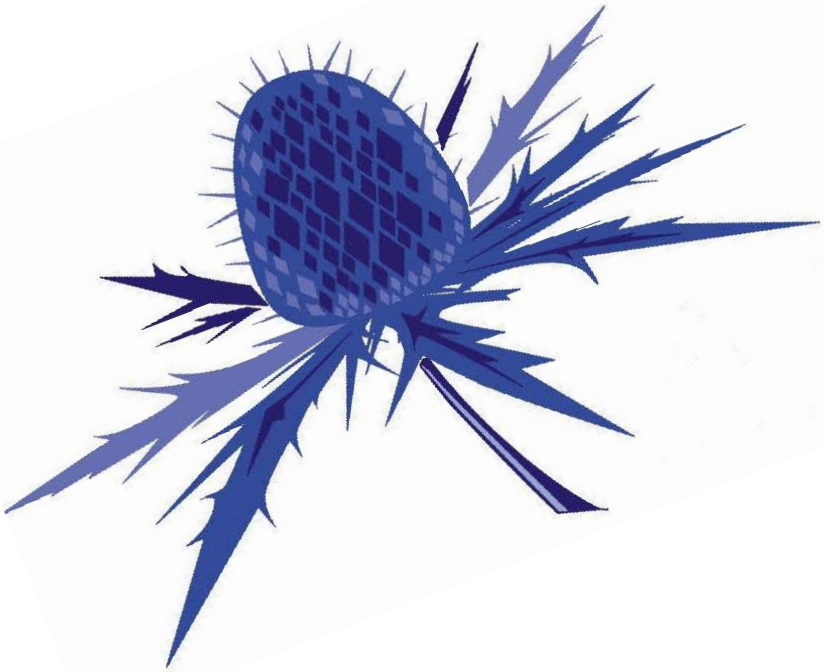


Care in the Community

Aberness Recruitment aims to provide a professional, personal and friendly service to all our clients. We will endeavour to provide a service on the basis of what a person needs, and not what is available. We will follow The Community Care Act 1990, enabling individuals to remain in their own homes for as long as possible. We will provide care following the ***National Care Standards (Care at Home)****.*

NATIONAL CARE STANDARDS

Care At Home

'Nationals standards for care at home relate to services that you receive in your own home. Traditionally, much home based care has been provided by local authorities. This has mainly been by providing services to older people through the home help service'.

Scottish Ministers set up the National Care Standards Committee (NCSC) to develop national standards. The NCSC carried out the work with the help of a number of working groups. These groups included people who use the services, and their families and carers, along with staff, professional associations, regulators from health and social care, local authorities, health boards and independent providers. Many others were also involved in the consultation process.

As a result, the standards have been developed from the point of view of people who use the services. They describe what each individual person can expect from the service provider. They focus on the quality of life that the person using the service actually experiences.

The main principles are dignity, privacy, choice, safety, realising potential and equality and diversity. Therefore, we must ensure that all our service users have the right to:

Dignity

- Be treated with dignity and respect at all times; and
- Enjoy a full range of social relationships.

Privacy

- Have your privacy and property respected; and
- Be free from unnecessary intrusion.

Choice

- Make informed choices, while recognising the rights of other people to do the same; and
- Know about the range of choices.

Safety

- Feel safe and secure in all aspects of your life, including health and wellbeing;
- Enjoy safety but not be over-protected; and
- Be free from exploitation and abuse.

Realising potential

- Achieve all you can;
- Make full use of the resources that are available to you; and
- Make the most of your life.

Equality and diversity

- live an independent life, rich in purpose, meaning and personal fulfilment;
- be valued for your ethnic background, language, culture and faith;
- be treated equally and live in an environment which is free from bullying, harassment and discrimination; and
- be able to complain effectively without fear of victimisation.

SERVICE USER

Your service user is the person you will visit in his or her own home. They may have recently become ill; been diagnosed with an illness or their health has deteriorated; they may have lost the person that normally cares for them; or they may be recovering from an illness or operation. Whatever the case, it is our duty to support them to stay at home and provide them with the care they have been assessed as requiring.

Prior to agreeing what provision is required, your Line Manager will have carried out a needs assessment. This would have been done in conjunction with the service user, family and normally a member of the Social Work Dept.

A Care Plan and Timetable will then be written out detailing as much relevant information as is required, to ensure that all the service user's needs are all covered.

The service user may be living at home, and have lost their independence through illness or could be in hospital unable to return home without a sufficient care package. Whatever loss has happened for them to require care will be difficult to accept, especially the fact that they are no longer fully independent and are now reliant on others for assistance.

The service user will be suffering loss and this must always be taken into consideration when providing assistance. They must always be treated with respect, compassion and dignity.

As you may be one of the few people that the service user will see, sometimes you may be the one that anger and frustration will be aimed towards. However upsetting this can be, normally it is not directed at you, but simply an act of frustration.

Prior to your first visit, your Line Manager will have given you all the required information about the service user. If possible, you will also have been introduced to the service user. This will help to ease and alleviate any worries that the service user has about a stranger coming into their home, especially if they are assisting with personal care.

CARER ROLE

What is expected from a Community Carer

As an Aberness carer you will strive to give the best possible care. You will provide a vital and important role, enabling people to remain in their own homes and be as independent as possible. You will be fully supported by your Line Manager, who will be available to support and advise you in your role.

You are often the only person that the service user might see on that day, and can be their only link with the community.

Therefore, you must be reliable; punctual; caring; have good communication and writing skills; maintain confidentiality; promote independence; provide a high standard of personal care; be a good listener. All these qualities are essential in becoming a good Carer.

A golden rule is 'to always treat someone the way you would want to be treated'.

Punctuality

You must always arrive punctually at your service user's home. This may be essential to their wellbeing;

- Medication requires to be taken at certain times of day.
- Toileting needs / catheter care.
- May be going out, or have appointments to attend.
- Causing unnecessary anxiety by being late.

Your service user may have been assessed as requiring 2 carers to attend to their needs. Therefore, it is essential that you both arrive at the same time, unless otherwise authorised by your Line Manager.

If you are running late for your service user, make your Line Manager aware, so that they can contact and advise the person, or make arrangements for another carer to attend.

If you are unable to work your shift, then you must contact your Line Manager immediately, so that they can make alternative arrangements to cover your shift.

Protective clothing

Staff should at all times, observe high standards of hygiene to protect themselves and their service users from the unnecessary spread of infection.

Gloves and aprons will be provided by Aberness, for use in each person's home. Carers must always follow the Infection Control policy as documented in their Employee Handbook.

It is each carer's responsibility to ensure that there is sufficient stock of gloves and aprons, in each service user's home. Stock will be located in the office.

Behaviour

Whilst an employee of Aberness, you must always behave in a professional manner towards all our service users, fellow colleagues, and other professionals you come into contact with.

You must refrain from using bad language, and not use insulting or offensive behaviour.

You must always include your service user in conversation, being especially vigilant when working with another carer.

Dignity

You must always treat your client with dignity and respect, always remembering that you are a guest in their home. This is vital, especially when carrying out personal care.

Choice

You must ensure that your service user is always given choices:

- Every morning and evening ask what clothes and shoes they would like to wear.
- Each meal time ask what they would like to eat and drink
- You will be informed by your Line Manager what time your service user likes to get up and go to bed. They will have already discussed this with them during initial assessment.
- Call your service user by the name they prefer.
-

EMERGENCIES

As a Lone Worker you are always supported by your Line Manager 24 hours a day.

Many of our service users are vulnerable and many may live alone. Therefore, we have a responsibility towards their safety. This includes locking and unlocking of doors as detailed in care plan; ensuring codes on key safes are jumbled up after use; reporting anything that you feel is untoward or suspicious.

If you find that your service user's door is unexpectedly locked and there is no response, always carry out the following procedures:

- Knock loudly and shout in through letterbox.
- If you are able, look in their windows to see if you can see anything.
- Call them, if you have their telephone number.
- Check with SHO (if sheltered housing) or neighbour if they live in community.
- Call and report to Line Manager, who will contact family.

If you are able to enter the house and find your service user is ill, you must first ask their permission prior to calling GP or family member. If they decline, contact your Line Manager, who will make the decision.

If you find that your service user has fallen on the floor – do not attempt to move them without first consulting them as to whether they have been hurt. If they are unhurt, and you both feel confident that without any lifting, you can assist them off the floor, proceed to support and guide them.

If the service user is hurt, get a pillow and blanket and ensuring they are comfortable, call for GP or ambulance. Do not attempt to move them. Also, with their consent call for family or friend.

If you find your service user unresponsive, call 999. If you know the family, call them or advise your Line Manager who will call them.

If the service user is admitted to hospital you must always advise your Line Manager. She will then arrange to call Next of Kin, Care Manager and other staff members who are due to visit.

ABERNESS CARE FOLDER

In each service user's home you will find a purple Aberness Care folder. This will contain all the information you will require about your service user, as well as other documentation that you must complete.

Personal Care Plan

A care plan is a written document which has been agreed between a service user and their Social Worker / Care Provider. It helps to assess what care they need and how it will be provided. All care plans have a person centered approach. The essence of being person-centered is that it is individual to, and owned by, the person being supported.

All Aberness service users will have their own detailed Personal Care Plan. This will be located in the service user's folder, which will be kept in their home. The care plan is devised in consultation with the person, and will detail all their individual needs and wishes. All essential information will be collated in the care plan, including who to contact in the event of an emergency. Prior to you commencing work with a new service user, you must familiarise yourself with the information in the Care Plan.

The information held in the Care Plan could change on a day to day basis. As a Carer you are responsible for advising your Line Manager of any changes. This ensures that the Care Plan is always kept up to date and the correct information is being shared. This is important to ensure that the service user always receives the best care possible.

The Care Plan must always be kept neat and tidy. All used communication and medication sheets, etc, must be returned to the office and will be stored in the service user's personal file.

You must advise your Line Manager if you are unable to locate a service user's Care Plan. Arrangements can then be made to issue them with a replacement.

Contents of Care Plan:

This gives you brief information of what to expect in a person's care plan. All this information is highly confidential and legally must not be destroyed.

Name:

During assessment the service user will be asked for their full name and title, and how they wish to be addressed. Some may prefer to be addressed as Mr or Mrs, whereby others prefer to be known by their Christian name. As their carer you must adhere to their wishes.

Address:

You will be given the service user's full address and postcode. You will also be advised on how they wish you to access their property. Some client's may not be able to answer their door, and may opt to have a keysafe fitted. In that case, you will be issued with a number to open the keysafe.

Health:

You will be given information about your service user's health and any other related issues. This will ensure that you are able to give them the best care to suit their needs.

Mobility:

You will be advised of any aids that your service user may use to mobilise, eg walking stick, zimmer frame. Details of any handling equipment will also be documented.

Medication:

An assessment will have been carried with the service user, to see whether they require any assistance with medication. You will be advised which method, if any, has been agreed with the service user.

Meals and Diet:

You will be made aware of any dietery requirement that the service user may have, and any associated risk with food eg, may have swallowing difficulties and requires a soft diet.

Personal care / Continence care:

You will be given details of how each individual prefers their personal care to be carried out. Some may have requested daily showers / baths, while other may have opted for a weekly shower. You will also be advised of any continence issues, e.g catheter, pads.

Domestic:

You will be advised whether any domestic tasks are included in the care plan. Obviously you will always clean and tidy up behind you, but extra tasks may be also documented, such as laundry, hovering, changing bed etc.

Finances:

This section will advise if the service user is independent with finances and bill payments, or whether support is required.

Contents in Aberness Folder

All these documents are legal documents and must be kept in a safe place. You must always write professionally on these documents, ensuring that you sign and not initial after each entry. These entries are about your service user and must always be factual, and not opinionated. If you feel upset or angry by any comment that has been made by someone, you must report to your Line Manager.

Contact Sheet:

This details names and telephone numbers of people who are involved with the service user's care.

Daily Communication Sheet:

Within the service user's Care folder, you will also find a daily Communication sheet. An entry must be completed during each visit, and must detail any concerns noted regarding the person, and also what action has been taken. This will also state whether medication was prompted or administered during visit. This must be signed and not initialled, and must also detail the time the entry was made. Completing the communication sheet is a care requirement, and also ensures that other professionals and family members are made aware of any changes or concerns about the service user.

Information Sheet

This is a separate communication sheet which is called an 'Information sheet'. This sheet is to be used by carers, families, health and other professionals, to pass on important information to each other. The service user will be aware and in agreement of this information being shared. This normally contributes towards the service users wellbeing.

Timetable

The timetable gives information about the care package that the service user receives. It details the amount of daily visits, the times and length of each visit, and which tasks are to be undertaken. It also states how many carers are attending, eg, the operation of a hoist would require 2 carers to be in attendance.

Review Sheet

This sheet is completed every time a care review is carried out and advises if any changes were made. It also advises when the next review is due.

Aberness Care

This leaflet gives the service user information about Aberness Care. It gives information on who we are, what our aims are, who to contact and our 24 hour telephone line.

Complaints

Our complaints leaflet, gives our service user the opportunity to detail any complaint or issue that they may have. This may be regarding the service they receive or an individual person that they're not happy with.

Questionnaire

To review our service, we ask all our service users to complete our questionnaires regarding the service that they are receiving. This may be compliments or complaints, about carers or the service. We value all feedback, and will endeavour to improve any area that has been highlighted to us.

PERSONAL CARE

Prior to commencing any personal care, you must always communicate with your service user, making them feel relaxed, comfortable and at ease in your company.

The Care Plan will stipulate what care the service user has agreed to during assessment. You must then follow these guidelines. If there are any risks, they will also have been identified, and a risk assessment put in place. This may include using various types of equipment, which you will have been trained to use.

Personal care is normally carried out in the service user's bathroom. However there are times, when this isn't possible and a bed bath may be required.

Bed Bath

For many elderly and disabled service users, a bed bath can be one of the most enjoyable and refreshing activities of the day. A bath can improve blood flow around the body, helping to ease any discomfort that the person may be experiencing.

It is also a good time to inspect the service user's skin for pressure areas. These can develop in individuals when they remain in one position for long periods of time. Circulation may be cut off to certain areas of the body, resulting in the breakdown of skin. This lack of circulation can be a serious problem if not cared for immediately. Early warning signs can be reddened areas on the skin (bottom, shoulders, back, heels and ankles). If you have any concerns, you must contact your Line Manager or your service user's District Nurse, who will visit and assess.

If your service user has any dressings that need replaced, you must not change them, but inform their District Nurse who will attend. Some dressings can be changed, but only by prior consent by the District Nurse and detailed in the Care Plan.

To respect your service user's privacy, you must always ensure that their curtains are drawn, doors are kept shut, and the room temperature is comfortable. Then follow the basic steps listed below:

- Fill a basin with warm water first and then top up with cold. Check temperature with thermometer, or test with your elbow. Have gloves, apron, soap, towels, sponge, cloth, toiletries, fresh clothes and bedding (if required) ready beside you. Always ensure that your service user is given the choice of what clothing to wear, toiletries to use, etc. Gloves are to be worn when dealing with blood or bodily fluids.
- Remove extra bedding, ensuring your service user is still covered to ensure privacy, dignity and warmth.
- Beginning with the top of the body, assist service user to remove clothing, keeping the bottom layer on, until top half is finished. When assisting to undress, any weak limbs must be left until last, before removing from clothing.
- Cover all the body apart from the area being washed.
- To wash face, place a towel below the person's neck and over the bed covers. If possible, encourage your service user to wash their own face, by handing them damp face cloth. Check if they wish the facecloth to contain soap. If they require assistance, commence with washing the eye area, wiping from the inner corner towards the ear. Then continue in the order of the forehead, nose, cheeks, chin, neck and ears. Dry face and neck with towel.

- If the service user requires assistance with shaving, this must be carried out using an electric shaver.
- To wash arms, place a towel under the arm furthest from you. Lift up the arm to be washed by supporting it at the elbow, then continue to wash finishing with underarm. Wash, rinse and dry other arm in same manner.
- If your service user is able to wash their hands, then allow them to soak them in the basin. Afterwards, assist to dry their hands, paying particular attention in between fingers. You may trim their nails if this is included in their Care Plan.
- Change water as required, and continue with the same procedure for chest, abdomen and legs. When removing lower garments, ask your service user whether they can lift their bottom. If they are unable to manage, clothes must be removed by turning to one side at a time.
- If your service user can sit up, then soak their feet in a basin. Ensure between toes are washed and thoroughly dried. Nails must **not** be trimmed incase the service user is diabetic or has circulation problems. This must be professionally done.
- To wash perineal area, change water and cloth. Ensure you are wearing gloves and place a towel beneath your service user, covering rest of their body. If they are able, hand them the cloth and briefly turn away to give them privacy. If your service user is unable to carry out the task, wash perineal area from front to back, ensuring area is thoroughly cleansed and dried.
- Change water and cloth, and wash your service user's back. Completely dry, and check whether deodorant or talc is required. Apply any creams or lotions as required. Assist to dress top half, starting with any physically involved limb.
- If your service user remains in bed, checking that there are no wrinkles or creases in clothes or sheets. This will minimise the risk of any redness or breaking of the skin.
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PALLIATIVE CARE

Palliative care is specialised medical care for people suffering from serious and chronic illnesses, such as cancer, cardiac disease, chronic obstructive pulmonary disease, kidney failure, Alzheimer's, Parkinson's and many more. It focuses on providing individuals with relief from the symptoms, pain and stress of a serious illness-whatever the diagnosis. The goal is to improve quality of life for both the person and their family. It focuses on symptoms such as pain, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficulty sleeping and depression.

Palliative care is a team approach to care. The core team includes GP, Nurses, Social Workers, Carers, Occupational Therapists, Physio, etc. This team provides care to enable the person to remain at home. As a Carer, you have a very important role within this team, and will work and liaise closely with Health colleagues to achieve the best possible care. Palliative care:

- Aims to improve the person's quality of life.
- Provides relief from pain and other distressing symptoms.
- Offers a support system to help people live as actively as possible until death.

- Offers a support system to help the family cope during the patient's illness and in their own bereavement.
- Uses a team approach to address the need of the person and their family.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten nor postpone death.

The process of dying is unique to each person. It can last a few hours or several days. Everyone is different, but in most cases there are common signs and changes that show a person may be close to death.

Less need for food and drink

- As people get more unwell, it is normal for them not to feel like eating or drinking. When this happens it can be upsetting because we want to do everything to help the people we care for.
- Eating and drinking becomes more of an effort. The person needs help to take sips of fluid. A drinking beaker or straw can making sipping fluid easier. Moistening the person's lips and tongue with water or oral gel helps keep them comfortable.
- A drip is occasionally used to give people fluid into a vein or under the skin. As the process of dying continues the body does not need the same amount of fluid and cannot cope with it. Fluid from a drip can make breathlessness worse as it tends to build up in the lungs, and staff may advise that a drip is stopped.

Changes in breathing

- When someone is dying their need for oxygen may lessen and the way they breathe changes. People who may have been breathless may feel less breathless at this time.
- As people get more unwell, their breathing may pause for a while and then start again. They use different muscles to breathe, which means their breathing will look different. Sometimes breathing can sound noisy or 'rattling' because the person is no longer able to cough or clear their throat. This can sound distressing but is generally not upsetting for the person. Often changing the person's position can reduce the noise of breathing or an injection of medicine may be given.

Changes in how the person looks and behaves

- During the process of dying a person's skin may become pale and moist. Their hands and feet can feel very cold and sometimes look bluish in colour.
- Dying people often feel very tired and will sleep more. Even when they are awake, they may be drowsier than they have been. As people get more unwell they will be awake less and less. They will eventually not waken up at all. They may still be aware of the presence of family and friends so you can still talk to them.

Healthy Mouth

- Keep mouth and lips clean, moist and intact; remove plaque and debris.
- Prevent oral infection, tooth decay and halitosis.
- Maintain fluid intake with frequent, small drinks.
- Oral care using a soft, small-headed toothbrush, fluoride toothpaste and water after each meal and at bedtime.
- Apply oral gel to dry lips after oral care.
- Dentures should be cleaned and soaked overnight in a cleanser.

With palliative care, the Nurse will take the lead role, and arrange suitable medication, continence aids, etc.

MEDICATION

Aberness Care will always ensure that arrangements are in place to allow our Carers to manage medications, safely and securely.

Prior to administering any medication (Level 3), you must be fully trained in Medicines Management, or an equivalent medicine training programme.

On completion of your training, you will be issued with an information booklet, which you should relate to at all times. If you are ever unsure about any medication issues, you must contact your Line Manager, or a member of the NHS.

When you visit a service user, they will have already been assessed by someone from Health or Social Work, and you will be advised what level of medication is appropriate for them. They will have consented with their Assessor which method is more appropriate. This information will be detailed in the service users Care Plan. There are 4 levels, and each service user will fit into one of the levels:

Levels of support

- Level 1 - The service user can take full responsibility for his / her medication – no assistance required.
- Level 2 - The service user is able to manage his / her medication with minimal assistance. Assistance may be required with ordering, collection, disposal of medication; reading of the medicine label; opening of bottles or removing dose units from strip packaging.
- Level 3 - The service user is unable to manage his / her medication.
- Level 4 - The assistance required is beyond the knowledge and skills of the carer and requires input from a GP or Nurse.

Level 1

No assistance is required.

Level 2

The service user may require assistance with the following;

- Requesting repeat prescriptions from the GP.
- Collecting medicines from the community pharmacist.
- Correctly disposing of medicines that are no longer required, by returning to pharmacy.
- Reading the medicine labels.
- Opening bottles, packets, dosette boxes and blister packs as requested.
- Confirmation of diagnostic tests (eg glucose levels).
- Prompting / reminding to take medication.
- Assisting to apply / remove surgical stockings

Level 3

The service user may require assistance with the following;

- Requesting repeat prescriptions from the GP.
- Collecting prescribed medicines and charts from community pharmacist.
- Correctly disposing of medicines that are no longer required, by returning to pharmacy.
- Administering oral medication as detailed on MAR chart.
- Applying creams and ointments to external areas.
- Inserting drops to ears, eyes or nose
- Assisting with the administration of inhaled medicines.

Level 4

The assistance required is beyond the knowledge and skills of the carer and requires input from a GP or Nurse.

You must NOT carry out any of the following;

- Leave out any medication for service user to take at a later time.
- Administer any medication that has been left out.
- Administer any medication other than is prescribed by GP, and documented on chart.
- Dispose of medication by any other means, other than returning to pharmacy.
- Force service user to take their medication against their will.
- Leave medication unlocked if there is a risk that the service user may take it.
- Administer any injections (including insulin); give enemas, or any other internal procedure.
- Remove medication from packaging and transfer into dispensing box.

Insulin

Some of your service users may be insulin dependent. At no time can you measure or administer insulin. You may assist your service user by observing that they are able to correctly read their blood sugar results, and are correctly administering insulin with an insulin pen. This must be authorised by your Line Manager and documented on the Care Plan.

If you have concerns that your service user isn't managing their insulin correctly, then you must report this to your Line Manager, who will contact their GP. They will then arrange for a DN to visit and administer as required.

Warfarin

Some of your service users may be prescribed warfarin, which is taken on a daily basis. Their warfarin level is monitored by a blood test, which monitors how long the blood takes to clot. This is known as an INR test (International Normalised Ratio). This is normally carried out by a District Nurse.

The DN documents the INR results in a yellow book – Oral Anticoagulant Therapy (OAT) Record Book. This is kept in the service users home, and shows the date it was taken; the results of the test; daily dosage of warfarin to be taken; when next test due and the signature of the person who took the test.

The DN will advise the service user of any changes to their dose; complete yellow book; advise carers via their Line Manager.

If you are assisting your service user with their warfarin dose, you must always check their yellow book to ensure that no changes have been made.

Eyedrops

Detailed below are basic instructions on how to administer eye drops:

- Wash your hands.
- Take the top off the bottle.
- Ask your service user to tilt their head backwards, and gently pull their lower eyelid down.
- Hold the dropper above one eye. Squeeze one drop into the pocket formed by gently pulling down the lower eyelid. Try not to touch the eye, eyelash, or anything else with the dropper tip.
- Let go of the eyelid and ask your service user to keep their eye closed for as long as possible after application of the eye drop.
- Wipe away any liquid that falls onto their cheek with a tissue.
- Repeat in the other eye if the drop is prescribed for both eyes.
- When two different eye drop preparations are used at the same time of day, wait for at least five minutes before putting the second drop into an eye. This allows the first drop to 'settle in' and not be washed out by a second drop if it is put in too quickly.

Eye drops are sterile (free from bacteria) before the bottle top is opened. Once it is opened:

- Keep the bottle closed in a cool, dark place (unless otherwise advised).
- Do not let the dropper or dropper nozzle touch eyes, fingers, or any other surface. This is to keep it free from bacteria (germs).
- Do not let anyone else use the drops.
- Throw out the bottle (and get a new one if required) after the recommended time. This is often four weeks after first opening the bottle. There is a risk that the drops may become infected if they are kept and used for longer than advised. (One tip is to write the date that you opened the bottle on the label so you will know when it is time to throw it out.)

- You service user may get a taste of eye drops in their mouth, or a feeling that the drops are running down their throat. This is normal as the tear duct which drains tears to the nose will also drain some of the eye drop.
- Some eye drops sting or irritate for a short while. Rarely, some people are allergic to some eye drops. Contact the doctor if eye symptoms become worse after using eye drops.
- Do not wear contact lenses whilst using eye drops unless otherwise advised. (Some drugs and preservatives in eye drops can accumulate in soft contact lenses and may cause harm.)
- Keep the eye drops out of children's reach.

INCONTINENCE

There are two types of incontinence:

- Urinary incontinence – when someone loses control of their bladder.
- Faecal incontinence – when someone loses control of their bowels.

This may happen all or most of the time, or may just be a case of occasional leakage. Urinary incontinence is far more common than faecal incontinence. Both types of incontinence may be treatable, so it is always important to consult with the GP, DN or Continence Advisor.

Incontinence is a very personal issue, and can be very distressing for a person. From a very young age, we are trained to control our urges to go to the toilet, so being incontinent can make someone feel like they are losing control. This affects a person's sense of dignity and self-esteem. Many people find it hard to accept that they need help from someone else in such an intimate area of their life.

There are a number of reasons why someone may become incontinent. Medical reasons include:

- Urinary tract infections – these usually respond to treatment with medication.
- Prostate gland trouble – this affects men, and may be resolved with an operation.
- Side-effects of medication – this can be resolved by GP changing medication.
- Severe constipation – constipation can put pressure on the bladder, and can also lead to faecal incontinence. Eating foods high in fibre, drinking plenty of fluids and regular exercise can help prevent constipation.

Non-medical causes are more common in people with dementia and may include:

- Forgetting to go to the toilet.
- Not recognising the need to go to the toilet, due to the damage caused by the dementia.
- Forgetting where the toilet is located.

Each person will react differently to the experience of incontinence. Some find it very upsetting, while others can deal with it better. Some common occurrences among people with dementia include:

- Hiding the evidence – If a person feels very ashamed of their incontinence, they may try and hide the evidence by removing their wet or soiled clothing and hiding them.

- Going to the toilet in the wrong place – If a person becomes confused about their surroundings, they may urinate in an appropriate place, such as a bin or basin that they have mistaken for a toilet.

If your service user has an accident, you must always approach the situation with sensitivity and compassion, ensuring the person is treated with the utmost dignity. Always remember that it is not the person's fault.

When someone has problems with incontinence, always check if there are any difficulties with relation to them getting to the toilet. Some of these listed are especially related to those suffering from dementia:

- Always ensure that your service user is aware of where the toilet is. A picture or sign on the door may be helpful.
- Ensure that there are no obstacles in the way, obstructing their path to the toilet.
- Leave the toilet door open.
- Check the location of any mirrors in the toilet. Someone with dementia may confuse their own image for someone else.
- Ensure that they are able to get on / off the toilet independently. If not, advise your Line Manager, who will arrange for an OT to visit and provide some aids.
- Sometimes if the toilet seat and pan are the same colour, this may cause confusion. A black seat and white toilet can be easier to see.
- Ensure that clothing can be removed easily. Sometimes buttons and zips can be difficult to open.

If your Service User has problems with incontinence, sometimes doing the following may alleviate the problem:

- At each visit, remind your Service User to go to the toilet, and assist if necessary. Taking a person to the toilet at each visit can prevent urine and faecal incontinence.
- Be aware of your service user showing signs of needing the toilet. These may include fidgeting, getting up and down, or pulling at their clothes.
- If a person is incontinent at night, encourage them to avoid drinking for approx. 2 hours before going to bed. However, ensure that they drink plenty of fluids during the day, as this could prevent a Urinary Tract Infection.

If a person is unable to go to the toilet during the night, they may receive a commode to have at their bedside. Advise your Line Manager, who would contact the District Nurse to assess.

Incontinence aids:

If you've tried everything you can and the person is still experiencing problems with incontinence, there are plenty of ways to help them feel more comfortable while also protecting items such as clothes and bedding. Various products are available from your local continence adviser or community nurse. Others are available at the chemist.

- Waterproof bedding – This will protect the mattress. However, make sure the sheet doesn't come into contact with the skin, as it may become chafed and sore. You can also buy special protective duvet covers and pillowcases.

- Absorbent undersheets – Reusable undersheets provide a dry surface on beds and chair beds.
- Incontinence pads and pants – These can be worn day and night, or during the night only, to keep the area next to the skin dry. These pads are made with material which absorbs liquid and turns it into gel. They come in different absorbencies, therefore it is important that the right type and size is used.

Good personal hygiene:

Incontinence can lead to skin irritation and a general feeling of discomfort. After someone has had an accident it is important to act quickly, to make sure that they feel comfortable again and to ensure good hygiene.

- If someone has become wet or soiled, help them to wash afterwards with mild soap and warm water, drying them carefully before putting on a fresh pad and clothing.
- Washed soiled clothes and bedding immediately, or soak them in an airtight container until they are washed.
- Put used pads in a bag and dispose of in an appropriate container.

MENTAL HEALTH

Some mental health problems are described using words that are in everyday use; for example, 'depression' or 'anxiety'. This can make them seem easier to understand, but can also mean people underestimate how serious they can be.

Mental ill health feels just as bad, or worse, than any other illness – only you cannot see it. Although mental health problems are very common – affecting around one in four people in Britain – stigma and discrimination towards people with mental health problems is still very common and there are a lot of myths about what different diagnoses mean. There is also a lot of controversy about the way mental health problems are diagnosed, what causes them, and which treatments are most effective.

However, despite these challenges, it is possible to recover from a mental health problem and live a productive and fulfilling life. It is important to remember that having a mental health problem is not a sign of weakness

Some people may require assistance with everyday tasks such as shopping, cooking, cleaning, paying bills or sorting out benefit payments. It's important not to do more than is necessary or you might increase the other person's feelings of inadequacy and dependency.

Some of the most commonly diagnosed forms of mental health problem are described below.

Emotional support

When people are mentally upset, their behaviour can be unpredictable. For example, they may:

- Become angry, frightened or aggressive
- Seem so depressed that you're afraid they will harm themselves

- Refuse to accept their behaviour is unusual
- Behave in embarrassing or unacceptable ways
- Find themselves unable to cope with day-to-day life
- Behave in a hostile manner towards you

Often people with mental health difficulties worry that people will tease or treat them differently, so it's important that you listen to them without judging. For example, if a loved one has hallucinations or delusions don't make fun, criticise or argue with them. The calmer and more accepting you can be the less alarming it is for them.

Reassure them that their diagnosis doesn't mean you feel differently about them, and that you'll do your best to care and support them by:

- Empathic listening – try to listen to how they feel about things without offering advice or solutions. Simply being there and offering unconditional support and encouragement can be very helpful.
- Respect limitations – remember it's not their fault that they're feeling this way. They may not feel able to do the things that once were easy for them. Offer patience and remind them that they may not always feel like this.
- Touching – holding their hand or hugging can be very reassuring and help a person feel they're not alone.
- Laughter/distraction – help take their mind off their problems by offering light relief with anything that shifts the focus from their illness.
- Empowerment - helping someone who's mentally distressed regain a sense of being in control of their life. One way is to try to help them think about what they want - from you, from others and from their life.

Some mental health disorders:

- **Alzheimer's**
- **Depression in the elderly**
- **Insomnia**
- **Schizophrenia**
- **Bipolar disorder**
- **Eating disorders**
- **Shock**

Alzheimer's disease:

The exact cause of Alzheimer's disease isn't known, although some risk factors are known. The risk of developing the disease increases with age, for example.

There's a higher risk of Alzheimer's if a family member has the disease. However, inherited genetic factors are responsible in only a small number of families.

Symptoms include poor memory and the ability to think clearly is gradually lost over time. There may also be a change in personality. Someone who used to be a calm person may become agitated or upset more easily, for example. Behaviour problems and communication difficulties may also occur.

People with severe Alzheimer's may find it difficult to perform everyday tasks, such as dressing, washing and eating. As time passes they may not recognise people or their surroundings, so it's common for them to go for a walk and get lost.

Other problems, such as depression, may also develop.

Depression in the elderly:

Several conditions can lead to depression in the elderly, including heart problems, low thyroid activity (hypothyroidism), vitamin B12 or folic acid deficiency and cancer.

Many drugs also cause, aggravate or trigger depression, including beta-blockers, blood pressure drugs, heart drugs such as digoxin, steroids and sedatives.

Depression often occurs after a stroke and getting it treated may be critical to restoring normal abilities. Depression is much more common in the years after retirement, when people may struggle to adjust to a new role and routine in life.

It's then less likely for the next decade until people are in their mid-70s, when factors such as chronic illness, frequent loss of peers and friends, and increasing restrictions on mobility may be factors.

Depression has a different pattern of symptoms in older people compared with the young. Anxiety is particularly common, as is the slowing of thought and activity.

Older people also tend to have more bodily symptoms, although it can be difficult to work out whether these are signs of depression or part of the increase in general illness seen with age. Older people are more likely to battle with weakness, for example, as well as headaches, palpitations, loss of interest in sex, abdominal or back pain, shortness of breath and constipation. Imaginary illness and hallucinations are also more common.

Deterioration in mental function can occur with depression at 18 or 88, but young people have greater mental reserves, so these problems often show up more in older people. However, it's important to separate the effects of depression from those of conditions such as Alzheimer's disease.

Insomnia

Insomnia is repeated difficulty in getting to sleep, staying asleep or getting enough good quality sleep, despite adequate opportunity, which leads to some form of impairment of performance or wellbeing during the daytime

Common triggers for sleeping difficulties are stress and worry. Some people are particularly vulnerable because they are more likely to show a more extreme response to stress, such as people who are depressed, chronically ill or struggling with other difficult issues such as relationship problems.

Other common causes include physical illness that causes pain, environmental noise, depression, shift work, caffeine or alcohol consumption, and medication side-effects. Other illnesses can disrupt sleep, such as menopausal hot flushes and urinary problems from infection or prostate disease causing night-time waking. Insomnia is much more common in older people.

Once triggered, sleep problems may then be perpetuated by the individuals beliefs and behaviours – they often worry excessively about the effect that inadequate sleep will have on them and so strive excessively hard to get to sleep, take daytime naps or sleep in late which can disrupt the natural rhythm, or turn to medicines or alcohol in the belief that this will help (most just induce unnatural patterns of sleep). A vicious cycle of poor sleep and stress is quickly set up and persists after the initial trigger has passed.

Insomnia contributes to excessive daytime tiredness, which in turn may be responsible for accidents, recurrent infections (inadequate sleep has been show to suppress the immune system), poor concentration, irritability, work and relationship problems and a general inability to cope.

In treating Insomnia, sleeping tablets may be prescribed for short-term use only, when the cause of insomnia has been identified as bereavement or jet lag, for example.

However, it's usually more important to address any underlying cause of the insomnia and attempt to restore a normal sleep pattern through changes in behaviour and lifestyle.

Deal with issues and anxieties which may keep you awake worrying. Make sure your bedroom is dark, cool and unstimulating. Make sure your bed is comfortable and not too hot. Try to follow a set routine, going to sleep and getting up at the same time and avoiding daytime naps, and don't work or watch TV in your bedroom. Recent research has shown that the effect of cooling on the body, and particularly the brain, such as following a bath, shower or hair washing, can induce sleep.

You should also try avoiding stimulants such as caffeine, nicotine and alcohol. Getting more exercise during the day, having a warm milky drink before bed, and herbs such as valerian and camomile can also help.

Schizophrenia:

Schizophrenia is a disorder which affects thinking, feeling and behaviour. It usually starts between the ages of 15 to 35 and affects about one in every 100 people during their lifetime.

Symptoms that represent a change in behaviour, or thoughts are called 'positive' symptoms. These include:

- **Delusions** - believing something completely even though others find your ideas strange and can't work out how you've come to believe them.
- **Difficulty thinking** – finding it hard to concentrate, drifting from one idea to another. Other people may find it hard to understand you.
- **Feeling controlled** – feeling as though your thoughts are vanishing, that they're not your own, or that your body is being taken over and controlled by someone else.
- **Hallucinations** - hearing, smelling, feeling or seeing something that isn't there. Hearing voices is the most common problem. The voices can seem utterly real. Although they may be pleasant, they are more often rude, critical, abusive or annoying.

Loss of normal thoughts, feelings or actions are known as 'negative' symptoms. They include:

- **Loss of interest, energy and emotions**. You don't bother to get up or go out of the house. You don't get round to routine jobs like washing, tidying, or looking after your clothes. You feel uncomfortable with other people.
- **Some people hear voices without negative symptoms**. Others have delusions but few other problems. If someone has only muddled thinking and negative symptoms, the problem may not be recognised for years.

Schizophrenia may be treated with Antipsychotic medication. This helps to weaken any delusions and hallucinations, and helps you to think more clearly and look after yourself better. It can control (but not cure) the symptoms in around four out of five people, and works best when taken regularly, even if you've felt better for some time.

Bipolar:

Bipolar (also known as manic depression) causes severe mood swings, that usually last several weeks or months and can be:

- Low mood, intense depression and despair.
- High or ‘manic’ feelings of joy, over-activity and loss of inhibitions.
- A 'mixed state' such as a depressed mood with the restlessness and over-activity of a manic episode.

The exact causes of bipolar disorder aren't known, but it’s thought the following play a part in the condition:

- Genes seem to be important; if you have a relative with bipolar disorder, then your chance of developing the condition is higher.
- There may be a physical problem with the brain systems which control mood - so bipolar disorder can often be controlled with medication.
- Stress can trigger mood swings.

There are a number of types of bipolar disorder:

- **Bipolar I**. There has been at least one high or manic episode, which lasts for longer than one week. You may have only manic episodes, although most people will also have periods of depression.
- **Bipolar II**. Where you have more than one episode of severe depression, but only mild manic episodes (called ‘hypomania’).
- **Rapid cycling**. You have had more than four mood swings happen over a 12 month period. This affects around one in ten people with the condition.
- **Cyclothymia**. The mood swings are not as bad, but are often longer.

If a mood swing becomes very severe, you may have 'psychotic’ symptoms. These include:

- When depressed, you feel guilty, worse than anybody else, or even that you don't exist.
- When manic, you may feel you’re on an important mission or you have special powers or abilities.
- You might also experience hallucinations - when you hear, smell, feel or see something that isn’t there.

Eating disorders:

Eating disorders is a broad name for a number of problems we face with food in our society. While many of us slip into overeating or comfort eating at some point, for some the problem goes to life-threatening extremes.

In both anorexia nervosa and bulimia, there is a deep fear of being overweight that leads to an obsession about restricting the number of calories the person is taking in. This leads to an extreme state of starvation, which in turn has a number of effects on the way that the body functions and how hormones are produced.

This is complicated in bulimia, when the person still finds comfort in the feeling of being full but dreads taking on the extra calories. This is when they may induce vomiting, causing long-term problems for their throat and teeth on top of psychological problems.

Common behaviour of someone affected by an eating disorder includes:

- Mentally keeping a balance between calories taken in and calories used up
- Deep-seated feelings of anxiety if they consume a few calories too many
- Self-loathing, depression or panic if they haven't lost any weight or put a little on, despite their best efforts

Psychologically, at the root of an eating disorder may be a combination of a number of issues, including:

- Distorted body image
- Low self-esteem
- Anxiety for some control
- An expression of deep emotions such as depression or trauma that can't be put into words

Shock:

The most common symptoms of shock include:

- A fast, weak pulse
- Low blood pressure.
- Feeling faint, weak or nauseous.
- Dizziness.
- Cold, clammy skin.
- Rapid, shallow breathing.
- Blue lips.

While psychological shock is less likely to kill you than physiological shock, its effects can persist for years and cause immense disruption.

Mild shocks leave you feeling stunned for a while, absorbed in your thoughts and unable to focus on anything else. After a while, though, the brain gets the event in perspective and normal life resumes.

However, especially if the shock is more profound, some people find it harder to return to normal, and may develop post-traumatic stress disorder (PTSD).

Physiological shock can be caused by:

- Severe bleeding.
- Pulmonary embolus (a blood clot in the lungs).
- Severe vomiting and diarrhoea.
- Spinal injury.
- Poisoning.

There are also specific types of physiological shock, with very particular symptoms.

Cardiogenic shock occurs when the heart is severely damaged - by a major heart attack, for example - and is no longer able to pump blood around the body properly, causing very low blood pressure. This develops after about eight per cent of heart attacks.

It can be difficult to treat, but drugs may be given to make the heart beat stronger. This may be enough to bring someone through the worst until the heart can mend itself, but cardiogenic shock is still fatal in as many as eight out of ten cases.

New treatments to 'revascularise' or restore blood flow to the heart muscle are improving survival rates.

Septic shock occurs when an overwhelming bacterial infection causes blood pressure to drop. It's fatal in more than 50 per cent of cases.

Although it's caused by bacterial infection, treating septic shock with antibiotics is far from simple, because the bacteria release massive amounts of toxin when they are killed off, which initially makes the shock worse.

It must always be treated in hospital where the correct drugs and fluid support can be given.

One type of septic shock is toxic shock syndrome - a rare but severe illness caused by certain strains of the bacteria *Staphylococcus aureus*.

Anaphylactic shock is a severe allergic reaction. Common triggers include bee and wasp stings, nuts, shellfish, eggs, latex and certain medications, including penicillin. Symptoms include:

- Burning and swelling of the lips and tongue.
- Difficulty breathing (like in an asthma attack).
- Red, itchy or blistered skin, sneezing.
- Watery eyes.
- Nausea.
- Anxiety.

Anaphylaxis requires urgent treatment in hospital. People at risk should always carry an emergency anaphylaxis treatment kit that includes adrenaline.

If you're with someone who goes into shock, prompt treatment can make all the difference:

- Lay the person flat and raise their legs by at least 25cm to help restore blood pressure (note that in anaphylactic shock, if the person is conscious but having trouble breathing, it's better to sit them up).
- Stop any bleeding by applying direct pressure over the wound or a tourniquet on extreme limb injuries (it's harmful to stop the blood flow to a limb for more than 10-15 minutes).
- Administer anaphylaxis treatment if necessary.
- Loosen tight clothing.
- Keep the person warm with layers of blankets (not a hot water bottle).
- Don't give them anything to eat or drink because of the risk of vomiting.
- Call an ambulance as soon as possible.

PHYSICAL DISABILITY

A **physical disability** is any impairment which limits the physical function of one or more limbs or fine or gross motor ability. Other physical disabilities include impairments which limit other facets of daily living, such as respiratory disorders and epilepsy.

Mobility impairment is a category of disability that includes people with varying types of physical disabilities. This type of disability includes upper limb disability, manual dexterity and disability in co-ordination with different organs of the body. Disability in mobility can either be a congenital or acquired with age problem. This problem could also be the consequence of some disease. People who have a broken skeletal structure also fall into this category of disability.

Visual impairment is another type of physical impairment. There are hundreds of thousands of people that greatly suffer from minor to various serious vision injuries or impairments. These types of injuries can also result into some severe problems or diseases like blindness and ocular trauma, to name a few. Some of the common types of vision impairments include scratched cornea, scratches on the sclera, diabetes-related eye conditions, dry eyes and corneal graft.

Hearing impairment is the category of physical impairment that includes people that are completely or partially deaf. People who are only partly deaf can sometimes make use of hearing-aids to improve their hearing ability.

Physical disabilities can:

- Be present from birth or acquired throughout life.
- Be short term (broken wrists) or long term (paraplegia).
- Improve over time, or become worse over time.
- Sometimes be controlled by medication and physical therapies.
- Be outwardly invisible; 'hidden disabilities' such as Multiple Sclerosis and Chronic Fatigue Syndrome.

Physical impairment refers to a broad range of disabilities which include orthopedic, neuromuscular, cardiovascular and pulmonary disorders. People with these disabilities often must rely upon assertive devices such as wheelchairs, crutches, walking aids, and artificial limbs to obtain mobility. The physical disability may either be congenital or a result of injury, muscular dystrophy, multiple sclerosis, cerebral palsy, amputation, heart disease, pulmonary disease or more. Some people may have hidden (nonvisible) disabilities which include pulmonary disease, respiratory disorders, epilepsy and other limiting conditions.

Although the cause of the disability may vary, persons with physical disabilities may face the following difficulties:

Access Issues:

- Inability to gain access to inaccessible building or room.
- Decreased eye-hand coordination.
- Impaired verbal communication.
- Decreased physical stamina and endurance.

Considerations:

- If a person uses a wheelchair, conversations at different eye levels are difficult. If a conversation continues and if it is possible to do so, sit down, kneel, or squat and share eye level.
- A wheelchair is part of the person's body space. Do not automatically hang or lean on the chair; it is similar to hanging or leaning on the person.
- Using words like "walking" or "running" are appropriate. Sensitivity to these words is not necessary. People who use wheelchairs use the same words.
- When it appears that a person needs assistance, ask if you can help. Most people will ask for assistance if they need it. Accept a "no thank you" graciously.
- Accept the fact that a disability exists. By not acknowledging this fact is the same as not acknowledging the person.
- People with physical disabilities are not "confined" to wheelchairs. They often transfer over to automobiles and to furniture. Some who use wheelchairs can walk with the aid of sticks, braces, crutches or zimmer frames. Using a wheelchair some of the time does not mean an individual is "faking" a disability. It may be a means to conserve energy or move about more quickly.
- If a person's speech is difficult to understand, do not hesitate to ask him/her to repeat.

Provide assistance if you are asked. Never come up behind a person who uses a wheelchair and push them. Always ask first while facing the person. Never take the door out of a person's hand to assist them in opening it, they may be using the door for balance. Always ask if you can help first.

Multiple Sclerosis (MS):

Multiple sclerosis (MS) is a condition of the central nervous system. Around 100,000 people in the UK have MS. It's normally diagnosed in people between the ages of 20 and 40. Once diagnosed, MS stays with you for life, but treatments and specialists can help you to manage the symptoms.

MS is complex, and has many symptoms. Most people won't experience them all, certainly not at the same time. Symptoms might include fatigue, vision problems and difficulties with walking, but MS is different for everyone.

Problems with memory and thinking - also called 'cognitive problems' - can affect people "Cognition" refers to memory and thinking. MS most commonly affects remembering recent events and remembering to do things. Problem solving and word finding may also be difficult on occasion.

MS may affect cognition in a number of ways:

Learning and memory

- There are different types of memory and the brain organises these in different ways.
- MS most commonly affects remembering recent events and remembering to do things.
- Some people with MS also say that it may take more time and effort to actively search for a memory. This is known as recall.

Attention, concentration and mental speed

- Some people find it more difficult to concentrate for long periods of time or have trouble keeping track of what they are doing if they are interrupted (they ‘lose the thread’).

- It may also be more difficult to do several jobs at once or carry on a conversation while the TV or radio is on.
- Some people with MS experience difficulties when making plans and solving problems.
- They know what they want to do but find it difficult to know where to begin, or find it difficult to work out the steps involved to achieve their goals.
- Problems with planning, structuring and taking an overview can make for confusion and stress, which in turn can hamper learning and memory.
- People with MS may have trouble finding the right word. ('It's on the tip of my tongue' – you know the word but just can't think of it.)
- It may be difficult to take part in a discussion because it takes too long to express an opinion or find the correct word, and the discussion has already moved on.

The impact of problems with memory and thinking

It can be frightening to feel that you don't have a grip on things that used to come more easily. Sometimes people worry that they are 'losing it' or going mad, or that they are becoming stupid.

Cognitive problems can also cause problems in relationships, with family life and work.

Various things can make memory and thinking worse:

- tiredness and fatigue
- relapses
- physical restrictions
- depression, anxiety and stress
- permanent brain lesions
- high alcohol consumption
- poor nutrition
- tranquilisers, sleeping pills and painkillers

Bladder problems are common in MS

There are two main types of bladder problems in MS:

- problems with storage
- problems with emptying

Doctors don't know why some people get one and not the other, or why some people get a bit of both.

A healthy bladder has the ability to 'hold on' and to activate at will. A warning system operates between brain and bladder to alert us when the bladder needs emptying and that we should take the next convenient chance to pass urine.

The muscles in the bladder need to work in co-ordination with each other when storing and emptying. One relaxes while the other contracts.

Problems with storage

When the nerve pathways in the spine are interrupted, even a small amount of urine in the bladder causes it to contract. This causes a need to urinate frequently – known as frequency.

There can often also be an inability to 'hold on', called urgency. If this is severe, urgency incontinence will be a problem.

Problems with emptying

The other main type of bladder disorder is to do with emptying. The bladder muscles don't work in coordination, which makes urine flow poor and interrupted, and bladder emptying incomplete.

People who think they don't empty are usually right, but quite a lot of people who think they do empty their bladders in fact do not, and they have a significant volume of urine left behind. Urine left in the bladder – this is called 'the residual' – stimulates further bladder contractions and can add to problems of urgency and frequency.

Urinary tract infections (UTIs)

Your GP, Continence Adviser or Nurse may also test for urinary tract infections (UTIs). This is important because symptoms of a UTI can be very similar to bladder problems caused directly by MS, needing to go very frequently for example.

An infection causes the urine to go cloudy and smelly, and some people may also have pain and become very confused. Infections can usually be treated with antibiotics.

Due to nerve damage in MS, the colon muscles can become weak and sluggish and the gut slows down, so that the processing of waste takes longer and stools become harder and more difficult to pass, causing constipation.

Nerve damage in MS could mean that the body is unable to interpret sensations in the rectum and upper anal canal. MS might affect reflexes and voluntary control of muscles, where anal sphincter muscles may not relax properly or squeeze tightly enough when you need them to. Straining to open the bowels can be a cause of leakage as the anal muscles are weakened.

Medication

Medication can also cause constipation, and medication taken to ease constipation may cause loose stools which, in turn, could lead to bowel incontinence.

Other MS symptoms

Bladder problems might lead to a low fluid intake which could in turn cause bowel problems. Fatigue and mobility can limit exercise and activity levels which may also have an impact on the bowel.

Emotional factors

Emotional and psychological factors might play a part - if going to the loo seems like too much of a struggle, you might not go. If you lose motivation or become depressed this can cause constipation.

- Muscle stiffness and spasms are common MS symptoms, and are often described as 'spasticity'.
- Muscle spasms or stiffness affect at least 20 per cent of people with MS at some time.
- Drugs and therapies (including physiotherapy and occupational therapy) can help you manage these symptoms.

Spasticity

Spasticity means there is an increase in 'muscle tone' (resistance or tension in the muscle). In other words, when the muscle is moved, there is more resistance to this movement than there normally would be. Muscles feel more rigid. Health professionals sometimes talk about 'spasticity' when describing the muscle stiffness.

Stiffness

Increased tone (resistance in the muscle) can mean muscles are slow to relax, and this can cause stiffness. Depending on the muscles affected, this stiffness can make it difficult to perform delicate movements with the hands and fingers, or make larger movements difficult, which can affect walking, for example.

Spasms

When affected muscles stretch, spasticity may also cause them to jerk in an uncontrolled way – a spasm. If muscles jerk repeatedly, this is known as 'clonus', for example when a foot taps repetitively on the floor.

Some people with MS experience other spasms - sudden involuntary movements that can make the arms or legs move in different ways. These can occur even without the muscle being stretched.

MS can cause swallowing difficulties if there is damage to any part of the brain that controls swallowing, or damage to the connections between the brain and the spinal cord (the 'brainstem'). Just like any other symptom of MS, swallowing difficulties may come and go.

STROKE

A stroke is a serious medical condition that occurs when the blood supply to part of the brain is cut off.

Strokes are a medical emergency and prompt treatment is essential because the sooner a person receives treatment for a stroke, the less damage is likely to happen. If you suspect that you or someone else is having a stroke, phone 999 immediately and ask for an ambulance.

The main symptoms of stroke can be remembered with the word FAST: Face-Arms-Speech-Time.

- **Face** – the face may have dropped on one side, the person may not be able to smile or their mouth or eye may have dropped
- **Arms** – the person with suspected stroke may not be able to lift one or both arms and keep them there because of arm weakness or numbness
- **Speech** – their speech may be slurred or garbled, or the person may not be able to talk at all despite appearing to be awake
- **Time** – it is time to dial 999 immediately if you see any of these signs or symptoms

Why do strokes happen?

Like all organs, the brain needs the oxygen and nutrients provided by blood to function properly. If the supply of blood is restricted or stopped, brain cells begin to die. This can lead to brain damage and possibly death.

Types of stroke

There are two main causes of strokes:

- ischaemic (accounting for over 80% of all cases) – the blood supply is stopped due to a blood clot
- haemorrhagic – a weakened blood vessel supplying the brain bursts and causes brain damage

There is also a related condition known as a transient ischaemic attack (TIA), where the supply of blood to the brain is temporarily interrupted, causing a 'mini-stroke'. TIAs should be treated seriously as they are often a warning sign that a stroke is coming.

The damage that a stroke causes to your brain can impact on many aspects of your life and wellbeing, and depending on your individual circumstances, you may require a number of different treatment and rehabilitation methods.

The two most common psychological conditions found in people after a stroke are:

- depression – many people experience intense bouts of crying and feel hopeless and withdrawn from social activities
- anxiety disorder – where people experience general feelings of fear and anxiety, often punctuated by intense, uncontrolled feelings of anxiety (anxiety attack)

You will receive a psychological assessment from a member of your healthcare team within the first month after your stroke.

Feelings of anger, anxiety, depression, frustration and bewilderment are all common, although they may fade over time. Your healthcare team, family, friends and organisations such as the Stroke Association can all provide you with support and care you need.

Advice should be given to help deal with the psychological impact of stroke. This includes the impact on relationships with other family members and any sexual relationship. There should also be a regular review of any problems of depression and anxiety, and psychological and emotional symptoms generally.

CEREBRAL PALSY

Cerebral palsy is a condition that affects muscle control and movement. It is usually caused by an injury to the brain before, during or after birth.

There is no cure for cerebral palsy, but physiotherapy and other therapies can often help people with cerebral palsy become more independent.

There are three main types of cerebral palsy. Many people with cerebral palsy will have a mixture of these types.

- Spastic cerebral palsy
- Dyskinetic cerebral palsy
- Ataxic cerebral palsy

No two people with cerebral palsy are affected in the same way. Some have cerebral palsy so mildly that it’s barely noticeable. Others may be profoundly affected and require help with many or all aspects of daily life

All people with cerebral palsy are individuals; some may have associated difficulties while others may not. These can include:

- Secondary musculoskeletal problems and motor control. Often contractures of muscles of the spine or hip dislocation. A referral to a physiotherapist may be helpful.
- Learning or cognitive impairment. These difficulties can be mild, moderate or severe and generalised or specific. The reported incidence varies because different studies define the impairment in different ways.
- Constipation, muscle spasms or problems with sleeping and sleep patterns.
- Sensory impairment such as difficulties with hearing and visual acuity.
- With speech, language or feeding difficulties, it may be useful to have contact with a Speech and Language Therapist.
- Epilepsy can occur in up to a third of children with cerebral palsy. Seizure types can vary.
- Spatial awareness and perception. This is about a person's ability to interpret what they have seen as opposed to problems with vision/eyesight.
- Sometimes behavioural or psychological behaviours (in attention, anxiety, over activity) may develop in one in four children with cerebral palsy (13).

PULMONARY DISEASE

Chronic obstructive pulmonary disease (COPD) is an umbrella term for people with chronic bronchitis, emphysema**,** or both. With COPD the airflow to the lungs is restricted (obstructed**).** COPD is usually caused by smoking. Symptoms include cough and breathlessness. The most important treatment is to stop smoking. Inhalers are commonly used to ease symptoms. Other treatments such as steroids, antibiotics, oxygen, and mucolytic (mucus-thinning) medicines are sometimes prescribed in more severe cases, or during a flare-up (exacerbation) of symptoms.

- Chronic means persistent.
- Bronchitis is inflammation of the bronchi (the airways of the lungs).
- Emphysema is damage to the smaller airways and air sacs (alveoli) of the lungs.
- Pulmonary means 'affecting the lungs'.

COPD is common. It is estimated that about three million people in the UK have COPD. However, in many of these people, the condition has not been formally diagnosed (normally these would be mild cases). This is because in the early stages, many people put up with a cough or mild breathlessness without seeing their doctor. They may only see see their doctor when symptoms get worse. COPD mainly affects people over the age of 40 and becomes more common with increasing age. The average age when it is formally diagnosed is around 67 years. It is more common in men than women.

What are the symptoms of chronic obstructive pulmonary disease?

- **Cough** is usually the first symptom to develop. It is productive with sputum (phlegm). It tends to come and go at first, and then gradually becomes more persistent (chronic). You may think of your cough as a 'smokers cough' in the early stages of the disease. It is when the breathlessness begins that people often become concerned.
- **Breathlessness (shortness of breath) and wheeze** may occur only when you exert yourself at first. For example, when you climb stairs. These symptoms tend to become gradually

worse over the years if you continue to smoke. Difficulty with breathing may eventually become quite distressing.

- **Sputum** - the damaged airways make a lot more mucus than normal. This forms sputum (phlegm). You tend to cough up a lot of sputum each day.
- **Chest infections** are more common if you have COPD. A sudden worsening of symptoms (such as when you have an infection) is called an exacerbation. Wheezing with cough and breathlessness may become worse than usual if you have a chest infection and you may cough more sputum. Sputum usually turns yellow or green during a chest infection. Chest infections can be caused by bacteria *or* viruses. Bacteria (which can be killed using antibiotics) cause about 1 in 2 or 3 exacerbations of COPD. Viruses (not killed with antibiotics) are a common cause of exacerbations too, particularly in the winter months. The common cold virus may be responsible for up to 1 in 3 exacerbations.
- Other symptoms of COPD can be more vague. Examples are weight loss, tiredness and ankle swelling.

HUNTINGTONS DISEASE

Huntington's disease (HD) is a hereditary illness which means it is passed through families. It is a neurological condition and is part of a group of diseases which affect the brain and central nervous system. In HD specific brain cells stop working properly and then die. This causes three types of symptoms which affect how muscles work, how the person processes thoughts and information and it also affects mental health.

In HD the person may develops jerky involuntary movements. They will also have less control over their movements. As the illness progresses, the person can develop problems with swallowing and communication such as slowed or slurred speech.

In HD the person will experience changes to the way they take in, process and remember information. HD isn't like Alzheimer's disease and the person who has HD knows who they are, where they are and who other people are. However the person's thinking becomes slowed down. Decision making becomes more difficult. Some people with HD become less able to make appropriate judgements about daily situations. Most people with HD experience problems with planning, organising, concentration and switching their attention from one thing to another.

Many people with HD experience problems with their mental health. Depression and anxiety are the most common difficulties and are often a reaction to the challenges caused by living with the illness. A very small number of people with HD may have more serious mental health problems.

There are some other symptoms which include weight loss, problems with sleep and difficulty regulating body temperature which also relate to changes in the person's brain and are more common as the illness progresses. HD is a long-term illness and usually brings about very gradual changes over a period of fifteen to twenty five years.

Huntington's disease is passed through families and a child who has a parent with the illness has a 50% chance of inheriting the gene that causes the disease. A test is available to anyone, over 18 years of age and involves several meetings with a genetic counsellor, before having a blood test.

There is presently no cure for HD, but worldwide research is giving hope for the future. There is however a great deal that can be done to improve and manage symptoms, ensure that families living with the illness get the support they need and enable them to enjoy a high quality of life.

MOTOR NEURONE DISEASE

Motor neurone disease (MND) is a rare neurological condition that causes the degeneration (deterioration and loss of function) of the motor system (the cells and nerves in the brain and spinal cord which control the muscles in our bodies). This results in weakness and wasting of the muscles.

MND is progressive and symptoms worsen over time. Sadly, MND severely reduces life expectancy and most people with MND die within five years of the onset of symptoms.

The motor system controls all of the movements we make with any part of our bodies, from a simple nod of the head or wave of the hand to more complex movements like walking or running.

A key part of the motor system is the complex system of motor neurones. These are nerve cells which control the function and activity of our muscles by transmitting messages through the central nervous system (the brain and the spinal cord) and through the peripheral nervous system (the network of nerves outside the central nervous system).

Motor neurones are divided into two groups: upper motor neurones (in the brain) and lower motor neurones (in the brainstem at the base of the brain, the spinal cord, and in the arms, legs and torso). Both upper and lower motor neurones can be affected by MND.

We do not know what causes MND. Various studies have been carried out around the world and the risk of developing MND does not appear to be affected by race, diet or lifestyle. MND does not occur in epidemics, it is not infectious and it does not appear to be caused by any other disease. It is more common in men than women. Most people experience the onset of symptoms after the age of 40 years and MND is most common in people aged between 50 and 70 years.

MND symptoms are progressive and worsen over time. Symptoms initially experienced in distinct parts of the body will eventually spread to the rest of the body. MND does not usually cause cognitive problems or affect an individual's intellect.

Main symptoms of MND:

- Muscle wasting (this is often first noticed in the muscles in one hand, or in one arm or leg)
- Muscle weakness (it might be difficult to open bottles or jars, carry heavy objects, or climb stairs)
- Fasciculations (involuntary contractions of part of a muscle, often felt as flickers of movement or small twitches just under the skin)
- Speech problems
- Swallowing problems and excessive saliva (drooling)
- Cramps and muscle spasms (spasticity)

In the later stages of MND, the muscles weaken in the chest, back and neck and people experience difficulties with breathing.

Unfortunately, there is no cure for MND. However, there are different treatments available. Some aim to slow the progress of the condition and others aim to treat your specific symptoms and improve your quality of life.

- **Riluzole** is the only drug treatment specifically for MND. It is used to slow the progression of MND symptoms. Riluzole can increase the life expectancy of people with MND by three to six months.
- Different specialist health professionals can provide therapies for your specific symptoms. A Speech and Language Therapist can help with speech and swallowing problems. A Physiotherapist can help with physical symptoms like mobility problems, pain from stiff joints and muscle spasms. An Occupational Therapist can advise on maintaining independence and using equipment around the home. A Dietician can advise on nutrition and maintaining a healthy weight.
- Drug treatments are available for cramps and muscle spasms (spasticity).
- You might develop swallowing problems that affect your ability to eat and drink safely. You might need to be fed through a tube in your nose, or by PEG (percutaneous endoscopic gastrostomy). This is a procedure to insert a feeding tube directly into the stomach.
- People with breathing difficulties might benefit from oxygen therapy (usually given at night) or assisted ventilation (usually given through a face mask).

EPILEPSY

There are different types of epileptic seizures, but they all start in the brain. There are other types of seizures which may look like epileptic seizures but they do not start in the brain. Some seizures are caused by conditions such as low blood sugar (hypo glycaemia) or a change to the way the heart is working. Some very young children have 'febrile convulsions' (jerking movements) when they have a high temperature. These are not the same as epileptic seizures.

- Most seizures happen suddenly without warning, last a short time (a few seconds or minutes) and stop by themselves.
- Seizures can be different for each person.
- Just knowing that someone has epilepsy does not tell you what their epilepsy is like, or what seizures they have.
- Calling seizures ‘major’ or ‘minor’ does not tell you what happens to the person during the seizure. The names of seizures used on this page describe what happens during the seizure.
- Some people have more than one type of seizure, or their seizures may not fit clearly into the types described on this page. But even if someone's seizures are unique, they may follow the same pattern for that person.
- Not all seizures involve convulsions (jerking or shaking movements). Some people appear vacant, wander around or seem confused during a seizure.
- Some people have seizures when they are awake, called 'awake seizures'. Some people have seizures while they are asleep, called 'asleep seizures' (or ‘nocturnal seizures’). The names 'awake' and 'asleep' do not explain the *type* of seizures, only *when* they happen.
- Injuries can happen during seizures, but many people don't hurt themselves and don't need to go to hospital or see a doctor.

Types of seizures

Seizures are divided into two main types: focal seizures (also called partial seizures) and generalised seizures. Epileptic seizures always start in the brain.

The brain has two sides called hemispheres. Each hemisphere has four parts called lobes. Each lobe is responsible for different things such as vision, speech and emotions.

Focal (partial) seizures

In focal seizures the seizure starts in, and affects, just part of the brain, sometimes called the 'focus' of the seizures. It might affect a large part of one hemisphere or just a small area in one of the lobes. What happens during the seizure depends on where in the brain the seizure happens and what that part of the brain normally does.

Simple focal seizures

In simple focal seizures (SFS) a small part of one of the lobes of the brain is affected. The person is conscious (aware and alert) and will usually know that something is happening and will remember the seizure afterwards. Some people find their simple focal seizures (SFS) hard to put into words. During the seizure they may feel 'strange' but not able to describe the feeling. This may be upsetting or frustrating for them. SFS are sometimes called 'warnings' or 'auras' because, for some people, a SFS develops into another type of seizure. Then the SFS is a warning that another seizure will happen (see secondarily generalised seizures below).

Temporal lobe simple focal seizures may include:

- a 'rising' feeling in the stomach or deja vu (feeling like you've 'been here before')
- getting an unusual smell or taste
- a sudden intense feeling of fear or joy.

Frontal lobe simple focal seizures may include:

- a strange feeling like a 'wave' going through the head
- stiffness or twitching in part of the body (such as an arm or hand).

Parietal lobe simple focal seizures may include:

- a feeling of numbness or tingling
- a sensation that an arm or leg feels bigger or smaller than it actually is.

Occipital lobe simple focal seizures may include:

- visual disturbances such as coloured or flashing lights
- hallucinations (seeing something that isn't actually there).

Complex focal seizures

Complex focal seizures (CFS) affect a bigger part of one hemisphere (side) of the brain than a simple focal seizure. The person's consciousness is affected and they may be confused. They might make strange or repetitive movements that have no purpose (called 'automatisms'). They may wander around, or behave strangely, and they may not be aware of what they are doing.

They might be able to hear you, but might not fully understand what you say or be able to respond to you. They may not react to you they would normally. If you speak loudly to them, they may think that you are being aggressive and so they may react aggressively towards you.

CFS often happens in the temporal lobes ('temporal lobe epilepsy') but can happen in other parts of the brain.

Temporal lobe complex focal seizures may include:

- picking up objects for no reason or fiddling with clothing
- chewing or lip- smacking movements
- muttering or repeating words that don't make sense
- wandering around in a confused way.

These CFS may start with a simple focal seizure and last around two or three minutes.

Frontal lobe complex focal seizures may include:

- making a loud cry or scream
- making strange postures or movements such as cycling or kicking.

These CFS usually last around 15 - 30 seconds.

Complex focal seizures in the parietal or occipital lobes are less common than in the temporal or frontal lobes. Like the simple focal seizures, CFS in the parietal and occipital lobes can affect the person's senses or vision. These CFS usually last around 15 - 30 seconds.

After a complex focal seizure, the person may be confused for a while, sometimes called 'post-ictal' (after seizure) confusion. It may be hard to tell when the seizure has ended. The person might be tired and want to rest. They may not remember the seizure afterwards.

Secondarily generalised seizures

Sometimes focal seizures spread from one side (hemisphere) to both sides of the brain. This is called a secondarily generalised seizure because it starts as a focal seizure and then becomes generalised. When this happens the person becomes unconscious and will usually have a tonic clonic (convulsive or shaking) seizure. If this happens very quickly, they may not be aware that it started as a focal seizure.

Generalised seizures

Generalised seizures affect both sides of the brain at once and can happen without warning. The person will be unconscious (except in myoclonic seizures), even if just for a few seconds. Afterwards they will not remember what happened during the seizure.

Absences (sometimes called petit mal)

Absence seizures are more common in children than adults, and can happen very frequently. During an absence a person becomes unconscious for a short time. They may look blank and stare, or their eyelids might flutter. They will not respond to what is happening around them. If they are walking they may carry on walking, but will not be aware of what they are doing. In typical absences, the person becomes blank and unresponsive for a few seconds. Because the seizures are so brief, they may not be noticed.

Tonic seizures

In a tonic seizure the person's muscles suddenly become stiff. If they are standing they often fall, usually backwards, and may injure the back of their head. Tonic seizures tend to be very brief and happen without warning.

Atonic seizures

In an atonic seizure (or 'drop attack') the person's muscles suddenly relax, and they become floppy. If they are standing they often fall, usually forwards, and may injure the front of their head or face. With both tonic and atonic seizures people usually recover quickly, apart from possible injuries.

Myoclonic seizures

Myoclonic means 'muscle jerk'. Muscle jerks are not always due to epilepsy (for example, some people have them as they fall asleep). Myoclonic seizures are brief but can happen in clusters (many happening close together in time), and often happen shortly after waking. In myoclonic seizures the person is conscious, but they are classified as generalised seizures. This is because the person is likely to have other seizures (such as tonic clonic seizures) as well as myoclonic seizures.

Tonic clonic (convulsive) seizures (sometimes called grand mal)

These are the seizures most people think of as epilepsy. At the start of the seizure:

- the person becomes unconscious
- their body goes stiff and if they are standing up they usually fall backwards
- they may cry out
- they may bite their tongue or cheek.

During the seizure:

- they jerk and shake (convulse) as their muscles relax and tighten rhythmically
- their breathing might be affected and become difficult or sound noisy
- their skin may change colour and become very pale or bluish
- they may wet themselves.

After the seizure (once the jerking stops):

- their breathing and colour return to normal
- they may feel tired, confused, have a headache or want to sleep.

Clonic seizures

Clonic seizures are convulsive seizures but the person's body does not go stiff at the start.

How to help in a tonic clonic seizure.

An individual's seizures usually last the same length of time each time they happen, and stop by themselves. However, sometimes seizures do not stop, or one seizure follows another without the person recovering in between. If this goes on for 30 minutes or more it is called status epilepticus, or 'status'. Status is not common but it can happen in any type of seizure and the person may need to see a doctor. However, **status in a tonic clonic (convulsive) seizure is a medical emergency** and the person will need urgent medical help. **Call for an ambulance if a tonic clonic seizure lasts for more than five minutes**.

AMPUTATION

An amputation is the surgical removal of part of the body, usually an arm or leg. There are three main reasons why an amputation is carried out:

- The limb has been affected by gangrene (when the body's tissue begins to die as a result of loss of blood supply)
- The limb poses a life-threatening danger to the person's health, for example because it has been affected by cancer or a serious infection
- The limb has experienced serious trauma, such as a crush or blast wound

How common are amputations?

- Approximately 5-6,000 major limb amputations are carried out in the UK every year.
- The most common reason for amputation is a loss of blood supply to the affected limb (critical ischaemia), which accounts for 70% of lower limb amputations. Trauma is the most common reason for upper limb amputation, which accounts for 57%.
- People with either Type 1 or Type 2 Diabetes are particularly at risk and are 15 times more likely to need an amputation than the general population. This is because the high blood glucose levels in diabetes can damage blood vessels, leading to a restriction in blood supply.
- More than half of all amputations are performed in people aged 70 or over and men are twice as likely to need an amputation as women.

Prosthetics

After the amputation, it may be possible to fit a prosthetic (artificial) limb onto the remaining stump. Prosthetic limbs have become increasingly sophisticated and can reproduce many functions of the hands, arms and legs.

For example, many people who have had the foot and lower section of the leg from beneath the knee removed (transtibial amputation) can walk or ride a bike using a prosthetic limb.

However, adjusting to life with a prosthetic limb requires an extensive course of physiotherapy and rehabilitation. Also, it takes a lot more physical energy to use a prosthetic limb as your body has to compensate for the missing muscle and bone. This is why frail people or those with a serious health condition, such as heart disease, may not be suitable for a prosthetic limb.

Many people who have had an amputation reported feeling emotions such as grief and bereavement, similar to experiencing the death of a loved one.

A phantom limb is also a common complication following an amputation. This is when a person experiences the sensation of their limb still being attached to their body, often causing pain.

SENSORY IMPAIRMENT

Sensory impairment is when one of your senses; sight, hearing, smell, touch, taste and spatial awareness, is no longer normal.

Examples - If you wear glasses you have a sight impairment, if you find it hard to hear or have a hearing aid then you have a hearing impairment. A person does not have to have full loss of a sense to be sensory impaired.

What is dual sensory impairment?

It is the combination of both hearing and sight impairment. It is not necessarily a total loss of both senses – indeed the majority of dual sensory impaired people do have some degree of sight and/or hearing. Those with a less severe degree of both sight and hearing impairment may also be referred to as having a dual sensory impairment or loss. The words dual sensory impaired and deafblind are generally accepted as inter-changeable words.

When a person has difficulties seeing and hearing then the person can be termed deafblind. Although it is more common to refer to someone as being deafblind if there combined sight and hearing loss which causes difficulties for them with communication, mobility and access to information.

The combination of the two sensory impairments intensify the impact of each other, which usually means that a deafblind person will have difficulty, or find it impossible, to utilise and benefit fully from services for deaf people or services for blind people. Meeting the needs of deafblind people therefore requires a separate approach.

Deafblindness is a unique and extremely complex disability that often requires specialist communication methods and and systems being introduced to the person and those around them to enable communication to take place. It has adverse effects on all areas of development, in particular the language acquisition process, conceptual development, motor development, behaviour and personality of a person.

People who are deafblind can generally be separated into two groups:

- **Congenital Deafblindness -** People who were born with a

  hearing and vision impairment. This category may also include individuals who are born hearing – sighted, but who become deafblind through accident or illness within the first months of their lives. The important factor being that they become deafblind before they had the opportunity to gain formal language skills.

- **Acquired Deafblindness -** People who develop deafblindness later in life.

Three combinations are possible:

a) Individuals who are born blind and later develop a hearing

impairment.

b) Individuals who are born deaf and later develop vision

impairment.

c) Individuals who are born sighted and hearing, but later develop a

vision and hearing impairment.

Every deafblind person is an individual and may not fit neatly into any of the above categories, or use the suggested means of communication. Their situation may be complicated by the existence of other factors such as physical and/or learning disabilities etc.

The ageing process is the most common cause of acquired deafblindness. Sight loss can occur through eye conditions such **as Cataracts** and **Macular Degeneration**. Hearing loss can be caused by a variety of factors. People who have worked in noisy environments all their lives may develop a hearing loss. Illness is another cause; or it may just be simply caused by the ageing process.

Our elderly population is the largest single group of people with acquired deafblindness. It is important to recognise that some people who have become deafblind later in life are unable to speak. This may the result of a stroke or another speech defect.

Often there becomes a point when adaptations and medical intervention are not enough for someone to fully support them self. Everyday tasks such as reading mail, going to the shops or answering the door become a challenge. Hobbies and leisure pursuits are not participated in and the cycle of isolation begins. Depression and anxiety are not uncommon, all of which does not help any underlying medical condition.

DIABETES

Diabetes is a lifelong condition that causes a person's blood sugar level to become too high.

The two main types of diabetes are:

- Type 1 diabetes
- Type 2 diabetes

Type 1 diabetes

In type 1 diabetes, the body's immune system attacks and destroys the cells that produce insulin. As no insulin is produced, your glucose levels increase, which can seriously damage the body's organs.

Type 1 diabetes is often known as insulin-dependent diabetes. It is also sometimes known as juvenile diabetes or early-onset diabetes because it usually develops before the age of 40, often during teenage years.

Type 1 diabetes is less common than type 2 diabetes. About 10% of all people with diabetes have type 1 diabetes.

If you are diagnosed with type 1 diabetes, you will need insulin injections for the rest of your life. You will also need to pay special attention to certain aspects of your lifestyle and health to ensure your blood glucose levels stay balanced – for example, by eating a healthy diet and carrying out regular blood tests.

Type 2 diabetes

Type 2 diabetes is where the body does not produce enough insulin, or the body's cells do not react to insulin. This is known as insulin resistance.

Type 2 diabetes is far more common than type 1 diabetes. In the UK, around 90% of all adults with diabetes have type 2 diabetes.

If you are diagnosed with type 2 diabetes, you may be able to control your symptoms simply by eating a healthy diet and monitoring your blood glucose level. However, as type 2 diabetes is a progressive condition, you may eventually need medication, usually in the form of tablets.

Type 2 diabetes is often associated with obesity. Obesity-related diabetes is sometimes referred to as maturity-onset diabetes because it is more common in older people.

Hypoglycaemia

A 'hypo' is when the blood sugar levels fall below normal. It's short for hypoglycaemia, which means low blood sugar.

A hypo may occur:

- After an insulin injection

- After taking oral diabetes medication
- If a meal is missed or delayed
- After strenuous exercise
- If alcohol is drunk on an empty stomach

The symptoms of a hypo vary from person to person. Mild hypo may cause:

- Weakness
- Dizziness
- Sweating
- Hunger
- Shaking
- Irritability
- Mood swings

A mild hypo can usually be treated with some form of sugar. Types of sugar to use during mild 'hypo':

- Dextrose tablets (carry these if you have diabetes)
- Three sugar lumps
- Two teaspoons of sugar
- Chocolate or sweet biscuits
- A sweet drink

When the blood glucose level falls even lower, then the person may behave strangely and become confused (often mistakenly interpreted as drunkenness). Under these circumstances it may be easier and quicker to give sugar in liquid form, such as a sweet drink.

In severe hypoglycaemia, the person loses consciousness. Under these circumstances an injection of glucagon is given, which temporarily raises the level of blood glucose. Once the person is conscious they can be given some sugar and a snack to prevent the hypo from recurring.

People with diabetes and those close to them are taught to look out for signs that their sugar level may be low, and are advised to always have sugar tablets or another form of sugar available to raise the level quickly. This solves the problem quickly and prevents serious consequences.

People with diabetes are advised to carry some form of identification saying that they have diabetes, so that people will realise their condition should they get into difficulty and need help.

It's also important that they are aware of the regulations related to driving. In 2011 the DVLA changed their regulations so that all Group 1 drivers (people who hold an ordinary driving licence for cars and motorcycles) who have diabetes that's treated with either oral anti diabetic agents or insulin, mustn't have had more than one hypoglycaemic event in the past 12 months. This means that if you have diabetes and have had two or more hypos in the past 12 months, your driving licence may not be valid, and neither will your insurance.

Hyperglycaemia

Hyperglycaemia is when the blood glucose level is too high. When it's mildly raised then symptoms of uncontrolled diabetes occur, namely excessive thirst, passing urine frequently, tiredness, weakness and lethargy.

If the blood glucose level becomes dangerously high then the person becomes dehydrated and may become comatose. This is a medical emergency that requires hospital treatment.

If you're in doubt as to whether a diabetic is having a hypoglycaemic attack or a hyperglycaemic attack it's safer to give some sugar, as it may massively improve a 'hypo' but won't make much difference to a 'hyper'.

LEARNING DISABILITY

A learning disability is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.

People with a learning disability tend to take longer to learn and may need support to develop new skills, understand complex information and interact with other people.

The level of support someone needs depends on individual factors, including the severity of their learning disability. For example, someone with a mild learning disability may only need support with things like getting a job. However, someone with a severe or profound Learning Disability may need full-time care and support with every aspect of their life – they may also have physical disabilities.

People with certain specific conditions can have a learning disability too. For example, people with Down's Syndrome and some people with Autism have a learning disability.

Learning disability is often confused with dyslexia and mental health problems. Mencap describes dyslexia as a "learning difficulty" because, unlike learning disability, it does not affect intellect. Mental health problems can affect anyone at any time and may be overcome with treatment, which is not true of learning disability.

It's important to remember that with the right support, most people with a learning disability in the UK can lead independent lives.

Some people with a learning disability also have other physical and emotional conditions, and may receive more than one diagnosis. This could have an impact on the kind of support they and their families need in their day-to-day life.

Down's Syndrome

Down's Syndrome is a condition someone is born with which causes learning disabilities, caused by an extra 'number 21' chromosome. It can come from either the mother or the father and there is no way to predict it. Down's Syndrome is the most common cause of developmental disability.

There are thought to be up to 120 features of Down's Syndrome, but many children experience no more than a handful of these. Aside from several physical traits, the main mental symptoms include a slower rate of learning new skills, meaning those affected often meet their 'developmental milestones' such as walking or talking later.

Parents or other carers of those with Down's Syndrome can feel extremely stressed, especially immediately after diagnosis. It is important during this time to seek help; usually a community midwife and health visitor will visit the family at home early on, offering emotional support and advice on practical ways of coping with difficulties such as feeding problems. The help they provide, as well as that provided by other organisations and support groups, can lead to a period of positive

adjustment and optimism as the realisation sets in that people with Down's Syndrome can live a life every bit as full and rewarding as anyone else.

Autistic Spectrum Disorders

Autistic Spectrum Disorder (ASD) is the generic term used for a range of disorders affecting the development of social interaction and imagination. Asperger Syndrome is a form of autism, a condition that affects the way a person communicates and relates to others.

A number of traits of autism are common to Asperger Syndrome; both can give those affected severe problems in making sense of experiences and other peoples' thoughts and feelings and difficulty in acquiring the subtle, unspoken rules of social interaction, especially in a complicated, constantly changing social world.

There is strong evidence to suggest that autism can be caused by a variety of physical factors, all of which affect brain development.

As the child grows up, meetings with the health visitor should be ongoing and can really help to look after the health of the family as a whole. A Speech Therapist, Physiotherapist and Occupational Therapist may well have important roles too, both from a very young age and later during the child's schooling.

REABLEMENT

There are a number of definitions of Reablement

- Support for people with poor physical or mental health or a disability to help them live as independently as possible by learning or relearning the skills necessary for daily living.
- An approach or a philosophy within homecare services – one which helps people “do things for themselves, rather than having things done for them”.

Evidence shows that timely bursts of social care re-ablement, focusing on skills for daily living, can enable people to live more independently and reduce their need for ongoing homecare support. Homecare re-ablement complements the work of intermediate care services to help:

- maximise independence
- minimise whole life cost of care.

Social care and health services will always need to make best use of limited resources. Demographic projections also show an increasing demand on all modes of care. The approach needs to ensure that the lowest appropriate level of intervention is provided set within an active and ongoing assessment process to balance risk against 'quality of life' for adults who need care. Other initiatives such as telecare services will also play a significant part in supporting people in their 'home', whether it for an individual residence, sheltered or extra care housing.

If you need assistance following a spell in hospital, Re-ablement can help you regain your independence.

The innovative programme provides short term support following an illness or operation, and enables you to continue to live independently by supporting you with the skills necessary for daily living. It aims to:

- improve your quality of life and help you become as independent as possible
- reduce your need for other health and social care services

- avoid unnecessary hospital admissions.

How re-ablement works:

If you are referred for Re-ablement someone from the Re-ablement Team will discuss your goals with you and how a Re-ablement programme can help you to achieve them.

Your Re-ablement programme is designed to help you become as independent as possible by helping you with the important tasks you need for everyday living. Re-ablement is about helping people to 'do things for themselves' rather than 'having things done for them'. It might include support with personal care, to prepare a meal, or manage your medication. At first you may need several visits every day but as you progress the number of visits may reduce. Many people who participate in a Re-ablement programme find that afterwards they can cope very well on their own without the need for further support.

COMMUNITY ALARM / TELECARE

Telecare

Telecare is a term that covers a range of devices and services that harness developing technology to enable people to live with greater independence and safety in their own homes.

Examples include devices that trigger a response from a contact centre, such as falls monitors and motion sensors. The responses may range from a phone call to the person, to alerting a local carer or neighbour or social service, to alerting emergency services if appropriate. Other examples include devices that directly alert the person in the home to a particular hazard, such as a water level monitor in a bath.

IT developments are continually extending the range of devices and services available and, as a result, the scope for telecare to support people with particular health and social care needs – such as older people and people with disabilities – to remain in their own homes and optimise their independence and quality of life.

Telecare consists of equipment and services that support your safety and independence in your own home. The equipment can sense risks such as smoke, floods and gas, can remind you to take pills and even call for help if you fall. A help centre can be contacted automatically if any of these problems occur in your home. If needed the contact centre can arrange for someone to come to your home or can contact your family, doctor or emergency services. The system can also warn you of problems by sounding an alarm, flashing lights or vibrating a box which can be kept in your pocket or under your pillow.

Community Alarm

A Community Alarm is a personal alarm system that provides a lifeline between you and people you can rely on, 24 hours a day, 7 days a week. The system connects to your phone through a base unit which you set off either by pressing the alarm button on the telephone itself or by pressing a radio button worn on your body, usually on a wristband or around your neck on a pendant. Once the alarm is set off, a call is put through to an operator at a contact centre, who has immediate access to the details you have supplied to them in advance and can:

- provide needed reassurance
- contact a keyholder - someone you name who holds a key to your home and could come and help you
- call emergency services if necessary

How does it work?

If you find yourself in a situation where you need help, all you need to do is push the button on the pendant or base unit. This will immediately connect you to the contact centre.

The operator can have a two-way speaker-phone conversation with you to find out what action is needed. Or, if you cannot speak or become unconscious after setting off the alarm, the operator will send help to your home as soon as possible.

A community alarm may be of help to you if you are at risk of falling or have had a fall in the past. An alarm gives you, and your friends and relatives, the security of knowing that you can get help at any time, even if you cannot reach a phone.

OCCUPATIONAL THERAPIST (OT) ROLE

Occupational Therapists help people with mental, physical or social disabilities to independently carry out everyday tasks or occupations. They work with children and adults of all ages, whose difficulties may have been presence since birth, or the result of an accident, illness, ageing or lifestyle.

Occupational Therapists create an individual treatment program to help people carry out their daily tasks and to do so with more confidence and independence. They may suggest changes to the person's environment, whether that be at home, work or school, and may introduce the use of equipment which will help with some activities. Occupational Therapists review the treatments periodically, evaluate progress and make changes to the treatment as needed.

Typical work activities

Occupational Therapists work with a diverse range of people who all have different needs. Their aim is to understand each person's requirements and lifestyle so they can create the best treatment plan for them. The work an Occupational Therapist carries out may include:

- advise on specialist equipment to assist with daily activities;
- develop a rehabilitation program to help re-build lost skills and restore lost confidence;
- advise on home and workplace environmental alterations, such as adjustments for wheelchair access; bathing; ability to use toilet independently, etc.
- teach anxiety management techniques;
- assist people to return to work;
- coach people with learning difficulties or poor social skills, e.g. in handling money and social interaction;
- mentor people on how to control their own behaviour;
- liaise with a wide variety of other professionals, such as Doctors, Physiotherapists, Social Workers, Equipment suppliers and Architects, as well as patients' families, carers and employers;

- organise support and rehabilitation groups for carers and clients;

PHYSIOTHERAPIST (PHYSIO) ROLE

Physiotherapists treat patients with physical difficulties resulting from illness, injury, disability or ageing. They treat people of all ages including children, the elderly, stroke patients and people with sports injuries.

Physiotherapists work with patients to identify and improve their movement and function. They help promote their patients' health and wellbeing, and assist the rehabilitation process by developing and restoring body systems, in particular the neuromuscular, musculoskeletal, cardiovascular and respiratory systems. They devise and review treatment programs, comprising manual therapy, movement, therapeutic exercise and the application of technological equipment, e.g. ultrasound. Physiotherapists also provide advice on how to avoid injury.

Typical work activities

Physiotherapists work in a range of settings, including hospitals, health centres, industry, private practices and sports clubs. They treat a wide variety of conditions, such as injuries and fractures (including sports injuries), orthopaedics and joints, strokes, post-surgical rehabilitation, intensive care or terminal illness, abdominal conditions, obstetrics and gynaecology, chest conditions, posture and movement, neurological conditions, learning difficulties and mental illness.

Treatment involves encouraging exercise and movement by the use of techniques such as therapeutic movement and exercise therapy, massage, manipulation, electrotherapy and/or hydrotherapy.

Tasks often include:

- working with patients to identify the physical problem;
- developing and reviewing treatment programmes;
- assisting patients with joint and spinal problems, especially following surgery;
- helping patients' rehabilitation following accidents, injury and strokes;
- supervising physiotherapy assistants;
- assisting in the supervision and education of junior physiotherapists;
- writing patient case notes and reports;
- collecting patient statistics;
- educating and advising patients and their carers about how to prevent and/or improve conditions;

- keeping up to date with new techniques and technologies available for treating patients;
- liaising with other healthcare personnel to supply and receive relevant information about the background and progress of patients, as well as referring patients who require other specific medical attention;

Physiotherapists often see patients for several consultations over a period of weeks or months.

DISTRICT NURSE (DN) ROLE

District nurses play a crucial role in the primary health care team. They visit people in their own homes or in residential care homes, providing care for patients and supporting family members.

As well as providing direct patient care, district nurses also have a teaching role, working with patients to enable them to care for themselves or with family members teaching them how to GIVE care to their relatives.

District nurses play a vital role in keeping hospital admissions and readmissions to a minimum and ensuring that patients can return to their own homes as soon as possible.

You will work closely with the District Nurses within your service user's home. The Nurse may visit weekly or daily, depending on the service user's needs.

The DN carries out all wound care and changing of the service user's dressings. They will visit to administer insulin and check INR levels. If your service user requires bowel care and 2 people are required, a mutual time will be set up between the Nurse and the Service Provider, which will suit the service user's needs.

ADULT PROTECTION

Adult protection and support.

We all know that children need to be protected, but sometimes adults, due to their vulnerabilities, need to be protected too. Adult protection is everyone's responsibilty.

What you need to know

It is not always the case that adults are able to protect and care for themselves. Some adults are particularly vulnerable to harm. All citizens, organisations and agencies have a responsibility to participate in adult protection.

The rights of every individual

Every individual has a right to:

- a life free from fear
- be treated with dignity
- have their choice respected and not be forced to do anything against their will

Who are adults at risk?

"Adult" means an individual aged sixteen years or over. Adults at risk have additional support needs and are dependent on others. They might be:

- older people who are dependent on the help of others
- people with learning disabilities
- people with a physical or sensory impairment
- people with mental health problems
- people unable to protect themselves from serious harm or being taken advantage of
- people who are controlled or suppressed by dominant partners

Most adults with additional support needs manage to live their lives comfortably and securely, either independently or with help from caring relatives, friends, neighbours, professionals or volunteers. However, for a small number, dependence on someone may produce conflict, exploitation and harm.

What is harm?

"Harm" includes all hurtful conduct and, in particular, includes:

- conduct which causes physical harm - including that of a sexual nature
- conduct which causes psychological harm - for example by causing fear, alarm or distress
- unlawful conduct which appropriates or adversely affects property, rights or interests - for example, theft, fraud, embezzlement or extortion
- conduct which causes self-harm

Where does harm take place?

Any adult at risk, man or woman, can experience harm or be at risk of harm in their own home, care homes, day services or hospitals.

What to do and who to contact?

If you are concerned that one of your Service Users may be at risk of harm you need to contact your Line Manager immediately. If you feel that they are in immediate danger then you should ring police on 999.

It is everyone's responsibility to play a part in adult protection and the protection of vulnerable people. Information and advice will be offered so that the person and their family can decide what practical help they need or what action they wish to take. If they are unable to make a decision, care will be taken to support and protect them.

Adult Protection is part of the council and they have a duty to investigate an alleged incident of harm. The investigation will be handled sensitively and the adult's wishes are considered. If the concerns are serious, they will act immediately to make sure the adult at risk is safe.