

PROTECTING THE VULNERABLE WITHIN THE FRAMEWORK OF SELF-DETERMINATION. pdf

1: Chapter Eight: Focusing on Vulnerable Populations

Chapter 7 Protecting the Vulnerable within the Framework of Self-Determination Introduction. A concept of internal self-determination which is informed by the colonial experiences of indigenous peoples and remains focused on achieving the overriding goal of liberating Aboriginal lands and communities from the alien governments that surround them, can do much to meet the core concerns of.

Individuals may be vulnerable to health care quality problems for one or a combination of underlying reasons, including those pertaining to their financial circumstances or place of residence; health, age, or functional or developmental status; or ability to communicate effectively. Other personal characteristics, such as race, ethnicity, and sex also have been shown to be associated with differential experiences in obtaining quality health care. Furthermore, characteristics of the evolving health system -- such as an eroding safety net -- can interact with personal characteristics to contribute to vulnerability. There is a clear need to increase the level of attention paid to vulnerable groups, including both those who, because of their chronic illness or disability, have many interactions with the health system, and those who have difficulty accessing the system and may be most likely to fall through the cracks during this period of rapid health system change. In the Consumer Bill of Rights and Responsibilities, the Commission articulated that consumers have the right to considerate, respectful care, free of discrimination. In this chapter, the Commission extends this work by specifically addressing ways in which the particular needs of vulnerable populations should be accounted for in the design of systems for health care delivery, quality measurement, and payment. The lack of evidence of effective approaches to enhance the health and functional status of persons with chronic illness or disabilities suggests the need for significant additional investment in research and innovation for health care and rehabilitation programs serving these patients. In addition, telemedicine and similar innovations, incentives for health care professionals to practice in underserved areas, and enhanced availability of prehospital emergency services should be assessed as approaches for improving the access to care of those facing geographic barriers to appropriate care. Development and evaluation of health care quality measures and measurement methods for vulnerable populations should be supported. A focus on vulnerable populations in the design of quality measurement initiatives is valuable, in part, because their experiences may provide new insight on systemwide problems. Attention to vulnerable populations should be integrated within general quality measurement strategies, recognizing that quality measures and measurement methods tailored to vulnerable groups will, in some cases, be required. Payments to health plans and providers should promote quality health care and improved health and functional status for all patients, including vulnerable populations. Adjusting payments for differences in health or functional status is especially important for Medicare, Medicaid, and other payers that have significant enrollment of individuals with chronic illness or disability so that health plans and providers have an incentive for developing innovative models of care that best serve these individuals. Risk-adjusted payments are also critical to sustaining the safety-net mission of certain providers that provide a disproportionate amount of care to vulnerable populations, such as community health centers, rural health clinics, and academic health centers. The Federal government should convene high-level stakeholders to determine how best to implement risk-adjusted payments for Medicare. Payment systems also can be better aligned with quality care for vulnerable populations by being broadly based across groups of providers and related health care services to encourage multidisciplinary, coordinated care; providing coverage for health care delivery approaches that have been demonstrated to improve outcomes, functional status, and satisfaction; and rewarding quality performance through financial incentives. Among others, these groups include the uninsured, the poor, the elderly, children, those living with mental or physical disabilities, racial and ethnic minorities, and the terminally ill. The vulnerability that these groups experience usually can be attributed to one or some combination of three factors: Not all sources of vulnerability can be fully explained by these factors, however, raising important questions for further research. Economic Status and Geographic Location

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Individuals may be vulnerable by virtue of their financial circumstances or geographic location. These factors can present obstacles to obtaining needed health care and can result in increased exposure to health risks. These barriers to access can lead to a lack of continuity, delays in obtaining care, and limited choices about where and from whom care may be received Newacheck et al. These patterns of utilization can contribute to adverse health care outcomes, including higher rates of preventable hospitalizations Billings et al. Poverty and lack of insurance can result not only in decreased access to health care, but also increased risk of poor health. Any of these factors can magnify exposure to environmental risks such as secondary tobacco smoke, poor sanitation, or lead exposure , safety risks such as traffic hazards and family violence , social and psychological stressors such as fear of crime , and lack of infrastructure supports such as counseling or educational services that contribute to an increased burden of poor health. For example, a recent study of Medicare enrollees in managed care plans found that nonelderly individuals with disabilities, the frail elderly, the functionally impaired, and persons in fair or poor health were much more likely than the general beneficiary population to report problems with access to care Nelson et al. Many of these same groups also have been shown to be vulnerable to access problems in fee-for-service Medicare PPRC, These vulnerable groups may be especially prone to difficulties in using the health care system, including discontinuity and lack of coordination among multiple providers, inability to obtain care from providers who have expertise in treating their conditions, and difficulty in receiving approvals for treatments that are expensive or not widely used. In addition, individuals with some conditions, such as mental illness or HIV disease, may face or fear undue stigma that makes it difficult to receive appropriate care. Developmental status and age can also be associated with vulnerability. Children have health and developmental needs that are markedly different from adults, and require age-appropriate care. Developmental changes, dependency on others, and different patterns of illness and injury require that attention be paid to the unique needs of children in the health system IOM, The elderly also have unique health care needs due not only to the increased incidence of illness and disability, but also to the multiple and complex interactions of other types of physical and social consequences of aging. Communication Barriers Vulnerability can in some cases be attributed to limitations in the ability to communicate with providers and other actors in the health care system. Persons who have difficulty communicating may experience problems in expressing treatment preferences, providing informed consent, obtaining services that are consistent with their cultural norms, finding providers who are sensitive to their particular concerns, getting problems resolved, and understanding or complying with treatment options. Unexplained Vulnerability Associated with Race, Ethnicity, Sex While categorizing sources of vulnerability in this manner is helpful in a number of respects, the above conceptual framework does not fully encompass the full range of vulnerable population groups. Other characteristics also have been shown to be associated with differential health care and inferior health status. Significant differences in treatment have been documented by race, ethnicity, and sex that are not explained by other demographic differences, insurance status, clinical factors, or provider characteristics. For instance, African Americans with colorectal cancer have been found to be treated less aggressively than their white counterparts Ball and Elixhauser, A number of studies have consistently demonstrated that African Americans are about half as likely as whites to receive interventional therapy for coronary artery disease Ford and Cooper, Differences between Latinos and nonhispanic whites in the use of invasive cardiac procedures also have been documented Carlisle et al. These studies are just a sample of the large and growing health services research literature documenting the vulnerability of these groups. Differences across racial and ethnic groups exist not only in treatment patterns, but also in indicators of health status. The underlying reasons for these demonstrated differences are not well understood. Whether these findings can be attributed to discrimination, cultural factors, or other causes is an important area for further study because of the implications for eliminating unwarranted variation in the provision of health services and for improving the health status of all Americans. In particular, populations vulnerable to health care quality problems need to be accounted for in the design of effective systems for health care delivery, the choice of appropriate health care quality measures, and the adaptation of payment mechanisms. Innovative

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models of health care delivery have emerged that attempt to better incorporate these elements of care, but continued research and development of more effective and efficient approaches for meeting the health care needs of patients with chronic conditions, disabilities and other sources of vulnerability remain important. While continued innovation in this area is important, it also must be accompanied by evaluation to determine effectiveness. To date, there is a lack of evidence supporting improved functional status or other clinical outcomes resulting from many health care delivery approaches for individuals with chronic illness or disability. Some elements of health care delivery that are particularly relevant to patients with chronic conditions include the use of multidisciplinary teams, continuity of care, patient and family empowerment, case management, and outreach or home-based care. A review of more than 50 published studies assessing whether innovative health care programs emphasizing these elements improved outcomes for individuals with chronic illness or disability ¹ found that improved clinical and functional outcomes were not consistently demonstrated. The review did find evidence that in general these approaches improved patient satisfaction with their care, but other improved outcomes were limited to specific models of health care within particular populations of patients. Specific areas where evidence demonstrated that innovative health programs improved outcomes are summarized below: Hospice care created increased patient and caregiver satisfaction at costs lower than or similar to conventional care; Programs providing aggressive community-based care to certain patients with mental illness were preferred by patients and resulted in reduced severity of symptoms and a more rapid and larger improvement in functioning; ² Community-based care for the frail elderly resulted in improved satisfaction; Patient empowerment among the frail elderly and adults with disabilities increased patient satisfaction and knowledge about their care; Multidisciplinary teams resulted in lower rates of homelessness for the mentally ill and decreased morbidity for patients with diabetes or congestive heart failure in some studies, but the beneficial effects were generally limited to the duration of the intervention. The lack of consistent evidence for improved clinical outcomes highlights the need for significant investment in research and innovation of health care delivery models addressing the needs of individuals with chronic conditions and other vulnerable populations. Evidence of enhanced patient satisfaction from models of health care delivery that emphasize continuity of care, multidisciplinary approaches, patient empowerment, and outreach to community settings should guide the development of innovative approaches to care that also aim to improve functional status and clinical outcomes. As evidence is developed to demonstrate effective models of care, health care providers should commit to practicing evidence-based care. Appropriate approaches to caring for individuals with chronic conditions, however, should recognize the unique needs of individual patients. For example, while innovative approaches to caring for individuals with mental illness e. Several health plans have designed innovative programs intended to provide better care for individuals with chronic conditions, and further demonstration and evaluation of such programs should be encouraged. Examples of these unique programs include: Harvard Pilgrim Health Care implemented a case management program to provide HIV- infected enrollees with more specialized care focusing on early intervention, education, and use of home care services. Oxford Health Plans has designed care management programs for individuals with serious heart conditions and asthma sufferers that combine health care treatment with lifestyle education and training programs. Health Partners in Minnesota has developed a program for chronically ill children to improve coordination of services, develop flexible benefit packages appropriate for children, expand case management services, and link families with social support services AAHP, Other populations beyond individuals with chronic conditions also face vulnerabilities that should be addressed in designing health care delivery systems. The availability of culturally-sensitive health care professionals and systems is particularly important for patients with communication barriers as well as for racial and ethnic minorities as further discussed in Chapter Telemedicine technologies, public programs that provide incentives for health care professionals to practice in underserved rural areas, and the availability of prehospital emergency services are delivery system characteristics that have the potential to improve health care delivery for patients whose location poses a barrier to accessing quality care. In addition, certain types of providers, including academic

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health centers and community health centers, have played an especially important role in delivering comprehensive, high quality care to vulnerable populations who otherwise could be underserved. Finally, establishing national aims for improvement, while not targeted specifically to vulnerable populations, is intended to stimulate efforts to improve the quality of health care delivery see Chapter 3. The setting of aims, while national in focus, should be sufficiently robust to reflect the needs of specific vulnerable populations and localities. This can be achieved through establishing specific objectives within the broader aims that reflect the unique needs of vulnerable populations, and ensuring that the tracking of national aims can support efforts to identify particular areas of concern to local areas and vulnerable populations. Quality Measurement Vulnerable populations require special attention in the design of health care quality measurement strategies for three distinct reasons. First, a focus on the quality of care experienced by vulnerable populations could provide new insight into health system problems or identification of problems that otherwise could go undetected. Second, some vulnerable groups are more likely to fall through the cracks. The same factors that contribute to their vulnerability can also affect their ability to safeguard their own needs and interests adequately. Third, for a variety of technical and other reasons, health care quality problems experienced by vulnerable populations are not well captured by measurement efforts designed for the general population. For the most part, these efforts do not utilize data collected over time or across multiple different settings for health care delivery. Finally, because individuals with chronic illness and disability consume a disproportionate share of health care resources relative to their share of the population, measuring the quality of their experiences with the health care system will lead to a focus on high-cost areas. Health care quality measurement for vulnerable populations either could be undertaken separately or be included in general strategies for evaluating quality. The combination of general and targeted strategies is most likely to identify efficiently and effectively the highest priority quality problems for vulnerable populations. In some cases, it may be less expensive to oversample one group in the population to explore whether the subgroup is experiencing more or different quality problems. In other cases, the use of specially tailored measures may be more effective. Including vulnerable populations in general strategies for quality measurement is likely to be more sustainable over the long run and sends the important signal that evaluating quality for vulnerable populations is equally, if not more, important. This strategy allows comparisons between vulnerable and general populations when the same measures are used. Such approaches may be more efficient if special sampling procedures can augment a generally applied measure so that evaluating problems for vulnerable populations can be done simultaneously. There are a few reasons, however, why targeted approaches might be necessary. For persons vulnerable due to economic circumstances, the key to including them in monitoring systems is the availability of variables to identify such persons and methods for bringing data on their patterns of utilization into integrated data systems e. For persons vulnerable due to health status, the key to inclusion in monitoring is the expansion of appropriate criteria for evaluating their care and the development of methods that can support analyses of quality problems using small samples. For persons who are vulnerable due to communication challenges, the key to inclusion will be the development of measurement tools that can be used with such populations. Different Quality Measures Needed. In some cases, different quality measures may need to be used to assess the care provided to vulnerable populations. Certain health care problems experienced by vulnerable populations differ from those encountered by others in the health care system either by their nature or in the frequency with which such problems are encountered , and will require a different set of measures to evaluate the quality of care they receive. For example, evaluating the quality of care delivered to persons with certain rare conditions may require developing clinical measures specific to the particular condition e. In other cases, existing measures might be adapted or refined to better accommodate vulnerable populations. Medicare and Medicaid, as public programs that insure a disproportionate share of many vulnerable populations e. In efforts to develop new health care quality measures, the deficits in quality that pose the greatest risk to vulnerable populations and the types of measures most likely to identify such deficits should be taken into account. Focusing new measure development on technical process quality has a number of advantages. First,

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scientifically sound measures of technical process quality are the most sensitive dimensions for providing an early warning of potential threats to health outcomes. A good measure of technical quality is one that is linked to health outcomes-- meaning that adhering to the indicator process more often will increase the likelihood of producing better health outcomes.

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2: Protecting the Vulnerable within the Framework of Self-Determination |

Part IV Broadening Horizons: Indigenous Peoples, Self-Determination and Protecting Children's' Rights under International Law: Indigenous peoples, self-determination and self-government in international law; Protecting the vulnerable within the framework of self-determination.

In lieu of an abstract, here is a brief excerpt of the content: Kennedy Institute of Ethics Journal Ruof "Special justification is required for inviting vulnerable individuals to serve as research subjects and, if they are selected, the means of protecting their rights and welfare must be strictly applied. The vulnerable require special justification to participate in human subject research in order to eliminate potential human rights abuses. The Nuremberg Code of was written in response to the extreme human subject abuses that occurred under the Nazi regime, and, although the intent of the Code was to protect human rights, rigid voluntary consent requirements deprived some individuals of the right to participate in clinical trials. Although various protective guidelines stipulate special protections for vulnerable populations, the concept of vulnerability and consequently the criteria designating vulnerable populations remain vague. Precisely who are the vulnerable? The word "vulnerability" stems from the Latin vulnerare, "to wound. In clinical research, the term [End Page] vulnerable generally is applied to individuals who are unable to give informed consent or who are susceptible to coercion. Although the Common Rule specifies certain vulnerable categories, the guidelines were not intended to be exclusive, leaving open the interpretation of vulnerability. In medical research and health policy, vulnerability is an abstract concept that has concrete effects both for those labeled vulnerable and for those not. Clinical researchers, healthcare workers, ethical reviewers, and policymakers must be able to identify vulnerable subjects to establish how healthcare resources will be allocated and who will qualify for special protections and socialized benefits. Attempts to quantify vulnerability in clear, measurable ways have met little if any consensus. As Alexander Morawa II, , p. In fact, there is no purposeful categorisation at all. Some of the authors cited in this Scope Note argue against the labeling and categorization of vulnerable individuals and populations. The categories of vulnerable groups listed under the Common Rule have been the source of controversy, "for example, many find the suggestion that pregnant women are vulnerable to be quite sexist" IV, DeBruin , p. Instead of creating categories of vulnerable populations, would it not be better to derive an account of just treatment from a just social policy at large that encompasses human vulnerabilities II, Brock , p. For some of the authors listed here, the concept of vulnerability is essential to bioethics. Robert Goodin I, , p. In contrast to the four American principles of biomedical ethicsâ€”autonomy, nonmaleficence, beneficence, and justiceâ€”the four principles of European bioethics and biolaw include vulnerability along with autonomy, dignity, and integrity. You are not currently authenticated. View freely available titles:

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3: Project MUSE - Climate Change Inundation, Self-Determination, and Atoll Island States

Within this context, the author identifies the limitations of reconciling the conflicting demands of self-determination and sovereignty and suggests that international law can provide more nuanced and culturally sensitive solutions.

Get Full Essay Get access to this section to get all help you need with your essay and educational issues. Protection is a vital part of safeguarding and promoting welfare, it is the process of protecting an individual who is either at risk or a risk as a result of abuse or neglect. The care group policy reflects the above statement, and the partners fully recognise that the majority of the clients in their care are considered vulnerable adults by the very nature of often-complex needs. In safeguarding a vulnerable adult you ensure all suitable procedures are in place to maximise the safety of the person and protect them from harm. It is also your responsibility to raise the alarm if you suspect or know abuse is happening. In protecting the individual all staff members before starting a new job in a care setting are subject to a checks from the Disclosure and Barring service DBS and Independent Safeguarding Authority ISA to confirm that the staff member is not barred, by checking these registers will eliminate workers who have been deemed unsuitable to work with vulnerable people, as with all things in life this is not full proof so all persons responsible for the safety of others need to be vigilant at all times. Within the home it is essential that we follow guidelines in place for safeguarding and follow new legislation when they arise. All staff would have been fully checked and the appropriate training given and they will receive any new updates so we all follow the same procedures. Staff should be aware of the homes policy which is kept in a file in the office, also the policy on whistle blowing. Agreed protocols may include: Boundaries- Areas of responsibility, Information sharing, Limits of authority, Decision making, Recording information. Policy developments not only have an impact on safeguarding policies and procedures within the home they strengthen them. I think by following the next statement on the principles of safeguarding , all vulnerable adults within our setting are being treated as an individual with the support from others. The statement reads; In practice, this means that agencies should adhere to the following guiding principles: Ensure the safety of vulnerable adult by integrating strategies, policies and services relevant to abuse within the framework of the NHS and Community Care Act , the Mental Health Act , the Public Interest Disclosure Act and the Registered Homes Act the provisions of which will be extended by the Care Standards Bill. Ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies; and ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process. The Mental Health Act provides a legal framework for acting and making decisions for people who lack the capacity to make decisions for themselves. The Mental Health Act allows action to be taken for people with mental disorders to get the care and treatment they need for their health or the protection of others. Safeguarding Vulnerable Groups Act aims to prevent unsuitable people from working either paid or unpaid with children or vulnerable adult. It does this by vetting all those who wish to do such work vulnerable groups and barring those where the information shows they pose a risk of harm. Health and Social Care Act highlighted important measures to modernise and integrate health and social care. In Panorama investigated Winterbourne view private hospital, where they exposed the physical and psychological abuse suffered by people with learning disabilities and challenging behaviour in their care. The undercover footage showed staff repeatedly assaulting and harshly restraining patients under chairs. Victims were shown screaming and shaking, and one patient was seen trying to jump out of a second floor window to escape the torment, and was then mocked by staff members. Systemic failings-The national regulator, the CQC did a nationwide check on facilities owned by the same company, Castlebeck Care as a result three more institutions have been closed. The head of the Care Quality Commission resigned ahead of a critical government report, a report in which Winterbourne View was cited. CQC have tightened inspection in all hospitals and care homes for vulnerable groups, CQC will share

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information, data and details they have about providers with the relevant Clinical commissioning groups and local authorities, from April and still ongoing provide information and data via the Joint Improvement Programme. CQC will assess whether providers are delivering care consistent with the statement of purpose made at the time of registration. The Local Government Association and NHS Commissioning Board will establish a joint improvement programme to provide leadership and support to the transformation of services locally. CQC will take enforcement action against providers who do not operate effective processes to ensure they have sufficient numbers of properly trained staff. Responsibility for safety and quality of care depends on all parts of the system working together: All staff now are subject to stringent checks before being employed. By following all new policies and procedures set in place and being trained in safeguarding abuse will hopefully stop these incidents occurring. The action to be taken if a member of staff suspects that a client is being abused in any way is to report it straight away to the manager; it is the responsibility of every member of staff to report instances of abuse and the responsibility and duty of every manager to instigate a thorough investigation. Failure to intervene may be construed as complicity in the abuse. Any concerns regarding the abusive behavior must be reported to the registered manager as a matter of urgency. If this is not immediately possible the matter must be reported to the proprietors or the group leader. If it is not appropriate to approach the above people because they are complicit in the abuse then contact the duty officer at Social Services and inform them of your concerns. It is the responsibility of the registered manager to then take all appropriate action. The manager should then not allow any evidence to be contaminated or tampered with in any way. Social services are to be informed for all safeguarding investigations, and the manager should be guided by their instructions and advice once they are involved. All written reports must be made available to the authorities, the matter must not be investigated wholly by the staff at the home. Medical attention may be necessary. Information must only be shared on a need to know basis. Remember that your report may be required as part of any legal action or disciplinary proceedings. These reports should have date, time, and the setting of the alleged abuse or the event witnessed. Make a note of anyone else who was there. Record what was said using the exact words of the person making the disclosure. Separate factual information from any opinions expressed. Date and sign your report, initial and date any corrections. CQC will be informed of the incident. Whilst we would promote the independence of the client we would also protect them as far as possible from danger or harm. By working with the client and making sure that they are fully aware of any risks involved, the risk assessment can be done and any dangers minimized. Risk assessments cover many things from showering themselves to going out on their own, they are done with the client looking at what they want and how it can be achieved, identifying any risks and how they can be avoided or reduced. One of our clients is very independent and uses public transport and goes to clubs on his own, at times the client is verbal and aggressive so when doing risk assessments these things need to be shown so to minimize the risk to himself and others. The hazards and risks are he may be unpredictable at times, he may forget his home number and telephone number, and he may become agitated, whilst out resulting with some verbal outburst. This is a low risk activity and the client has signed the risk assessment agreeing to its contents, by placing this in his care plan and all staff members knowing of the procedures in place will minimise any problems arising. By following person centred planning the client gets to pursue what they want to do, and the risk assessment helps to protect them from harm or danger. Physical abuse- signs are bruising, pressure sores or rashes from wet bedding or clothing, scratches or cuts, bruised ears. Improper use of restraints. Sexual abuse – urine infections, blood on underwear, bruises on body, refusal to undress. Institutional abuse- privacy is not respected, clients not given any choice. Self-neglect – confused, clothes are dirty and smelly, unexplained weight loss. Theft by stealing their money or possessions. Discriminatory abuse- verbal abuse, inappropriate use of language, harassment, deliberate exclusion. Working with person centred values- by getting to know the clients likes and dislikes and the way that they usually act will hopefully pick up on any risks before they happen. Encourage active participation – by involving the client in activities and relationships and encouraging them to express their needs will probably help them confide any problems they are experiencing.

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Promoting choice and rights- I would encourage them to voice their own concerns, I would tell them at times that they can say NO, they also need to know their rights. C If an alleged or suspected case of abuse arises, you should stay calm, reassure the person that they were right to report this and that you need to tell the manager, if any of the emergency services are needed call them. Record exactly what the person tells you and record the conversation, date and time this as it may be needed as evidence. The manager will call in Social Services who will tell you what they want you to do. Within the home there are policies and procedures to follow. The policies and procedures in place are; The partners of the group consider that abuse is a direct anti-thesis of care and therefore no incidence of abuse toward a client, in any form or to any degree, will be tolerated. Any abuse of clients, as defined in this policy will constitute gross mis-conduct and will be grounds for dismissal from employment. Safeguarding Vulnerable Adults training must be made available to all staff and this must be renewed after 1 year or earlier if necessary. This training can be accessed via the group manager and will be part of the training programme for the new care staff. It is the responsibility of every member of staff to report instances of abuse and the responsibility and duty of every manager to instigate a thorough investigation. People within our care setting will expect to be treated with respect in an environment free from any level of bullying. We also have a policy covering Mental Capacity, Decision making, Best interest for clients who may lack the capacity to act for themselves. All staff are only employed when a D. Policies and procedures are in place so all staff know what to do in the case of abuse or harm. A review of policies and procedures are done yearly or before if needed, and any changes handed over so all personal know. All staff are monitored through DBS checks and ISA checks before being employed, new staff are trained in safeguarding in the induction period and updated after one year, all other staff have updates every two years. Staff meetings and supervisions cover any concerns that staff may have, Staff are reminded of the policies and procedures in place and know how to raise the alarm if abuse is suspected and how to proceed, the whistle blowing act will be brought to the attention of the staff. By all staff following the policies and procedures and being told of any new changes i. Ensuring that this happens is the prime responsibility of those who provide and commission services and the main focus for those who regulate standards in care. Clarity on roles and responsibilities is especially important. The outcomes should be to: By following all of the above will set up a practice that supports the protection of vulnerable adult. In providing training and updates this will keep staff aware of what is needed if the case arises. There are many organisations that work with each other and follow certain protocols to set up a framework to protect vulnerable adults. Social services are the main coordinators that set up policies and procedures to follow, CQC monitor and provide guidance on what health and social care providers must do to safeguard others from abuse, the safeguarding policies, procedures and systems developed are in place to prevent others from being abused. The police investigate possible crimes and share information with other agencies, to support the person suffering from abuse. Doctors, specialists and nurses give the care and treatment needed when incidents have happened, and by supporting enquiries when needed, also following up with referrals and liaising with other agencies. Care managers respond to concerns from the person involved or by family or friends, if they lack Mental Capacity best interest assessors will be involved or their advocate. The service provider agrees to follow the protocols in place, vetting staff before employment, giving adequate training in safeguarding, adhere to follow up on incidents, complaints and whistleblowers. Take disciplinary action against staff that have abused or neglected people in their care. Other agencies who would be part of the organisation are clubs, support groups, voluntary organisations, these agencies would have policies in place for safeguarding also the service provider would have risk assessments in place for every client that uses these outlets. Within our setting this is done by inspections from CQC visiting the home and handing over any policies or procedures that need changing, and if there are any discrepancies they will give you a time frame to rectify the problem.

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6: Project MUSE - Vulnerability, Vulnerable Populations, and Policy

however, we approach self-determination within a social-ecological approach in which self- determination is a psychological construct that refers to self- (vs. other-) caused actionâ€”to people acting volitionally, based on their own will.

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