a care electronically via a laptop computer. This was then checked over by the trainer.

The learners liked the session with the social worker because it should the practical importance of care plans but were less comfortable with the use of computers.

## **Pilot in Uppsala, Sweden**

This was piloted in February 2008 in Uppsala as part of a programme covering learning units 2, 3, 4, 5 & 6.

The main component of the training for these units was a trainer preparing the learner to do a live interview with the user who was in a ward for older people with palliative care needs. The trainer then observed the live interview and fed back to the learner.

Afterwards the trainer led a group discussion on how to record the care plan. They stressed the importance of writing respectfully and clearly so that it could be easily understood by other staff. Each learner then wrote a care plan using the Uppsala format and this was checked by the trainer and discussed with the learner.

## LEARNING UNIT 5

### CARE PLAN IMPLEMENTATION

Through this unit, the learner will be able to take active responsibility for ensuring that the care plan is implemented. To do this, they will need to work sensitively but assertively with their colleagues.

This unit was tested in three European countries:- Italy, Sweden and Estonia

#### Pilot in Florence, Italy

The unit was piloted by a specialist training organisation in Firenze with eight care workers who were not native Italian speakers and had limited experience of Italian care systems.

The trainer began by introducing the learning unit and then discussing the soft skills that were needed rather than strictly technical skills. The trainer then used interactive techniques, particularly role play, to help the learners practice their communication skills. The trainer then gave the learners pre-prepared case study reports around care plans and then led a group discussion about how the care plans could be put into place.

Additionally, the trainer used pre-prepared observation grids as part of the learning for this unit.

#### Pilot in Uppsala, Sweden

This training took place in Uppsala, Sweden in February 2008. The trainer explained the contents of the learning unit, then the learner went through the process of implementing a real care plan and was observed by the trainer, who provided feedback afterwards.

In evaluating the training unit, it was felt the skills outcome of “demonstrating the ability to persuade” needed careful translation, as it can imply greater degrees of forcefulness than was intended in the original language (English).

#### Pilot in Tartu, Estonia

When delivering this unit in Tartu, Estonia in May 2008 it was delivered to eight staff by one trainer. The training included elements of Learning Units 3 (Care Plan Production) and 4 (Care Plan Recording). The aim was to ensure that care planning was seen as crucial to delivering quality care and thus should be thoroughly implemented.

The training itself was split up into several sessions.

#### **Introduction:**

The learners and trainer introduced each other and the trainer outlined the Percentage Programme.

#### **Lecture:**

The trainer delivered a talk on the purpose of a care plan, the aims of independence, its purpose for other employees, when it needs to be amended, who is involved and what roles they have, the role of the key worker and implementation.

The pilot showed that some experienced staff were doubtful about the need for a care plan, so the trainer gave examples of actual users whose care would be much improved by having a pre-agreed care plan. The trainer also provided written examples of the format of a care plan (the official documentation in Tartu).

### ***First Role Play***

The trainer set up a role play after carefully explaining its purpose and the role of each individual. Some trainees formed an observation group. The role play practised communicating with the user and discussing care needs and how they wanted to meet them. The information on needs and ideas for meeting them was recorded.

### ***Review of Role Play***

The observation group of learners then commented on how well the user had been involved, how successfully the information had been obtained and how effective the care plan would be. The group then contributed their own additional ideas.

### ***Second Role Play***

The role play was then re-run with the inclusion of an additional specialist and a more detailed recording of the care plan.

### ***Group discussion***

There was then a group discussion led by the trainers about successful implementation of the care plan.

The lessons learned from the pilot were that it was important to get across the role of the key worker as being responsible for implementing the care plan. It is important that new colleagues are able to understand that the care plan has been properly negotiated and agreed. It is important to explain that obligations established by staff must be documented.

## LEARNING UNIT 6

### SENSITIVE COMMUNICATION

Through this unit, the learner will be able to show increased skills in communicating with the user about highly personal needs. They will demonstrate the ability to use sympathetic listening and communication skills to cover highly sensitive issues in the care plan.

This unit was piloted in two European countries:- Italy and Sweden.

#### Pilot in Florence, Italy

This training was delivered in February 2008 to eight care staff who were unfamiliar with Italian care systems and for whom Italian was not their mother tongue. The trainer was a specialist in communication theory.

The training included prepared slides on communication theory. The learners found these difficult to understand because of language problems, so the trainer explained their meaning in simpler language.

The trainer then used self-evaluation tools to help learners become more aware of their communication skills. This participative approach was considered helpful by the learners.

In the last hour, the trainer set up a role play with active roles for four learners and observation roles for the other four learners. After the role play was complete, the observers scored the performance of the role play on grids prepared by the trainer.

#### Pilot in Uppsala, Sweden

This unit was piloted in February 2008 in Uppsala, Sweden. The technique used was to involve staff groups in discussions about successful communication techniques. These included:-

- Showing that you as a listener are calm and interested
- Showing respect to the user and boosting their confidence
- Asking questions in a way that opens up discussion (“how”, “why” etc)
- Waiting calmly for answers
- Active listening
- Using follow up questions

The evaluation showed that it was important for staff to learn when to let someone else take over in working with the users or bring in someone else to work alongside them. It was also emphasised that in addition to learning about unequal relationships, staff should also know about empowering the user.

## **LEARNING UNIT 7 CARE PLAN EVALUATION**

This unit focuses on the learners' ability to judge how effective the care plan is in terms of meeting the users' needs.

This unit was piloted in two European countries:- Italy and Finland.

### **Pilot in Florence, Italy**

This unit was delivered in February 2008 to eight care workers unfamiliar with Italian care systems and were not native Italian speakers.

The trainer began by giving a talk on techniques for collecting qualitative and quantitative data. The trainer then worked with the learners as a group to prepare a question sheet about changing care plans. This was used to evaluate the effectiveness of the care plan and work out how it needed to be changed.

The group then split into three smaller groups to work in more detail on the changes needed. Finally there was a large group discussion to agree the way the plan should be changed.

The experience of this pilot is that these learners found this unit particularly difficult and would have needed much longer (about 8 hours). It helps, however, to keep the language used very straightforward.

### **Pilot in Helsinki, Finland**

This pilot was undertaken in Helsinki, Finland in February 2008 and focused especially on the skills outcome "carry out standardised interviews with clients and others important to them". The learners were eleven students who were training as care staff.

The training was combined with learning units 2 & 9. The two trainers demonstrated the development of a care plan by acting the parts of a user and a care worker. This care plan was evaluated by the learners in a group discussion.

The then learners were split into pairs and undertook the same role play.

This was again discussed in the full group so that the care plan could be openly evaluated.

The learners found the training very helpful as it enabled them to watch the task done and then practice it themselves.

## **LEARNING UNIT 8**

### **REPRESENTING USER'S NEEDS AND INTERESTS**

This unit focuses on the learners' skills in representing the user in negotiating changes in care plans. This is particularly important as the key workers must fully understand the position of the user and communicate this to colleagues.

This unit was piloted separately by two organisations in Italy.

#### **Pilot in Veneto, Italy**

This pilot was undertaken in January and February 2008 in the Veneto region of Italy with thirteen learners from a variety of countries who were working as homecare workers.

Training techniques included formal talks by key professionals, work observations, role plays and, at the end, the production of a handbook for staff that included exercises and simplified information leaflets.

#### **Pilot in Florence, Italy**

The pilot was run in Florence in February 2008 with the same group of eight learners as with the preceding learning units.

The trainer was an expert in care planning and provided the learners with written material on representing user views. This was followed by a talk by the trainer and a group discussion.

The trainer then ran a role play of a member of staff trying on behalf of a user to negotiate a change in the health care arrangements.

This was followed by a group discussion with the trainer asking each learner questions about what they had learned.

The experience of the pilot was that the four hours scheduled for this learning unit were too short and at least six hours are needed. In terms of the design of the training the written material was the least liked by the learners because of language difficulties. The role plays were popular because they were practical and verbal. It was also necessary to teach the learners the ability to balance the needs of the user and those of the organisation.

## **LEARNING UNIT 9**

### **MAXIMISING INDEPENDENCE THROUGH CARE PLANNING**

This unit focuses on developing the care workers' skills in recognising the users' ability and potential to care for themselves and to actively contribute to the care plan.

This unit was piloted in two European countries: Finland and Italy

#### **Pilot in Helsinki, Finland**

When this unit was piloted in Helsinki, Finland in February 2008 the primary technique was the use of case studies given to the learners and discussed as a field group.

This was supported by talks from trainers and also the learners were given homework assignments.

Additionally, some learners were observed on visits to clients.

#### **Pilot in Florence, Italy**

This pilot was run in Firenze with the same group of learners as in the preceding learning units.

The first 10 minutes were used by the trainer to clarify what was covered in this learning unit. The trainer then gave out written examples of useful tests that establish the user's comprehension level. The trainer explained these to the whole group, then split the trainers into three subgroups to practise the tests.

Then the trainer introduced, as a witness, the son of a patient who explained what a family expected in terms of representing the user's view.

Lastly, the trainer introduced an older person and each learner asked them a couple of questions.

The evaluation of this unit is that it might have been more useful to have two witnesses so that each could have a different opinion.

Again, the more interactive techniques were preferred by this group of learners.

## LEARNING UNIT 10

### CARE PLANNING & PERSONAL BELIEFS

This unit helps the learner develop their ability to recognise the user's personal beliefs and takes full account of these in working out a care plan. This includes religious and cultural needs and the treatment of pain and death. It was piloted in two European countries:- Italy and the UK.

#### Pilot in Florence, Italy

This was carried out in February 2008 with the same group of learners as in the preceding learning units.

For the first 30 minutes the trainer gave a talk on Italian culture and the catholic religion. This was needed because it was a new topic for this group of learners.

The group was then split into three subgroups, each of which was given a different case narrative to talk about as a group. Then there was a plenary group session where each subgroup fed back on their case narrative for 10 minutes. Then with the help of slides, the trainer gave a talk on consent, pain and wishes regarding death. The focus was on pain management and the care of people with terminal illness, including users with behavioural problems. It also covered users' links with their families

The evaluation of this pilot was that the design of the training was too difficult for this group of learners. They needed more use of interactive techniques. The trainer also found that it was necessary to give a lot of help to the subgroups working on the case narratives.

#### Pilot in Surrey, U.K.

The pilot in Surrey was carried out as a half-day session in August 2008 with one trainer and four learners who work as care staff in a care home for older people. The training was delivered in the following elements:-

##### ***Introductions***

The trainer and learners introduced themselves and the trainer then outlined the learning to be covered.

##### ***Individual Questionnaire***

The learners were each given a list of six questions covering ethnic, language and cultural needs of users. Learners were asked to think about these on their own for 30 minutes.

##### ***Group work***

The issues in the questionnaire were then discussed in a group work session led by the trainer. The learners were encouraged to base their discussion on older people that they were working with. When group consensus was reached, the group answers were recorded on a flip chart

##### ***Handout***

The trainer then gave out a prepared answer sheet to the questionnaire, which was then discussed in the group. The trainer also gave out a very extensive information booklet

on the cultural and religious needs of 30 religions/ethnic groups. This was discussed in the group.

***Reflective accounts***

The learners were asked to complete an account of what they thought they had learned from the training.

***Evaluation of training in Surrey***

Both the trainer and the learners enjoyed the training. The small group and the focus on their direct work as care staff helped to make the learning very relevant. Learning about dietary needs and death arrangements was particularly useful. It was also helpful to see how important these issues are and how formal care plans help to make sure that these needs are met.

## LEARNING UNIT 11

### ACCESSING HEALTH SERVICES

This unit focuses on the learners' ability to ensure that the care plan helps the user get the health care services they need. It was piloted in two European countries: - Italy and the UK.

#### Pilot in Florence, Italy

This was delivered in February 2008 to the same group of learners as in the preceding learning units.

The trainer, supported by a tutor, spent 20 minutes asking each learner what they knew about local health services, using a map of the Florentine area. There was then a talk by an external speaker who worked in the local emergency services. Using simple language, she explained the arrangements for emergency and priority services, together with procedures for recording incidents and updating written records. The learners asked a number of questions and one of them spoke about an emergency that had happened to her, so the session became very interactive.

The trainer then split the learners into three subgroups and gave each a test sheet to complete. The results were then discussed as a full group.

The pilot showed that it is important for staff to understand local services and the introduction of someone working in local emergency services helped the learners to meet someone they might work with in future.

#### Pilot in Surrey, U.K.

This training was piloted in Surrey in August 2008 in a half day session. There was one trainer and four learners who were working as care staff in a care home for older people.

The training was split up into the following elements.

##### ***Introductions***

The trainer and learners introduced themselves and the trainer gave a brief overview of what the training would cover.

##### ***Lecture***

A senior nurse who manages a local community hospital gave a talk to the learners on common health issues for older people. She also gave out handouts on catheter management, diabetes and wound dressing management.

##### ***Led discussion***

The trainer and senior nurse led a group discussion about local healthcare services and how to access them.

##### ***Questionnaire***

Learners were asked to individually prepare answers to a series of questions on handling health issues for older people.

***Group work discussion***

The questionnaire was then discussed by the group and when consensus was reached, the answers were recorded on a flipchart

***Handout***

A pre-prepared handout of answers was then given out by the trainer and discussed as a group.

***Reflective Account***

The learners were then asked to write a short report on what they had learned in the session.

***Evaluation of training in Surrey***

The learners very much enjoyed the training. It was helpful that it was focussed on their work and on local services. They felt that they had increased their ability to respond to health needs and to write up health issues into the care plan.

## LEARNING UNIT 12

### MEDICATION MANAGEMENT

The aim of this learning unit is to enable frontline workers to include in care plans for individual users, suitable arrangements for the safe handling of medication. Clearly, the decisions about medication will be taken by a qualified person (doctor, pharmacist or nurse prescriber). However, the care staff need to understand the risks and safe handling of medication so that they can make safe arrangements and alert qualified people if changes need to be made.

This unit was piloted in two European countries:- UK and Italy.

#### Pilot in Surrey, U.K.

When this learning unit was piloted in Surrey UK it was delivered to six frontline care staff who work in an in-house residential care home for older people. It was led by the managers of two care homes and it took place in a training room of the care home. It was a half day session delivered in a morning.

The programme was split up into several elements:

#### **Introduction** (10 minutes)

A short introduction by the trainers on the aims and content of the course.

#### **Group Discussion led by Trainers** (30 minutes)

The learners were asked as a group basic questions about common medication for antibiotics covering: common side effects, action to be taken if side effects were noticed, whether these should be in a care plan and where else they should be reported.

The group were then asked the same questions about common medication for pain management.

The group were then given a one page list of competency requirements for medication management and these items were discussed in the group.

#### **Role Play** (40 minutes)

The role play was split into two parts. In the first part, the two trainers acted the part of a care worker and an older person. The care worker was shown to be insisting on giving medication, whilst the service user was determined to refuse medication.

There was then a led discussion about: ways to engage the user in issues about medication, their problems with side effects, their preferences for different methods of receiving medication (e.g. liquid, tables etc.), their preferences about the timing of medication (e.g. early or late in the day, around mealtimes etc.), ways to make sure that medication really had been taken and ways to review arrangements for medication.

The role play was then re-run, taking account of the points raised in the discussion.

#### **Break** (20 minutes)

#### **Group Discussion led by Trainers** (20 minutes)

The trainers led a group discussion on the role of care staff in making sure that care plans included safe arrangements for medication. This was based on the “underpinning

knowledge” element of the learning unit contents and included: side effects, behaviour patterns, roles of care staff and “medication prescribers”, storage of medication and permitted arrangements for giving medication if refused by the user.

***Written Question sheet for each Learner (80 minutes)***

Each learner was asked to complete a written question sheet consisting of 15 questions about medication management. Their answers were then given to the trainers. The trainers then provided a prepared best answer sheet giving the right answer to each question and these were discussed as a group. A copy of this questionnaire and answer sheet is attached as Learning Unit 12 Appendix A and Learning Unit Appendix B.

***Group Workshop (30 minutes)***

The trainers led a Workshop on the inclusion of medication management into the care plans for an individual care user.

**Evaluation**

Each learner completed a reflective account of the delivery of the learning unit to record what they had learned. Their reports showed that they gained: an understanding of the importance of medication arrangements in the care plan, an appreciation of problems that could happen and an understanding of good ways to handle medication issues.

The trainers provided written reports on the delivery of the course. They confirmed the above points. They also concluded that there needed to be written material on the common side effects of each item of medication as an addition to the written care plan for each user.

<b>Pilot in Florence, Italy</b>
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This unit was piloted in Florence in February 2008 with the same group of users as in the preceding learning units.

The trainer started by giving a talk about behaviour patterns of service users, likely side effects of medication, safe storage procedures and secure arrangements for the movement and delivery of medicines. This led into a full group discussion about several of these issues.

This was followed by a role play session with the learners split into three subgroups. The role play was about safe storage of medicines. The learners were then given a written test and their answers were discussed in a plenary group.

The role play element of this training was considered to be the most effective session. However, the learners did find the talk by the trainer very helpful. This was unusual, as in previous learning units they had not found lecture/presentation style learning helpful. It would suggest that this particular area (Medication Management) is usefully taught through lectures and written handouts.

**Question sheet**  
**Unit 12**

1.	When medication has been administered, when do records need to be completed?
2.	Can you share medicines prescribed for one service user with another?
3.	<u>How do you record any refusal to take medicines?</u>
4.	What is meant by the term self-administration of medicines?
5.	<u>Do you have to record when a medicine has been taken on a MARR sheet, if the service user self-administers?</u>
6.	Where are self-administered medicines stored?
7.	Where would details be found that a service user is able to self-medicate?
8.	Does the service user have the right to refuse medication?
9.	How long should medication be maintained after the death of a service user?
10.	What is homely remedy?

11.	Who may have access to medication?
12.	Where are controlled drugs stored in your care home?
13.	Why should staff avoid touching tablet form medication?
14.	What is the procedure if the wrong medication is given to the wrong service user?
15.	When a homely remedy is administered, where should this be recorded?

**Answers**  
**Unit 12**

1.	Immediately after medication has been observed being taken.
2.	No, never.
3.	Using the designated codes at the foot of the MARR sheet and notes overleaf if required.
4.	Where the service user chooses to take their own medication and is judged competent.
5.	NO.
6.	In a cupboard or locked drawer provided by the care setting.
7.	In the Care Plan.
8.	YES.
9.	7 days.
10.	Any non-prescribed medication from the approved list.
11.	Designated trained carers.
12.	Controlled drugs cupboard.
13.	Can be absorbed through the skin.
14.	Immediately report to the Senior Care Officer.
15.	On the MARR sheet and the Care Plan. Homely remedy book.

## LEARNING UNIT 13

### RISK AWARENESS & SAFEGUARDING IN THE CARE OF OLDER PEOPLE

The aim of this unit is to ensure frontline care workers are able to become aware of health and safety and adult abuse risks for each service user and take these into account in designing their care plan. This unit was piloted in two European countries UK and Italy.

#### Pilot in Surrey, U.K.

When this training was piloted in Surrey U.K., it was delivered to six frontline care staff working in care homes for older people. It was led by the manager of the care homes and it was split into two with the morning on health and safety and the afternoon on safeguarding against adult abuse (adult protection). The training took place in a training room in the residential care home.

#### HEALTH AND SAFETY

##### **Introduction** (20 minutes)

The training began with trainers and staff introducing themselves and the trainers summarising the contents of the day's training programme.

##### **Exercise** (60 minutes)

The trainees were then taken to a resident's room in the care home where the trainers had already placed several hazards. The learners were asked to go round the room trying to identify all hazards and risks. They were split into two groups and encouraged to discuss possible risks. There was then a plenary meeting where the trainers asked the trainees to say the hazards that they had found. These hazards were then discussed as a group to identify what made them potentially dangerous and how the danger could be avoided. The present hazards were: a hoop on the floor, a table blocking the exit, medicine on the table, scissors on a chair, cable on the floor, kitchen cleaning fluid on the window ledge, windows open, radio on the edge of a table and the room too cluttered/too much furniture.

The trainees successfully identified all the pre-set hazards. Additionally, the trainees identified hazards that had not been pre-set, such as a broken picture frame.

##### **Break** (20 minutes)

##### **Role Play** (45 minutes)

A trainer acted the role of an elderly resident and another trainer tried to transfer her from a bed to a chair. The "resident" did not want to move and the "member of staff" attempted to move her in a number of inappropriate ways. These included: moving a resident who did not want to move, failing to properly engage with the resident, trying to lift the resident using an underarm grip and using a sling that was damaged. The trainees were encouraged to say what was wrong with each method of lifting. The trainers then exchanged roles and demonstrated how the lifting process should be carried out.

### **Quiz (20 minutes)**

The trainers were then given a Quiz, which consisted of 10 short questions on health and safety. This was given to them on paper for individual completion. Their answers were then discussed as a plenary group. The trainers then gave them written answers. (These questions and answers are included at Learning Unit 13 Appendices A & B.)

### **Mop up (15 minutes)**

The trainers led a discussion summarising the learning points and the learners' experience of the training.

## **LUNCH**

### **SAFEGUARDING (ADULT ABUSE)**

#### **Video (30 minutes)**

After a short introduction to the contents of this session given by the trainers, the learners were shown a video/DVD of a user with learning disabilities who went to a day care centre and was sexually abused by a care worker during a respite care weekend. The user did not immediately report the abuse. Other care workers were suspicious but did not immediately raise concerns. The user became very different in mood and eventually his mother and staff helped him to reveal the abuse. However, it was not possible to prosecute the abuser.

#### **Presentation by Expert in Safeguarding (30 minutes)**

An expert in safeguarding gave a talk and presentation on the ways of identifying adult abuse and the local procedures for reporting.

#### **Group discussion on Case Studies (30 minutes)**

The safeguarding expert provided two short written case studies of older people who had experienced adult abuse. These were discussed by the trainers as a group. Particular points were how the danger of abuse could be recognised and the vulnerabilities of older people to abuse.

### **RISK & SAFEGUARDING IN CARE PLANS**

#### **Group Discussion (30 minutes)**

The trainers led the group in a discussion about how the risks and safeguarding concerns should be included in a care plan for an individual user.

#### **Evaluation**

Each learner completed a one/two page handwritten reflective account of what they had learned. Each of the learners working as a group scored each element of the course on a 1-10 scale. The trainers also wrote a report.

The learners reported that they learned about the importance of the care plan, about knowing the service user as an individual, about recognising risk and about making sure their care plan helped the user to be safe.

In the group evaluation of each element of the course the learners all rated the following elements:

*Very High:* Hazard exercise, hazard role play, safeguarding presentation, safeguarding case studies, care planning.

*Good:* Hazard Quiz

*Average:* Video on safeguarding.

The trainers were very pleased with the delivery of the training. They felt that they had managed to engage the learners well and that the learners had been helped to think methodically about risk in their work. The most successful elements of the course were the hazard finding and the discussion about risks in caring for older people. The least successful element had been the video. This was perhaps because it was non-participative, it was not related to older people and because it was a painful subject. The trainers felt that the case studies should have been prepared in more detail and that examples of successful care plans could have been studied.

### **Pilot in Florence, Italy**

This unit was piloted in Florence, Italy in February 2008 with the same group of learners as in the preceding learning units.

The trainer spent an hour giving the learners written information on the manual handling policy, the adult protection and safeguarding policy and health and safety requirements relevant to safeguarding vulnerable adult service users (e.g. safe storage regulations). At the same time the trainer talked the group through the material, simplifying the language used.

The full group discussion on this lasted for a further 30 minutes.

For the last 90 minutes there was a group discussion with the trainer urging the learners to report suspected or actual incidents of adult abuse. This turned out to be more difficult than expected, as the learners felt uncomfortable with the idea of bringing the police into their work. This might be because of fears around their immigration status or that of their families.

**Health & Safety Question sheet**  
Unit 13

1.	How would you describe <b>health</b> in relation to health and safety at work?
2.	How would you describe <b>safety</b> in relation to health and safety at work?
3.	What are 3 factors that affect our health and safety at <b>work</b> ?
4.	What are the employee's responsibilities?
5.	How would you describe an <b>ACCIDENT</b> ?
6.	How would you describe a <b>HAZARD</b> ?
7.	How would you describe a <b>RISK</b> ?
8.	What does "a hazardous substance" <b>mean</b> ?
9.	How can hazardous substances get into the <b>body</b> ?
10.	What precautions should be taken?

**Health & Safety Question sheet**  
Unit 13

**ANSWERS:**

1.	Health describes and implies that risks have been reduced to an acceptable level in order to carry out your job role in a healthy environment. Health also means acceptable standards of physical, mental and social wellbeing.
2.	Safety describes and implies that risks have been reduced to an acceptable level, which means that provision and maintenance of safe working environments and equipment and work methods are adhered to.
3.	Moving and Handling, Fire safety, Food and Hygiene and COSHH.
4.	All employees have a duty to take care of themselves and others; they must report hazards and take reasonable care of themselves and others affected by their work.
5.	An accident is an uncontrolled event causing injury or harm.
6.	A hazard is a possible source of harm / the potential to cause harm.
7.	A risk is the chance great or small that someone will be harmed by a particular hazard / a combination of likelihood and severity of harm.
8.	A hazardous substance is a dangerous substance with the potential to cause harm.
9.	Hazardous substances can enter the body through inhalation, absorption, or orally.
10.	Correct protection, such as gloves, aprons, masks, goggles etc., otherwise known as PPE.