Northern Ireland Social Care Council

Personal Development Plan

Identified training (development) needs	Plan to address training needs	How will this help the Registrant in their job?	Achievement timescale
Capacity/consent training.	Deprivation of Liberties training	Better understanding of areas of capacity and consent within health care setting. Increased knowledge of legal framework. Ensuring practice informed by a clear framework.	December 2015
MARAC/PPANI training	Attend Trust workshops	Link in with IO duties. To gain knowledge re criteria for referral, referral tools and procedures to improve safeguarding practice.	Sept – Oct 2016
Adult Safeguarding Policy	Attend Trust workshop	Awareness of all changes to Policy. Improve quality of practice as an IO.	Nov 2016 – April 2017
Self-Directed Support Training	Attend Trust workshop	Increase knowledge base re support options to provide choice to service user and facilitate empowerment.	Nov - 2016
Carer's Assessment Training	To be arranged within a hospital social work team meeting	Increase awareness of needs of carer and improve knowledge base re Carer's Assessment process.	June – Dec 2016
Mandatory training	To go online and book onto available mandatory training	Meet mandatory training requirements as identified for hospital social work role.	2016-2017
eNisat training	Attend available training	Awareness of the changes made re method of client case recording. To enhance quality of same.	2014 and as required
Palliative Care Training	Attend available training	Enhance knowledge of impact of terminal illness on service user and family and hospice support available. Enhance skills such as counselling.	2016-2017

Mental Capacity Bill Training	Attend available training	Update re legislation relevant to work role/IO duties.	2017
Signed (Registrant)			
Signed Line Manager/Mentor (if available)			

PRTL Submission Form

Full name:

Employer name (if in employment):

Registration Number:

Summary of Work Role (maximum 500 words)
Total words: 500

I have worked in my current post as a hospital social worker for a number of years, during which time my role has been redefined many times as it adapts to the changes within acute care and the hospital setting.

I am primarily attached to an acute medical ward specialising in the treatment/management of heart and chest conditions such as chronic heart failure, chronic obstructive airways disease or lung cancer. There are also a small number of general frail elderly beds where patients are admitted with issues such as confusion, dementia and falls.

The age of the patients admitted ranges from 18 years to the very elderly and from those newly diagnosed and more independent to those at the end stage of their disease who require palliative care. However, as people are living longer, due to the advancements in modern medicine, the majority of the patients admitted are usually very elderly and it is common for them to be living with a myriad of conditions, which either relate to or are separate from their reason for admission. Relationships and support networks can break down or be affected very negatively. This obviously impacts on the length of stay in an acute medical bed as discharge plans are explored. Rock et al, (1996) states “It is not so much the acute care illness itself, but its consequences that matter.”

My role is to assess and co-ordinate discharge planning in conjunction with the ward multi-disciplinary team (MDT), patient, family and community colleagues. Discharge planning outcomes include discharge home with support services, to an intermediate care setting for rehabilitation or for ongoing assessment of confusion/delirium, or into a permanent nursing or residential placement. I also make onward referrals. The daily challenges affecting me as a hospital worker relate to the speed in which I am expected to expedite complex discharges. As a multi-disciplinary team member I need to contribute to the efficient running of the ward and hospital by aiming to meet discharge and performance targets, including providing daily updates on each case, but as a social worker I need to practice in a safe and effective way which is person-centred, respectful and compassionate and where my social work values are not

compromised.

Risk assessment and safeguarding awareness is an inherent part of my discharge planning. The cases I am referred are often highly emotive for both patient and family due to the strain the illness has created and the greatest challenge is to promote the autonomy and protect the rights of the service user while acting in their best interests, e.g. if a patient wants to return home when a spouse has said they can no longer cope, how can this happen. Ongoing communication is at the centre of my work to ensure the needs of the patient/family have been met as best as possible.

I regularly meet with the MDT and medical students to heighten awareness of my role and discuss how we can improve what we do.

PRTL Submission

Personal Statement (page 1) (Maximum 1500 words):

This should demonstrate that you have evaluated your learning and describe how you met standards 3 and 4. Additional space is provided on pages 20 and 21.

Total words: 1542

Kolb (1984) states that "learning is the process whereby knowledge is created through the transformation of experience". Through this piece of work, I have had the opportunity to process different forms of new learning into experience using Kolb's Experiential Learning Cycle and to review my own learning style.

Regarding formal learning, capacity training was of key interest to me. Most of my referrals are elderly patients, who often have other problems, apart from the presenting condition. I have been involved in numerous cases where the elderly patient has presented as confused, whether from dementia or a delirium resulting from the hospital admission. In these cases, it is most important that the patient (service user) has an advocate to ensure wishes are respected and human rights met.

The Deprivation of Liberties course was a significant source of learning to me as it focused on Human Rights awareness, incorporating capacity, consent and the deprivation of liberty. The case of AG relates this learning to my practice. AG was a 74 year old lady living with her husband and was initially admitted with 'not coping' at home. She had recently fallen and fractured her shoulder and also had a background of confusion. After her shoulder was x-rayed, she was made medically fit for discharge and stated she wanted to go home. Her family, however, felt unable to cope and had no suggestions as to how a conclusion could be reached. Her husband was exhausted from the supervision required to keep her safe, as, on occasion, she wandered.

Through my holistic social work assessment, I discovered that her confusion had been a problem for some time and I was advised by the Psychogeriatrician involved, that the cognitive impairment could be caused by medical reasons not yet investigated. As AG was 'blocking' an acute medical bed, this lengthy investigation could not take place in hospital and so discussions between the Consultant started to take place regarding capacity and AG's human rights (Articles 5 and 8) and what was in her 'best interests'. The Deprivation of Liberty Safeguards state that it is unlawful to hold someone against their will in a social care setting, unless they have been formally detained under the Mental Health Order (1986) and AG certainly did not need this form of intervention. She did, however, need a safe discharge.

The Consultant assessed AG to have capacity to make a decision regarding her future care. When I was assessing AG's capacity myself, my knowledge from the course enabled me to use skills such as utilising the method of communication that worked for AG – a more relaxed style of questioning, which still remained decision-specific, put her at her ease and encouraged communication from her. The background information I had gathered prior to assessing her capacity had been directed by my training.

AG was eventually discharged home with a POC. Through the Self-Directed Support training, I had learned about the different options available and AG's husband felt Direct Payments may work better for him. We also discussed a Carer's Assessment. The Carer's Assessment training informed my practice, by enhancing the information I could offer. This person-centred practice gave AG's husband not just choice, but also sought to empower him in a situation, that had initially seemed out of his control. I have often reflected that if the family had remained adamant that AG could not return home, I may have had to explore a temporary placement in AG's best interests.

While the training gave me a strong point of reference to work from, it also highlighted the impact of cognitive impairment on an individual and their family as well as their expectation of the professionals involved. As well as problem solving, therapeutic work is required to help families deal with the anger and frustration they feel. I think the positive relationship between myself and the Consultant and also myself and the family developed through a 'diverging' learning style. To me, this case is an example of the medical and social models working alongside each other instead of in conflict, for the benefit of the patient/service user.

With reference the area of Adult Safeguarding, I have a statutory obligation to keep up-to-date with legislation and policy changes, and as an Investigating Officer (IO) it was essential for me to attend the training on the Adult Safeguarding Policy and Procedures. Safeguarding awareness and risk management are always at the forefront of my practice, and I have been involved in the investigation of alleged financial and physical abuse while practising hospital social work. The course covered the changes made within the new policy, as directed by NIASP. Main changes centre around changes to the language, i.e. 'vulnerable/vulnerability' has been replaced by 'at risk of harm/ in need of protection' and also the safeguarding pathway, where the VA1 which I would have previously completed is now the AP1. There is now also an expectation for the IO to make a risk determination and my responsibilities are more specific.

I was able to apply this learning to my practice in the case of RL, a 65 year old lady suffering from heart problems, who made allegations that her daughter was financially abusing her. The Safeguarding Pathway provided the framework for my intervention and risk assessment. Through liaison with the community, I determined that the allegation was an ongoing one with PSNI involvement. Ultimately I did not need to make a referral to the Safeguarding Team, but I felt the course had equipped me with the skills to work through the process competently. I carried out a risk assessment to determine if RL would be able to return home, given her concerns re her safety and in addition, her poor health. A needs-led support plan was put in place for discharge in conjunction with RL and the family members she felt able to trust and she

was discharged to the care of family.

The Multi Agency Risk Assessment Conference (MARAC) training added further to my knowledge base regarding adult safeguarding by providing information on the DASH assessment tool – the means by which a victim of abuse is identified. The Public Protection Arrangements Northern Ireland (PPANI) training provided information on the criteria for entry into PPANI and for persons subject to PPANI. From my experience, physical/mental illness puts a great strain on relationships and for health care professionals working in this emotive area, it is essential to be vigilant for any form of abuse while also having knowledge of the pathways and policies which direct action.

There is no doubt that work-based learning in the form of direct supervision and in the support and discussion inherent in team meetings contributes to my ongoing learning. It affords me the opportunity to gain a fresh perspective on difficult cases and reflect on my experiences in practice with different service users. We often would 'do it differently' if we could do it again, but there is little chance to reflect on this without taking 'time out' in the supportive and safe environment provided by supervision and team meetings. In addition, we as hospital social workers, are able to discuss operational and Board issues which affect our practice such as meeting discharge targets and how we can balance accountability and autonomy. Team meetings also provided learning in the form of identifying mandatory training and new developments/tools being utilised within the hospital, e.g. Adult Social Care Outcomes Toolkit (ASCOT). This aims to assess the patient/service user experience over a 6 month period, commencing in hospital and for community review.

Through supervision, I am able to discuss and draw up a plan of identified training needs through the Knowledge and Skills Framework, which is reviewed annually to meet Governance requirements. It is also an opportunity for reflection on my personal as well as professional self.

The mandatory training on e.g. Data Protection and Confidentiality of Service User Information, reinforced for me the importance of treating all sensitive information with the respect and professionalism it warrants.

Self-directed learning relating to hospital social work research gave me the opportunity to relate research to practice. Auerbach et al (2007), in 'Evidence that Supports the Value of Social Work in Hospitals' talk of the ethical dilemmas when there are role conflicts between 'hospital representative' vs 'patient advocate'. They demonstrated that social workers in acute care settings often are referred the most complex cases involving an array of complex factors beyond the scope of diagnosis alone, resulting in increasing amounts of time being spent trying to resolve disagreements with families over discharge planning, such as in the case of AG.

The research has made me consider how much my role as a hospital social worker has been redefined over time and has reminded me that despite the pressures within the hospital environment, I am committed to upholding good practice and putting the needs of the service user and their families first. I regularly meet with medical students to discuss and promote the hospital social work role.

Moving forward, I plan to review my training needs as identified in my PDP, with particular reference to Palliative Care training and ongoing mental health training, including the Mental Capacity Bill (NI). I am also considering ASW training.

Please note that with reference the two case studies, the initials 'AG' and 'RL' were picked randomly for the purposes of service user anonymity.

PRTL Submission
Summary of PRTL Activities

Date	Duration (hours)	Brief description of activity
15.7.14	7	eNisat training – training on the electronic system used for service user records and recording assessments.
17.2.15	7	Cruse Bereavement Care – Community Bereavement Awareness Workshop. Examined the stages of grief and advised re support services available.
10.12.15	7	Deprivation of Liberties training – examined the legal rules governing assessment of capacity and consent and the process which must be followed when a 'best interests' decision has to be made.
9.5.16 – 12.8.16	5	eNisat Version 4 Awareness Session – updated re changes made. eNisat training – to clarify processes and practice using.
1.7.16	3	Data Protection Awareness Training – promoting safe and effective use of personal information.
5.7.16	1	Meeting with medical students – to provide awareness of hospital social work role and promote same.
12.8.16	3 hrs x 2	Self-directed learning – 'Evidence that Supports the Value of Social Work in Hospitals' (Auerbach, Mason and LaPorte, 2007) and 'Key Factors Impeding Discharge Planning in Hospital Social Work: An Exploratory Study (McAlynn and McLaughlin, 2008) - read online research relating to the role of the hospital social worker and the pressures affecting practice.
23.9.16	7	MARAC training – to promote understanding of the MARAC process, how to complete DASH referral and understanding of the risk assessment and safety planning process.
7.10.16	7	PPANI training – follow on from MARAC. Provided information re criteria for entry into PPANI. Discussion re statutory safeguarding responsibilities.

26.10.16	2	Carer's Assessment training – discussion re importance of the carer/carer's rights. Information re the Carer's Assessment.
1.11.16	7	SDS training – information re options available to service users re managing their services to benefit service delivery/service user experience.
22.11.16 – 24.4.17	10	Adult Safeguarding Policy update – information session followed by Adult Safeguarding Policy and Procedures update. Information given re the changes in language and safeguarding pathway. Information re the completion of protection plans.
'16 - '17	5	Student placements – participation in their learning through shadowing etc.
12.1.17 – 29.3.17	7.5	Mandatory Training – Fire Safety Awareness. Complaints and Improving Service User Experience – raising professional awareness of the treatment of those in our care. Code of Practice on Protecting the Confidentiality of Service User Information – information re ensuring confidentiality in all areas of professional practice.
2014-2017	68 hours 34 sessions	Team meetings – sharing of Operational information re performance, such as hospital Discharge Policy, Safety, Quality and Experience, key performance indicators, Patient Flow reporting system and meeting discharge targets. Learning from the sharing of research and the relation to caseloads. Opportunity to discuss cases/'brainstorming' and learn from each other/different perspectives/skill sets/knowledge base. Opportunity to discuss training availability.
2014-2017	68 hours 34 sessions	Professional development through KSF – monitored and reviewed annually. The opportunity to highlight training needs and PRTL requirements in a supportive empathetic environment. Formal and ad-hoc discussion of case studies and learning obtained from the application of theory to practice. Time to reflect on practice which could have been improved on.

Total training and learning for period of registration

Hours: 217.50

Registrant Declaration
I confirm that I have undertaken the activities recorded on this form and that the details I have provided are accurate. I understand that failure to meet Post Registration Training and Learning Requirements, or the provision of false information in relation to meeting these requirements, may be considered by the Northern Ireland Social Care Council as misconduct.

Signed (Registrant):