

Chapter 1 : Caregiving | Family Caregiver Alliance

Working with Older People and their Families is recommended reading for students on health related courses such as nursing, medicine and the therapies. It is also of relevance to students of social work and social gerontology, researchers, managers and policy makers.

Then when I tell them that I work with older people, they automatically assume that I work in a care home, or with people with dementia. But working with older people is as diverse as working with any other age range. I work in the community, with older people not previously known to adult social care. Some may just need information and advice about universal local services. Others may need equipment or home adaptations to meet their needs, and some need access to services. We are focused on wellbeing and seek to maintain and enhance their quality of life. Read more It was in my final year as a social work student in a learning disability team that I first started to see how older people seem to be written off by society. In the learning disability team, the adults would be encouraged and supported to maintain their independence and were taught skills such as how to use public transport or manage their money. I had a client with a learning disability who was supported with accessing the community in a personalised way. But I have come across older people only being offered access to the local day centre, not given the choice of going somewhere on their own and doing something they had chosen to do. But, despite the importance of this work, it seems like fewer students are opting to work with older people. In one lecture at university, we were asked to say what sort of social work we wanted to do when we finished the course. Most of the class, around three-quarters, wanted to work with children and families. Social work education and practice needs to be focused on and interested in older people. One home visit made me realise just how important my job is, and how much I enjoy this type of work, no matter the challenges along the way. I recently carried out an assessment of an older person following a referral from their son. The individual lives alone, but has visits from their sons who provide some support. One of the sons was present during the assessment. I feel honoured that people let me into their lives and trust me, a stranger, with making things better for them. The Social Life Blog is written by people who work in or use social care services.

Chapter 2 : Elderly care - Wikipedia

Addressing the needs of older people and their carers is an essential element of both policy and practice in the fields of health and social care. Recent developments promote a partnership and empowerment model, in which the notion of 'person-centred' care figures prominently.

Family caregiving raises safety issues in two ways that should concern nurses in all settings. First, family caregivers are unpaid providers who often need help to learn how to become competent, safe volunteer workers who can better protect their family members. This chapter summarizes patient safety and quality evidence from both of these perspectives. The focus is on the adult caregiver who provides care and support primarily for adults with chronic illnesses and chronic health problems. The focus is not on those with developmental disabilities. In the first section, we discuss the evidence for protecting the caregiver from harm. The second section addresses research aimed at protecting the care recipient from an ill-prepared family caregiver. Caregivers as Clients For centuries, family members have provided care and support to each other during times of illness. Who are these family caregivers, what do they do, and what harm do they face? What does the research tell us about ways to assess the needs of these hidden patients and evidence-based interventions to prevent or reduce potential injury and harm? This section answers these questions and highlights the need for nurses to proactively approach family caregivers as clients who need their support in their own right. Description of Caregiver Population The terms family caregiver and informal caregiver refer to an unpaid family member, friend, or neighbor who provides care to an individual who has an acute or chronic condition and needs assistance to manage a variety of tasks, from bathing, dressing, and taking medications to tube feeding and ventilator care. Recent surveys estimate there are 44 million caregivers over the age of 18 years approximately one in every five adults. Those caring for someone 50 years or older are 47 years old on average and working at least part-time. About two out of three older care recipients get help from only one unpaid caregiver. Nurses have a limited view of this interaction. Caregiving can last for a short period of postacute care, especially after a hospitalization, to more than 40 years of ongoing care for a person with chronic care needs. On average, informal caregivers devote 4. More than half of family caregivers provide 8 hours of care or more every week, and one in five provides more than 40 hours per week. But those concepts do not adequately capture the complexity and stressfulness of caregiving. Supervising people with dementia and observing for early signs of problems, such as medication side effects, are serious responsibilities as family members are often unable to interpret the meaning or the urgency. Family caregivers often feel unprepared to provide care, have inadequate knowledge to deliver proper care, and receive little guidance from the formal health care providers. Due to inadequate knowledge and skill, family caregivers may be unfamiliar with the type of care they must provide or the amount of care needed. Family caregivers may not know when they need community resources, and then may not know how to access and best utilize available resources. Health professionals in emergency departments and inpatient hospital settings do not adequately determine the after-care needs of older patients when they are being discharged. Effective discharge planning is impeded by gaps in communication between the hospital and community interface, such as illegible discharge summaries and delays in sending information to the physician. Many caregivers felt abandoned at a critical time, and none of the focus group participants had been referred by any health care professional in the hospital to community-based organizations for emotional support or any other kind of support. Caregivers are hidden patients themselves, with serious adverse physical and mental health consequences from their physically and emotionally demanding work as caregivers and reduced attention to their own health and health care. Declines in physical health and premature death among caregivers in general have been reported. Elderly spouses who experience stressful caregiving demands have a 63 percent higher mortality rate than their noncaregiver age-peers. These researchers found that, with a high level of caregiving activities, the odds of the caregiver not getting rest, not having time to exercise, and actually not recuperating from illness were also high. In addition, caregivers were more likely to forget to take their prescriptions for their own chronic illnesses. Providing care poses a threat to the overall health of caregivers, which can compromise their ability

to continue to be caregivers. If caregivers are to continue to be able to provide care, relief from the distress and demands of maintaining the required care must be considered. Both highly negative and highly positive consequences of providing care may exist simultaneously. Picot and colleagues 41 , 42 worked primarily with African American caregivers and found that the rewards perceived by caregivers were more important than coping. A specific Picot Caregiver Reward Scale of 25 items exists and has been widely used to show that both rewards and costs can exist in the same care situation. Caregivers who attempt to balance caregiving with their other activities, such as work, family, and leisure, may find it difficult to focus on the positive aspects of caregiving and often experience more negative reactions, such as an increased sense of burden. They have difficulty maintaining work roles while assisting family members. Overall, financial concerns cause particular distress for caregivers during long treatment periods, 52 , 53 as resources become depleted. Higher-income families, with greater financial resources to purchase needed care, might not become as distressed or burdened as those with limited resources. The constant concern for managing disruptive behaviors such as turning on stoves, walking into the street, taking too many pills, yelling, screaming, or cursing also affects the caregivers negatively. Pain management is an intractable problem for caregivers that results in substantial caregiver distress, as caregivers assist with both nonpharmacologic and pharmacologic pain-management strategies.

Interventions for Caregivers as Clients The literature provides substantial evidence that caregivers are hidden patients in need of protection from physical and emotional harm. Interventions directed to the family caregiver should serve two purposes see Evidence Table. First, interventions can support the caregiver as client, directly reducing caregiver distress and the overall impact on their health and well-being. In this intervention approach, the caregiver is the recipient of the direct benefit and the patient benefits only secondarily. Second, interventions can be aimed to help make the caregiver become more competent and confident, providing safe and effective care to the patient, which can indirectly reduce caregiver distress by reducing their load or increasing their sense of certainty and control. In this section, we focus on the research evidence supporting caregivers as clients. Evidence Table Supporting Family Caregivers in Providing Care Despite the importance of information and support to help family caregivers, studies on interventions to increase support for family caregivers have lagged far behind those provided for patients. Few randomized clinical trials of educational interventions directed toward family caregivers have been conducted or published, and there is limited research to inform us about skills training for caregivers to prevent back injuries, infection, and other potential risks inherent in the caregiver situation.

Interventions To Reduce Burden and Distress Recent meta-analyses of caregiver interventions found mixed results, which are important to note. Multicomponent interventions, rather than single interventions like support groups or education, significantly reduced burden. Reasons for this are unclear. The effectiveness of caregiver interventions lasts approximately 7 months. Few studies are funded for long-term followup. Comprehensive counseling sessions for spouses caring for a person with dementia help reduce depression. An automated, interactive voice-response telephone support system for caregivers reduced burden for those caregivers with a lower sense of control over their situation. Home visits and enhanced social support also can help reduce caregiver depression.

Interventions To Improve Competence and Confidence Smeenk and colleagues 80 investigated the quality of life of family caregivers who received a home care intervention that consisted of a specialist nurse coordinator, a hour nurse telephone service with access to a home care team, a collaborative home care dossier and case file, and care protocols. The care dossier was used to assist with communication and coordination between caregivers and health professionals. From these reports, specific patient intervention approaches were developed. The intervention significantly improved caregiver quality of life at 1 week and 4 weeks after discharge from the hospital. Houts and colleagues 81 describe a prescriptive program that is based on research on problem-solving training and therapy. COPE teaches caregivers how to design and carry out plans that focus on medical and psychosocial problems that are coordinated with care plans of health professionals. Although proponents of this program assert it has positive outcomes for caregivers, a formal evaluation of COPE was not found.

Caregivers as Providers Twenty-five years of research have documented that the work of family caregiving can be stressful. That stress can adversely harm both the caregiver and the care recipient. This section addresses research aimed at protecting the care recipient from an ill-prepared or emotionally stressed family caregiver. It describes the

link between the work of caregiving and patient harm, and examines interventions that aim to make the caregiver a better worker and less likely to harm the patient. The Potential for Harm Caregivers can place their family members at risk in two ways, and both situations are preventable. First, despite their good intentions and hard work, if caregivers do not have the knowledge and skills to perform their work, they may unintentionally harm their loved one. This risk for injury is directly related to lack of knowledge and competence, which can be improved through caregiver education and support. For example, a recent study confirmed that patients had many negative outcomes when untrained informal caregivers managed their home enteral nutrition or tube feeding. A second concern is that the demanding work of caregiving can put caregivers at risk of engaging in harmful behaviors toward their care recipients, particularly among caregivers of persons with cognitive impairments. Caregivers who are at risk of depression while caring for spouses with significant cognitive or physical impairments are more likely to engage in neglect or abusive behaviors, such as screaming and yelling, threatening to abandon or use physical force, withholding food, hitting, or handling roughly. They also might not understand the standard for quality and might not provide the level of care that is needed. The risk of elder abuse The presence of dementia and cognitive behavioral problems put the care recipient at risk for abusive behaviors by the caregiver. Caregiver neglect may occur because the dementia patient is unable to communicate and the caregiver is unable to understand or know how to deal with nutritional intake and pain management. Mittelman and colleagues 88 , 89 found that counseling and support for caregivers who face disruptive behaviors from their ill family members will decrease their stress over their multiyear caregiving responsibility. A substantial number of community-dwelling elders do not recall receiving any instructions on taking their medications. Travis and colleagues 12 found that caregivers manage between one and 14 medications on a daily basis, have difficulty keeping so many prescriptions filled, and often miss doses due to their work schedules. Their responsibility to monitor for adverse or toxic effects in family members who are not capable of reporting problems themselves is important in preventing dehydration brought on by vomiting and diarrhea, and even more serious emergency situations. When caregivers themselves are distressed, burdened, or depressed, they might leave elders alone for long periods of time, ignore them, or fail to provide any companionship or interaction. The amount of care demands and time per week, impaired sense of own identity, clinical fluctuations in the patient, and nocturnal deterioration in the patient predict the caregiver breaking point. When there is family conflict, there is less assistance to the patient. Bourgeois and colleagues 94 looked at the consequences of disagreement between primary and secondary caregivers and found divergence in perceptions. There was, however, more agreement on patient behaviors and caregiver strain. Primary caregivers with pessimistic secondary caregivers were less distressed than those with optimistic ones. Given and Given 18 found that secondary caregivers left the care situation over time and only returned with increased physical care needs. Caregivers may also relinquish caregiving when they are unsuccessful in maintaining a relationship or when the care becomes difficult, such as when the care recipient loses cognitive function. Conflicts can also occur with unfulfilled or mismatched aid. Negative interactions with kin include despairing comments on caregiving, caregiver health status, and criticisms of care decisions. Interventions for Caregivers as Providers Interventions designed to help the caregiver become a more competent and confident provider are important to ensure that the patient receives safe and effective care. These interventions are aimed at: In these situations, interventions, such as role playing and rehearsal, are designed to help the caregiver better understand how to communicate with the care recipient and manage negative reactions, or remove the care recipient from a dangerous caregiving situation. A focus on the former may help prevent the latter. Caring for patients ranges from providing direct care, performing complex monitoring tasks e. Each type of involvement demands different skills and knowledge, organizational capacities e.

Chapter 3 : Working with older adults | Consumer Financial Protection Bureau

Attempts at a synthesis of themes about making a reality of 'person-centred' care. This book seeks to unite the perspectives of older people, family and professional carers in promoting a holistic.

Definitions and differences between these two terms
Family Structures: How the family structure is changing through the years
Intergenerational Relations: What the major types of intergenerational relations are and support for the elderly within the family
Introduction We will face many new issues as our society ages. Never in the history of America or the world has the population had more older adults than children. This publication discusses some issues that happen as a result of having a greater number of older adults than children. It also looks at the roles of the family and intergenerational relationships supporting our aging society. For example, how will the smaller workforce cope with providing for a larger retired community? What is the role of the family in caring for more than one generation of elders? How will modern families decide to distribute and share resources with aging parents and stepparents?
The Role of the Family Most of us live our entire lives in the context of a family. Our family provides us with the important resources we need to help us learn independence as children and remain independent as older adults. Throughout our lives we exchange help and support within the family. These exchanges can involve providing emotional and physical care, as well as financial support. The family becomes more and more important for the elderly as the need for support increases. Yet we must remember that the aging person and the family are all part of a larger society. Society impacts the resources and services available to older adults and their families. Two terms, generation and cohort, are frequently used when discussing aging. These terms help explain family and societal aspects of aging. We use the term generation to better understand the impact of aging on the family. A generation is a group of people at the same step in the line of the family. In a family, children, parents, grandparents, and great-grandparents reflect different generations. People in the same generation often have common roles, responsibilities, and expectations. We use the term cohort when we are talking about society instead of the family. A cohort defines a group of people who were born during the same time in history. People in the same cohort were born around the same time, which means they have lived through time and history together. They may share common experiences and often common beliefs. They experienced the years of the "traditional family" e. The cohort born in the early part of the 19th century shared two World Wars as well as the Great Depression. Clashes between cohorts occur when people from different cohorts fail to recognize the differences in their experiences.
Changes in the Structure of the Family In the s, families in the United States commonly had many children. Also, grandparents usually died before their grandchildren reached adulthood. This meant the family structure looked like a pyramid with a large number of children and parents and very few grandparents. In the s, however, the family model is more like a lopsided rectangle. More generations are alive at the same point in time than in past eras. Families have fewer children, but grandparents and great-grandparents are living longer. By the boomers will be grandparents and great-grandparents. This means the top of the pyramid will be quite broad, and there will be fewer parents and children. Understanding the impact of these changes is important for families and society. More members in the older generation may help families raise children. But older members may require care and support. Policy makers must consider these changes as they plan for schools and health care.
Intergenerational Relations We have all seen the ideal image of the family often portrayed by the media. On television, family members rarely argue. And, when they do, the problems are solved before the program ends. In real life, family members often disagree. Sometimes they may decide to leave the family entirely. Frequently, the disagreements are between people from different generations. Relationships between children and their parents, parents and grandparents, or children and their grandparents are called intergenerational relationships. Generations interact differently in different families. Some are emotionally close, while others are emotionally distant. Some families spend a great deal of time together, while others rarely see one another. Researchers look at three dimensions of intergenerational interactions to better understand families: Using these three dimensions we see five types of intergenerational relations in families: Families are emotionally close and have frequent contact with one another. If they live

close together, they see each other often. If they live farther apart, they remain close emotionally with frequent phone calls, emails, or letters. These families take care of one another across generations. Families are emotionally close across generations and have frequent contact with one another. They are less likely to provide care for one another. They rely on others to provide care for family members. Families see one another frequently and provide support across generations. Adult children are more likely to have a tight-knit relationship with their mothers than their fathers. Adult children are also more likely to have a detached relationship with divorced parents. Social Support Older people often rely on family members for help. They may need help with the demands of everyday life because of a chronic illness or during a crisis. Adult children may have a strong sense of responsibility and commitment toward their aging parents. Many adult children provide caregiving in spite of time, distance, or competing responsibilities. The help provided to older adults is called social support. Family members provide four basic types of social support: Housework, transportation, shopping and personal care. Confiding, comforting, reassuring, and listening to problems. Advice in seeking medical treatment, referrals to agencies, sharing family news. Help paying bills, sharing a home. We know that families provide most of the help for frail and disabled elderly who live in the community. Family members and the elderly often prefer it that way. There are two ways of understanding how older adults get help: Principle of Substitution Task-Specific Model The Principle of Substitution describes the order in which older adults choose their care providers. Married older adults prefer to receive help from their spouses. If a spouse is not available or unable to help, they turn next to their children and other relatives. Friends and neighbors help by driving, picking up groceries and medicines, and checking on the older person. Older adults turn to professionals as a last resort. The Task-Specific Model states that different tasks require the help of different people. For example, spouses and close family members provide the kind of help that requires a great deal of time and energy. They also perform personal tasks such as bathing. Friends and neighbors help with errands, provide transportation, and offer leisure activities. Professionals are called only when the tasks of social support become too time-consuming, too technical, or too difficult. If the time comes when continued professional help is needed, the family may have to consider institutionalization, such as a nursing home. That choice is only made when the people identified in the Principle of Substitution are no longer able to continue managing in-home care. Family Relationships in an Aging Society [http: Adapting the Home](http://www.ifas.ufl.edu/extension/aging_society/) [http: The Future of Aging Is Florida](http://www.ifas.ufl.edu/extension/aging_society/) [http: It was originally published in and was supported by a grant from the Associate Provost for Distance, Continuing and Executive Education, Dr. Original publication date May Revised August and November Visit the EDIS website at \[http: The Institute of Food and Agricultural Sciences IFAS is an Equal Opportunity Institution authorized to provide research, educational information and other services only to individuals and institutions that function with non-discrimination with respect to race, creed, color, religion, age, disability, sex, sexual orientation, marital status, national origin, political opinions or affiliations.\]\(http://edis.ifas.ufl.edu/\)](http://www.ifas.ufl.edu/extension/aging_society/)

older people and for the first time the NSF will set national standards which, in moving towards evidence-based care, will recognize that the views and experiences of older people and their carers are an essential part.

Licensed Clinical Psychologist More About Avrene In this article we will be looking at the changes that senior adults and their families encounter as parents transition into being "older adults". These changes will be described and recommendations made as to how to adjust to change and maintain a fulfilling lifestyle. As adults approach their senior years many aspects of life physical, social, financial, and employment are changing. For most seniors, the retirement years are anticipated positively and with an expectation of more leisure time and a lessening of demands and responsibilities. Neither seniors nor their families are adequately prepared for the stresses that also accompany aging. The goal during the senior years then is to maximize the positive and develop strategies for coping with the stresses. Look at Change Realistically As with anything in life, the discrepancy between what one expects and what actually exists can be a set up for disappointment and frustration. It is therefore important to realistically look at changes which may occur and which may be experienced as losses from life as it was. To begin with, the aging process brings physical change. Older adults may not feel or look as well as they did. There may be a general slowing down of activity level and cognitive speed. Seniors can still do the same things but it can take longer. The changes though, can impact on mobility in terms of going places, driving and pursuing activities. There are also changes in identity and roles, which accompany retirement. Our jobs typically define much of our identity. Retirement from a job can create a gap and affect self-esteem. It is also not uncommon that seniors are faced with necessary changes in their living situation. Health and safety issues may necessitate a move from a place that was home for many years. There is then a loss of the familiar, of neighbors, of possessions, of a place of worship, and so on. Transitions and losses associated with moving can echo and intensify earlier losses of friends and family through death or through their also moving away. In addition to the role change that occurs with retirement from a job, gradually, over time, there is a role change that occurs with seniors vis-a-vis their children. Children of adult seniors may begin to take over responsibilities for finances, physical well being, getting places and so forth. Neither senior parents nor their adult children find this role reversal comfortable. For seniors, giving up decision-making and choice is an affront to their self-esteem. For adult children, it may be embarrassing and arouse anxiety to see their parent as dependant and vulnerable. For adult children there is also the challenge of balancing their own lives, families, careers and social needs with that of their aging parent. If not handled well, the issue can lead to tension frustration and conflict between adult children and their aging parent. Empowering Your Senior Parent Adult children can be an enormous resource for their parents who are navigating through the retirement years. There are adjustments and decisions to be made. The goal to keep in mind is the attainment of a sense of well being, purpose and self-esteem. A primary objective, which is important throughout the life cycle, is "empowerment"- the feeling that one has the ability and opportunity to make choices and have input in ones life. This is a key aspect of older adults feeling fulfilled. With that as a guiding principle, let us look at some of the areas in which empowerment is a factor. Where You Live The primary decisions for seniors are where they will live and how they will spend their free time. For most seniors their preference is to stay in their homes, independently throughout life. Some are fortunate in this regard but for others, they may reach a point where health and safety factors indicate that independent living is no longer possible. Except in cases of acute or sudden onset of a situation, there is usually a gradual increase in signs that an alternate arrangement is needed. Families who wait too long to solve the problems may not use all possible resources and may not involve the senior parent enough. To the extent that families plan long range, explore options and work collaboratively, the transition will work better. To the extent that a rapid emergency decision is made with little choice and input from the elderly, adjustment will be affected. The result may be feelings of malcontent, loss, abandonment and being misunderstood. Any change, be it arranging for help in the home or moving to a facility, is best done with the senior parent evaluating, and expressing their feelings, preferences and comfort level. There is a "goodness of fit" between a person and a

place. All places tell you how fine they are and all the amenities they provide. In fact, facilities vary widely in their ambiance and the specific services that they offer. The person, who will be living there can best assess their comfort level in a given setting. The lack of opportunity to have input can result in the feeling of being "placed" or "put. What You Do Wherever the older adult lives they have an increase in available leisure time. By the time seniors are 60 and older, they have a good sense of what brings them pleasure. To begin with it is important that senior adults stay mentally and physically active because this has been shown to improve health and longevity. Staying socially connected is important because isolation has been associated with poor health and depression. Families are a valuable resource here. If the senior adult lives alone, transportation should be set up to get them out. Families are a resource for getting the adult parent out of assisted living and nursing facilities for the day. Seniors rally when they get out. Sometimes getting out even one-week day is an anchor and gives seniors something to look forward to. Families should encourage their loved ones in assisted living and nursing facilities to participate in outings and activities and to be out of their room. Sometimes a family member going along and participating helps the parent begin to progress. In line with this, contact with the community through a religious or volunteer activity can provide a sense of being involved in something that goes beyond oneself and fosters a connection with the world. Families can be involved in finding these resources, setting them up and initially participating to get things going. Senior citizens possess a wealth of information. They have lived a long time and learned a lot. They need to be appreciated for that fact that what they think and say has value. Family members need to listen to the concerns and ideas of their loved one. Their transition issues are real, their observations valid and not just complaints. If family members minimize, ignore or deny what their loved one says, i. How could you not like it? Some older adults have excellent ability to adjust, transition, and keep busy, while others struggle more with change. Family involvement and support is a crucial factor in enhancing and facilitating adjustment and helping parents establish a fulfilling life in the senior years.

Chapter 5 : Transition Issues for the Elderly and Their Families

Working with Older People and their Families combines extensive reviews of specialist literatures with new empirical data in an attempt at a synthesis of themes about making a reality of 'person-centred' care.

Printer-friendly version Introduction Caregiving takes many forms. Many of us help older, sick, or disabled family members and friends every day. We are glad to do this and feel rewarded by it, but if the demands are heavy, over time we can also become exhausted and stressed. We think we should be able to handle caregiving roles on top of busy work and family schedules and begin to feel guilty and depressed as our stamina wanes. About 44 million Americans provide 37 billion hours of unpaid, "informal" care each year for adult family members and friends with chronic illnesses or conditions that prevent them from handling daily activities such as bathing, managing medications or preparing meals on their own. The short answer is most of us, at some point in our lives. Caregivers are daughters, wives, husbands, sons, grandchildren, nieces, nephews, partners and friends. While some people receive care from paid caregivers, most rely on unpaid assistance from families, friends and neighbors. Caregivers manage a wide range of responsibilities. In your family, for example, are you the person who: Buys groceries, cooks, cleans house or does laundry for someone who needs special help doing these things? Helps a family member get dressed, take a shower and take medicine? Helps with transferring someone in and out of bed, helps with physical therapy, injections, feeding tubes or other medical procedures? Makes medical appointments and drives to the doctor and drugstore? Talks with the doctors, care managers and others to understand what needs to be done? Spends time at work handling a crisis or making plans to help a family member who is sick? Is the designated "on-call" family member for problems? In small doses, these jobs are manageable. But having to juggle competing caregiving demands with the demands of your own life on an ongoing basis can be quite a challenge. Caregiving roles and demands are impacted by a number of other factors, including: Long-distance caregiving is usually defined as care provided by a caregiver living more than an hour away from the care recipient. Caring from a distance is difficult both emotionally and logistically, and is most common in situations where adult children and their parents do not live in the same area. Urban versus rural settings. Caregivers living in rural settings face unique challenges. These include fewer available formal services, fewer physicians and health education services, transportation difficulties, weather problems in winter, geographic distance and isolation. In many cultures, there are family expectations about the caregiving roles of adult children; this is especially true in cultures where daughters or daughters-in-law are expected to assume the primary caregiver role for aging parents. For some people, caregiving occurs gradually over time. For others, it can happen overnight. Caregivers may be full- or part-time; live with their loved one or provide care from a distance. Caregivers provide a wide range of services, from simple help such as grocery shopping, to complex medical procedures. For the most part, friends, neighbors, and most of all, families, provide "without pay" the vast majority of healthcare in this country. Help for New Caregivers It is easy to become overwhelmed as a new caregiver. Five steps that can help are: Start with a diagnosis. Talk about finances and healthcare wishes. Having these conversations can be difficult, but completing Durable Powers of Attorney for finances and healthcare can help relieve anxiety and better prepare for the future. Consider inviting family and close friends to come together and discuss the care needed. This meeting gives caregivers a chance to say what they need, plan for care and ask others for assistance. Take advantage of community resources such as Meals on Wheels and adult day programs. These resources help relieve the workload and offer a break. Look for caregiver educational programs that will increase knowledge and confidence. The most important thing is for caregivers to not become isolated as they take on more responsibility and as social life moves into the background. Online and in-person groups can be very helpful in connecting with others in the same circumstances. Caregivers can call Family Caregiver Alliance at to learn about local services, or visit www. Data from many studies and reports reveal the following information about caregivers: In a study, caregivers were found to spend an average of 4. Family caregivers are being asked to shoulder greater burdens for longer periods of time. In addition to more complex care, conflicting demands of jobs and family, increasing economic pressure, and the physical and emotional

demands of long-term caregiving can result in major health impacts on caregivers. They are at risk for high levels of stress, frustration, anxiety, exhaustion and anger, depression, increased use of alcohol or other substances, reduced immune response, poor physical health and more chronic conditions, neglecting their own care and have higher mortality rates compared to noncaregivers. Caregivers face the loss of income of the care recipient, loss of their own income if they reduce their work hours or leave their jobs, loss of employer-based medical benefits, shrinking of savings to pay caregiving costs, and a threat to their retirement income due to fewer contributions to pensions and other retirement vehicles. The cost to businesses because of partial absenteeism e. Sixty-seven percent of family caregivers report conflicts between caregiving and employment, resulting in reduced work hours or unpaid leave. Policy changes have also supported family caregivers. Companies with 50 or more employees must comply with the Family and Medical Leave Act FMLA , which allows for up to 12 weeks of unpaid leave to care for a seriously ill parent, spouse or child, while protecting job security. Smaller firms can use the FMLA guidelines to provide support for individual employees. Paid Family Leave PFL provides workers with a maximum of six weeks of partial pay each year while taking time off from work to care for a seriously ill parent, child, spouse or registered domestic partner, and has been instituted in several states, including California. Policy changes that could also benefit family caregivers include paid sick leave that can be used by employees for themselves or to care for family members and expanding FMLA beyond immediate family members to include care for siblings, in-laws and grandparents. An attorney can help plan for the financial aspects of long-term care needs, assist with surrogate decision-making tools such as the durable power of attorney DPA and a durable power of attorney for health care DPAHC , and provide guidance in obtaining a conservatorship should the care recipient lack the capacity to make decisions. Support services include information, assistance, counseling, respite, home modifications or assistive devices, caregiver and family counseling, and support groups. Services that improve caregiver depression, anxiety and anger benefit both the caregiver and the care recipient. A federal investment in family caregiver support is needed now more than ever. A national agenda is needed that: Supports the National Family Caregiver Support Program NFCSP to provide caregivers with information and assistance, counseling, support groups, respite, caregiver training and limited supplemental services. Funds Lifespan Respite Care so that family caregivers can take a break from the demands of providing constant care Expands the Family and Medical Leave Act FMLA and paid leave policies to increase financial support for workers providing essential care for family members. Promotes financial incentives, career advancement, geriatric education and training, and long-term care policies to expand the geriatric care workforce. Enacts legislation providing refundable tax credits for family caregivers to defray long-term care costs and compensate for expenses that family and informal caregivers at all income levels incur. Strengthen Social Security by recognizing the work of family caregivers who leave the workforce to provide full-time support and care for an ill, disabled or an elderly family member. Conclusion With the dramatic aging of the population, we will be relying even more on families to provide care for their aging parents, relatives and friends for months and years at a time. Yet, the enormous pressures and risks of family caregivingâ€”burnout, compromised health, depression and depletion of financial resourcesâ€”are a reality of daily life for millions of American families and pose great strain on family caregivers, many of whom are struggling to balance work and family responsibilities. Families need information and their own support services to preserve their critical role as caregivers, but frequently they do not know where to turn for help. When they do seek assistance, many community agencies cannot provide adequate supports due to funding constraints and out-dated policies. The federal government can help by taking steps to ensure that all family caregivers have access to caregiver assistance and to practical, high quality, and affordable home and community-based services. These are tough economic times, but supporting family caregivers is one of the most cost-effective long-term care investments we can make. As long as caregivers are able to provide care, they are often able to delay costly nursing home placements and reduce reliance on programs like Medicaid. San Francisco, CA, June Family Caregiver Alliance, Caregiver Assessment: Principles, Guidelines and Strategies for Change, Volume 1. San Francisco, CA, April American Journal of Nursing, "State of the Science: Professional Partners Supporting Family Caregivers. Caregiving in the U. The Lewin Group, Making the case for ongoing care. Johns Hopkins University, Principles,

Guidelines and Strategies for Change. The plight of vulnerable caregivers. Cues for improving discussions with families prior to the transition. The Metlife study of employer costs for working caregivers. Metropolitan Life Insurance Company. Work and Eldercare, In Search of Clinical Significance. The Caregiver Health Effects Study. Effects of Adult Day Care Use.

Chapter 6 : Confidentiality and Duty of Care Issues - Strong Bonds - Building Family Connections

Working with Older People and Their Families: Key Issues in Policy and Practice Sander, Ruth They identify six 'senses' that could form a framework for providing care.

This is an open access article distributed under the Creative Commons Attribution License , which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The family has a particularly important role in respite care, which is an extension of care provided at home. However no published studies were found on this subject. The data were collected through qualitative interviews. The results lend support to earlier findings which emphasize the complexity of relationships between nurses and family carers. A novel finding here is that these relationships may also develop into friendships. Greater emphasis must be placed on primary nursing so that the nurse and informal carer can build up a genuine relationship of trust. If periods of respite care are to help older people and their families to manage independently, it is imperative that nurses have the opportunity to visit their patients at home. Introduction Supporting family carers is a globally recognized objective in elderly care [1]. Nevertheless the development of appropriate services has been a relatively slow process, and the main focus in those services is still on the needs of the care recipient [2]. Support is granted mainly on grounds of need for help and on how closely the carer is tied to care provision. Support for informal care includes both a cash benefit min. The sums earmarked for the benefit vary from one municipality to the next depending on their financial situation, which means that informal carers in different parts of the country are not in an equal position. Informal care is of great importance to the national economy. Estimates for suggest that without the contribution of carers, an extra 11, persons would have needed permanent institutional care. Nevertheless the number of carers receiving government support remains much smaller than the number of those who receive no support at all [4]. The costs of cutting public services for older people have often been borne by informal caregivers [5]. Institutional respite care services are provided via both the public and private sector. The cost of service use to the client is the same in either case, and most of the cost is borne by the state. In both cases services are governed by provincial authorities. Most smaller municipalities in the country have chosen to organize respite care as part of their regular long-term health care services, but many larger towns often have dedicated wards in connection with nursing homes. Carers argue that their frail family members need more services, more support and more guidance, rehabilitation, and training [6]. One of the most important forms of support available to caregivers is respite care. If home care is to succeed and indeed if the carer is to cope with all the demands of care, it is crucial that work is stepped up to develop the range of supportive services available [5]. However, no reliable evidence was found that respite care delays entry to residential care or adversely affects frail older people [8]. Collaboration between nursing staff and family members in the home care of older people has recently received increasing research attention, but even so this remains a comparatively under-researched area [9]. This is true particularly in the case of short-term institutional care [10]. Earlier studies have shown that caregivers greatly value the opportunity to use respite care services [10 â€” 12]. They give them the opportunity for freedom and a normal life for a change and on the other hand release them from concerns about the quality of care. When they had good cooperation with the nurse, carers could trust that their family member would receive proper care; this allowed them to take a break from their care relationship for the duration of respite care. Caregivers wanted to have a close and personal relationship with nurses [10 , 13]. Carers have been found to benefit not only from the break in care provision afforded by respite care, but the support they receive from professionals in terms of information and skills is also important to the continuity of home care [11 , 12]. Revising family caregiving through an empowerment framework has been shown to guide health professionals in promoting caregiver well-being [14]. Ward-Griffin and McKeever [9] and Jeon [15] have studied the relationship between nurses working in community care and caregivers. Both found that this relationship is a learning process in which both parties learn to work together, albeit at different levels and through different stages. Earlier research in acute hospital

settings [16 , 17] and nursing homes [18 , 19] has shown that genuine family involvement in the nursing team is far from a matter of course. The relationship between nurse and family often remains superficial, formal and rather forced [18 , 19]. One of the reasons lies in uncertainties about the allocation of powers and responsibilities [20]. A major focus for many earlier studies has been on factors that promote and hamper collaboration between the nurse and carer. One of the key requirements for close collaboration is that family members themselves take the initiative and show an interest in working closely with nurses [10 , 19]. Earlier studies have shown that the personal characteristics of both nurses and family members can both promote and hamper collaboration [25]. Hertzberg and colleagues [21] found that nurses actually try to avoid relatives who they find difficult. According to Gilmour [10] it is particularly important for nurses in short-term care to locate themselves in a secondary and supporting care giving role.

Materials and Methods

2. Aim

The study reported here is part of a research project on family nursing underway at the School of Health Sciences, University of Tampere. The aim of this study was to answer the following question: Sample The sample consists of 22 informants, registered nurses and practical nurses , four of whom were men. The informants were employed in two nursing home units specializing in institutional respite care. Furthermore, the interviewees had completed the formal qualifications of primary nurse. After graduation the nurses had worked primarily with older patients on average for Practical nurses in Finland have developed from mere auxiliary workers into health care professionals who work closely with other professionals. They hold a key position in the client-oriented care of older clients [26]. The nurses were informed about the ongoing research project both orally and in writing. Appointments were made with each of the 22 nurses and the interviews were conducted during working hours in a conference room outside the ward. The topics of the interview were formulated on the basis of earlier studies [9 , 27] Table 1. The interviews lasted from 55 to 90 minutes mean 75 min and they were all conducted by the same researcher. All the interviews were tape recorded and transcribed verbatim. The total research material ran up to pages at 1. Topics of interviews with nurses. Data collection was designed with a view to maximizing information yield, and saturation was reached after interviews with 19 nurses. However, since the final number of participants was not specified in advance [28] and all the nurses wanted to participate in the research, the interviews were continued until all of them had been interviewed. Data Analysis Data analysis consisted of conventional content analysis [29] Figure 1. First, the research material was read through by one of the researchers several times in order to gain a sense of the whole. The data were then coded verbatim in order to extract key notions. In the process of analysis the researcher made notes of her impressions, thoughts, and preliminary interpretations. A tentative coding system was created by using labels extracted directly from the text. These codes were then grouped into meaningful clusters. At this stage there were still a large number of clusters to facilitate classification. The analysis was continued by combining clusters with similar contents into subcategories, which were given appropriate labels to describe their contents. Subcategories comprising similar contents were finally combined into categories and labelled according to their contents. Example of category development in content analysis. Ethical Issues The ethical principles of qualitative research that warranted attention in this study were the autonomy and beneficence of nurses. Only very few of the nurses in the sample had previous experience of research interviews and therefore it was considered important to stress to them that participation was voluntary and that all the data collected would be handled in confidence and anonymously. All interviewees were in the employ of the same organization and they also knew one another well. To minimize any risk that the interviewees might be identified, they were interviewed alternately from both wards. Results The interviewees described their relationship with carers via four categories Figure 2. Collaborative relationship between nurse and family carer in respite care for elderly patients. Conscious Ignoring Conscious ignoring Figure 1 in the nurse-caregiver relationship was reflected in the mutual sense that there was not enough time for interaction. Family carers did not seem to have the time to get genuinely involved in matters concerning their relative. Nurses presumed that carers were simply so exhausted that the only way they could try to cope was to skate over problems as quickly as possible. Nurses, for their part, were also extremely pressed for time in their job. Sometimes up to nine new patients were being admitted at the same time, and on top of that the previous group of patients was being discharged. Especially in the case of regular clients it was felt that there was no

point wasting precious time talking to family members. The relationship was described as a matter of routine, with communication effectively confined to asking whether there was anything new or special that the nurses needed to know Figure 1. Nurses seemed to think that family members were withdrawn and reluctant to have any closer contact with the nurses. Some nurses said they positively loathed the idea of asking carers how things were at home; this was tantamount to prying into private matters. As a result they also developed no caring relationship with the family. Nurses took the view that family members lacked the courage to approach them and speak to them. Some of the nurses admitted to their own reluctance to approach family members. Nurses were apprehensive when they knew a difficult family member would be visiting the ward and preferred to keep away when they did. I mean this wife she spent hours on end here every day and every day there was something she â€¦ there was always something that was wrong. This required an active interest on the part of nursing staff as well as a keen grasp of situations because carers rarely took the initiative to approach nurses. The carer did not necessarily have to say anything about their situation at home, but the nurse would simply observe their facial expressions, gestures, and the whole way they carried themselves. Many carers were also said to have a deeply felt need to give vent to all the pent-up emotions caused by their current situation. That, however, required a close relationship of trust and confidence, which the nurses described as being on first-name terms. In this situation nurses felt they were capable of offering support to carers. Both were keen to ensure the continuity of home care as well as institutional respite care. Many carers had written instructions for nurses, who had no objection to this. Nurses recognized that the carers were competent care providers.

In the context of caring relationships, for older people, for staff, and for family carers, there are six "senses" needed: a sense of security, a sense of continuity, a sense of belonging, a

A Universal Occupation Most people will become caregivers or need one at some point in their lives. A caregiver is anyone who provides basic assistance and care for someone who is frail, disabled, or ill and needs help. But that care may be required for months or years, and may take an emotional, physical, and financial toll on caregiving families. For some people, caregiving occurs gradually over time. For others, it can happen overnight. Caregivers may be full- or part-time; live with their loved one, or provide care from a distance. For the most part, friends, neighbors, and most of all, families, provide without pay the vast majority of care. Many American families care for an adult with a cognitive brain impairment. Cognitively-impaired people have difficulty with one or more of the basic functions of their brain, such as perception, memory, concentration, and reasoning skills. Although each disorder has its own unique features, family members and caregivers often share common problems, situations, and strategies. These changes often present special challenges for families and caregivers. An ordinary conversation, for example, can be quite frustrating when your loved one has difficulty remembering from one moment to the next what has been said. Individuals with moderate to severe dementia or another cognitive impairment often require special care, including supervision sometimes 24 hours a day, specialized communication techniques, and management of difficult behavior.

Challenging Behaviors Individuals with cognitive impairment may experience a range of behavioral problems that can be frustrating for caregivers. Some people may develop behavioral problems early on, while others go their entire illness with only minor issues. Most cognitively-impaired persons fall somewhere in the middle, having good days and bad days or even good or bad moments. Anticipating that there will be ups and downs, and maintaining patience, compassion, and a sense of humor will help you cope more effectively with difficult behavior. Helpful suggestions for managing these problems include communication techniques, such as keeping language simple and asking one question at a time. Break down tasks and questions. Wandering and poor judgment may signal the need for hour supervision. If wandering or aggressive behaviors are problems, you may need to contact emergency, police, fire, or medical systems.

Ten Steps to Get You Started Whether you have moved into the role of caregiver gradually or suddenly, you may feel alone, unprepared, and overwhelmed by what is expected of you. These feelings, as well as other emotions—fear, sadness, anxiety, guilt, frustration, and even anger—are normal, and may come and go throughout your time of providing care. Although it may not seem possible, along with challenges will come the unanticipated gifts of caregiving—forgiveness, compassion, courage—that can weave hardship into hope and healing. Each caregiving family faces unique circumstances, but some general strategies can help you navigate the path ahead. As a traveler in new terrain, it is wise to educate yourself as best you can about the landscape and develop a plan accordingly, with the flexibility to accommodate changes along the way. Below are ten steps to help you set your course. Establishing a baseline of information lays the groundwork for making current and future care decisions. Talk with your loved one, family, and friends: How has she changed? How long has she been forgetting to take her medicine? When did she stop paying her bills? Answers to questions such as these help create a picture of what is going on and for how long. This basic information not only gives you a realistic view of the situation, but also provides an important foundation for professionals who may be called in to make a more formal assessment. Get a medical assessment and diagnosis. Many medical conditions can cause dementia-like symptoms, such as depression and medication interactions. Often these conditions can be reversed if they are caught early enough. A confirmed diagnosis is essential in accurately determining treatment options, identifying risks, and planning for the future. Take your loved one to a memory disorder clinic, if one exists in your community, to get an accurate diagnosis. Educate yourself, your loved one, and your family. Talk to doctors, health and social service professionals, and people going through similar experiences. Read books and brochures. Do research at the library and on the Internet. Learn how the disease progresses, the level of care that will be needed, and what resources may be available to help. Keep a

notebook and a file folder of information you collect that you can refer back to when needed. Knowledge will increase your confidence and may reduce the anxiety and fear that many of us feel in the face of the unknown. Care assessment tools include a variety of questionnaires and tests designed to determine the level of assistance someone needs and establishes their personal preferences for care. Each situation is different. Assessments usually consider at least the following categories: Another option is hiring, for a fee, a geriatric care manager or licensed clinical social worker. These professionals can be helpful in guiding you to the best care in your area, advise you on community resources, assist in arranging for services, and provide you and your loved one with continuity and familiarity throughout the illness. Outline a care plan. Once your loved one has received a diagnosis and completed a needs assessment, it will be easier for you, possibly with help from a professional, to formulate a care plan—a strategy to provide the best care for your loved one and yourself. To start developing a plan, first list the things you are capable of, have time for, and are willing to do. Then list those things that you would like or need help with, now or in the future. List any advantages and disadvantages that might be involved in asking these people to help. Write down ideas for overcoming the disadvantages. It is important to set a time frame for any action or activities planned. Also, it is wise to have a back-up plan should something happen to you, both for the short-term and the long-term. Most people prefer to keep their financial affairs private. This transition can be uncomfortable and difficult. Assistance from a trained professional may reduce family tension and, if desired, provide you with a professional financial assessment and advice. Try to include your loved one as much as possible in this process. Next, develop a list of financial assets and liabilities: Keep a record of when to expect money coming in and when bills are due. Like finances, legal matters can also be a delicate, but necessary, subject to discuss. These documents can authorize you or another person to make legal, financial, and health care decisions on behalf of someone else. Again, having an attorney bring up the issue and oversee any necessary paperwork can take the pressure off of you, as well as provide assurance that you are legally prepared for what lies ahead. At some point, you may need to determine eligibility for such public programs as Medicaid. Information about low-cost elder legal services may be available through the Area Agency on Aging in your community. Caregivers often learn, through trial and error, the best ways to help an impaired relative maintain routines for eating, hygiene, and other activities at home. You may need special training in the use of assistive equipment and managing difficult behavior. It is also important to follow a safety checklist: Be aware of potential dangers from: Emergency exits, locks to secure the house, and, if necessary, door alarms or an identification bracelet and a current photo in case your loved one wanders Bathroom grab bars and grips, non-skid rugs, mats, paper cups rather than glass Supervision of food consumption to ensure proper nutrition, and to monitor intake of too much or too little food Emergency phone numbers and information Medication monitoring Supervision of alcohol and drug use for fall prevention and proper nutrition Step 9. Joining a support group will connect you with other caregivers facing similar circumstances. Support group members provide one another with social and emotional support, as well as practical information and advice about local resources. Support groups also provide a safe and confidential place for caregivers to vent frustrations, share ideas, and learn new caregiving strategies. See Resources below to find a support group. Take care of yourself. Although this step appears last on this list, it is the most important step. Caregiving is stressful, particularly for those caring for someone with dementia. Caregivers are more likely than their noncaregiving peers to be at risk for depression, heart disease, high blood pressure and other chronic illnesses, even death. Caregivers of persons with dementia are at even higher risk for poor health. The following simple, basic preventative healthcare and self-care measures can improve your health and your ability to continue providing the best care for your loved one. Talk to your doctor about an exercise routine that is best for you. Eat nutritious meals and snacks. Caregivers often fall into poor eating habits—eating too much or too little, snacking on junk food, skipping meals and so on. Much of eating is habit, so make it a point each week to add a new healthy eating habit. For example, if breakfast is simply a cup of coffee, try adding just one healthy food—a piece of fresh fruit, a glass of juice, whole-grain toast. Small changes add up, and can be realistically incorporated into a daily schedule. Many caregivers suffer from chronic lack of sleep, resulting in exhaustion, fatigue, and low energy levels. Depleted physical energy in turn affects our emotional outlook, increasing negative feelings such as irritability, sadness, anger, pessimism,

and stress. Ideally, most people need six to eight hours of sleep in a 24-hour period. If you are not getting enough sleep at night, try to take catnaps during the day. If the person you care for is awake at night, make arrangements for substitute care or talk to his or her physician about sleep medication. Get regular medical check-ups. Even if you have always enjoyed good health, being a caregiver increases your risk for developing a number of health problems. Regular medical and dental check-ups are important health maintenance steps.

Chapter 8 : Supporting Family Caregivers in Providing Care - Patient Safety and Quality - NCBI Bookshelf

family therapists need to confront both their own internalised ageism and ageist practice within services We urge colleagues to offer supervision, to integrate work with older.

Resources Confidentiality and Duty of Care Issues As a youth worker, you will be aware of your legal duty to keep information confidential, unless you have consent to disclose it, or there is a risk of harm to a young person or others. You are likely to have organisational practice standards, which require you to talk to a young person about confidentiality and the limits to this at the beginning of your therapeutic relationship. Assisting young people to build connections with family or others, within the limits of your role, is therefore an important priority. Family-aware practice, however, raises several challenges and dilemmas for youth workers for whom the primary client and focus is the young person. There is a common concern among youth workers that having contact with family may jeopardise the trust and rapport of clients, or go against their developmental need to individuate and develop independence. There is also a common concern that having contact with family will jeopardise confidentiality requirements. Usually workers are more concerned about asking to speak to family than young people are about being asked. This sheet aims to provide practical tips for workers with young people to maintain confidentiality requirements while assisting a young person to build connections with family or other significant support people. Take the time to develop a Confidentiality Agreement with a young person, including: Laws Professional Codes of Ethics back up laws and provide guidance to practitioners regarding practice issues and dilemmas. This body has developed model policies for youth workers in non-residential settings, which are available on website: These policies are used as the basis for the ideas in this sheet, in the absence of equivalent policies for Victoria. Therefore, we encourage you to utilise legal services prior to adopting any controversial ideas within programs or services. Consent to Disclose Personal Information Privacy laws in relation to casework require that client information needs to be kept confidential, unless consent is given to disclose information to another person. Consent needs to be: Capacity can be assumed unless there is some evidence that it is impaired. In such cases capacity can be achieved with support, such as using simple language in the case of people with an intellectual disability and a support person, or using an interpreter in the case of people with English as a second language. People can make bad decisions while still having mental capacity. In a case of a young person being intoxicated, there are no clear guidelines about whether they are able to give consent, and therefore as in all cases, use your own professional judgement and organisational policies. Consent may be verbal or written. Written may minimise confusion. If verbal, make a note in the file. Consent may be implied, for example: This means to take reasonable care to predict any harm that may be caused by your actions or inactions. It also means if there is imminent serious risk to the life or health of a young person or another person, and you can do something to reduce it, you should do it. In order to reduce this risk, you may need to disclose personal information to someone else. Always consult with management staff in your organisation first, when making decisions about disclosing personal information without consent. Refer to organisational policies and discuss with supervisors your own professional judgement. In situations where you need to disclose personal information about the young person to another person in the interests of their safety, it is good practice to be transparent about this with the young person if possible, and involve and inform them about the process. This maintains trust and reduces fears. There are situations, however, when safety issues, such as a young person being psychotic, require a different response 4. Gaining consent to speak to family members Family-aware practice ideally involves family or significant others in assessment and at other times during your involvement with a young person, for example, to receive or share important information. Given this, it is important to talk to young people from the outset about the benefits and importance of involving family or significant others, while reassuring them about confidentiality in relation to any contact you may have with family members or significant others. It is also important to explore with them what information you may seek from family members, or you would like to share with family members, in the interests of the young person. It is important to establish an agreement with them from the outset, about what they are comfortable for you to share, and

with whom. This will change at times, however, and it will be important to revisit this as needed. If your client does not want you to speak to any family members, this is their clear right and this should be respected. Your relationship and work with the young person is a priority. You may still find opportunities to utilise family-aware practice, by working with the young person on family background issues or family dynamics, as well as by modelling and helping them gain relationship skills. This may in time lead to a willingness to more openly communicate with family.

Confidentiality Agreement It is important to put your confidentiality agreement with a young person in writing. Include any restrictions the young person has about contacting them and restrictions on information you are allowed to disclose to family members, emergency contacts, other professionals etc. Provide a written statement about any limitations on confidentiality from your perspective - the circumstances upon which you are obliged to disclose information even without their consent eg: Both young person and worker can sign and date the agreement. For an example of an agreement, go to: When gathering information from family members about the young person as part of the assessment process, it may be appropriate to let the family members know that the young person has a right to access their file. The family members should be asked to let you know if there is anything they have told you that the young person is not aware of or that may affect them adversely if they knew. How do you feel about that? Would you be able to tell them what you have told me? To help avoid dilemmas, it may be useful to ask the young person how you should handle contact from members of their family. Are you happy for me to hear what your family may say? Is it ok for me to discuss your problems with your family? Are you happy for me to provide them with general information and refer them to other services which may help them? Are you happy for me to mention things to them which I think may be helpful for them to know, for example? Would you prefer to be present if I was to speak to them? Other benefits for young people Apart from the benefits of helping young people in their relationships with family, working with young people around confidentiality and consent issues may produce other benefits for young people. Working with the young person to decide what issues they would like to be discussed with family members can assist the young person to practice setting appropriate personal boundaries, develop negotiation and conflict resolution skills. As a worker you play an important role in empowering the young person to set these personal boundaries and make informed choices. Too often young people with complex needs are inclined to disclose personal information about themselves to anyone who asks! They are so used to professionals and others intervening in their lives. Teaching them to communicate carefully and appropriately is important. Service providers can unwittingly reinforce a sense of self-blame and guilt, which is unlikely to assist entrenched dynamics or increase a sense of hope for anyone. Even where consent is not received from the young person for you to share or to receive specific personal information from family, families should be treated with the utmost respect and care. They should, at the very least, be given general information and assisted to find suitable support for themselves. Policy and Practice Research Unit.

Chapter 9 : Working with Older People and Their Families - Google Books

People in later life have a wealth of experiences that includes an increasing possibility of losses. These may be construed as positive, negative, or with a mixture of significance. Older people who have 'come to grief' may seek help from professionals. Ageist attitudes can impede referral for.

Share via Email Due to an ageing population, there are now whole generations within the bracket of "older people". It underlines the pace at which demographics are changing. There are now whole generations within the population traditionally referred to as older people, so their needs and aspirations are as wide-ranging as those of any other social group. A socially isolated year-old with multiple health problems will require more support than an active nonagenarian with strong social and family networks. This is one of the starting points for a discussion paper published today by the College of Social Work " where I am chair of the adults faculty " in a bid to define what excellent social work with older people looks like. Many older individuals can face difficult life decisions in an increasingly complex, and largely commercial, care services market. This is where social work as a distinct discipline really comes into its own: It also involves tackling head-on the discrimination or sense of being overlooked that older people often feel. As social workers we are powerful advocates with the knowledge, skills and values to really change lives. We should use this demographic challenge to build on the experience and assets of older people rather than adopt the unhelpful rhetoric that so often frames the debate. The current crisis within the NHS is largely viewed through a healthcare lens, describing older people as bed blockers; but can also be seen as an opportunity to consider the potential to join up services. Social workers can help individuals, families and communities build on their strengths, and unlock their potential, for example, by supporting older people to begin volunteering, thus ensuring that other care users are not isolated. When decisions about complex or highrisk situations need to be made, or where families are in crisis, older people should have access to a social worker who can support them. This should not depend on whether you are eligible for publicly funded support, nor on the amount of care required. It also means other professionals and non-registered staff in social care have access to advice and input from social workers too. Excellent social work with older people requires it to be valued and visible. Practitioners would actively seek to work in this specialism. Older people and those who care about them would understand that social work is a service they could benefit from. Social workers are skilled in assessing and planning care needs from a holistic perspective; in providing professional leadership for teams working around older people and their families; and in offering calm support at times of crisis, particularly when relationships may be strained. We hope that as many people as possible share their views with us through our survey. The drivers for change are clear and, promisingly, the methods may exist too. The Care Act, which comes into force in April, could provide an opportunity for action. The duties placed on local authorities, such as promoting wellbeing for adults and carers, preventing need, providing information and strengthening safeguarding will all require the skills that social workers possess, particularly in complex situations. Longer, older age is something to be celebrated, not endured. Excellent social work with older people has the power to make a significant contribution. Why not join our social care community? Becoming a member of the Guardian Social Care Network means you get sent weekly email updates on policy and best practice in the sector, as well as exclusive offers. You can sign up " for free " online here Topics.