Developing end of life care practice:

A guide to workforce development to support social care and health workers to apply the common core principles and competences for end of life care.
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Skills for Care is the employer-led strategic body for workforce development in social care for adults in England. It is part of the sector skills council, Skills for Care and Development.

Skills for Health is the sector skills council for all health employers—both NHS and independent.

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1. Overview

This guidance has been developed to ensure that workers involved in supporting someone who is at the end of their life are properly trained to be able to undertake their work effectively and appropriately. It should be read alongside the Common core competences and principles for health and social care workers working with adults at the end of life, published in 2009 by Skills for Care, Skills for Health, the National End of Life Care Programme and the Department of Health (available on all their websites).

The principles and competences in that publication remain current, but in this guide there are some additions to the competences in order to reflect emerging understanding of the importance of issues related to spirituality (understood as widely as possible) and bereavement. The sequence of some of the 2009 material has been altered in this guide, too. These changes follow consultation with people who have been using the 2009 material.

This guide completely replaces the 2010 A framework of National Occupational Standards to support common core principles for health and social care workers working with adults at the end of life, published by the same organisations as this present guide.

Each section gives an explanation of the area of work, and includes important links to further information and resources. There is also a ‘practice scenario’ to show how the competences are connected, and how they can be used to help in developing services and in ensuring that workers are appropriately trained and skilled.

Supporting people at the end of life

The common core principles for end of life care published in 2009 are:

1. Choices and priorities of the individual are at the centre of planning and delivery.

2. Effective, straightforward, sensitive and open communication between individuals, families, friends and workers underpins all planning and activity. Communication reflects an understanding of the significance of each individual’s beliefs and needs.

3. Delivery through close multi-disciplinary and interagency working.

4. Individuals, families and friends are well informed about the range of options and resources available to them to be involved with care planning.

5. Care is delivered in a sensitive, person-centred way, taking account of circumstances, wishes and priorities of the individual, family and friends.

6. Care and support are available to anyone affected by the end of life and death of an individual.

7. Workers are supported to develop knowledge, skills and attitudes. Workers take responsibility for, and recognise the importance of, their continuing professional development.
National Occupational Standards (NOS) describe performance as the outputs from a person’s work. They focus on what the person needs to be able to do, as well as what they must know and understand to work effectively. They are designed to allow workers to be assessed against them. Health and social care NOS are relevant to many people who work within the health and social care sectors. They apply across the National Health Service, local government, and independent sector organisations both private and voluntary.

NOS describe performance (what a person does), the performance criteria (the national standard they should achieve) and the underpinning knowledge and understanding required to undertake that particular function.

To become competent, a worker needs to have developed the appropriate skills (the ability to undertake specific activities in an appropriate and professional manner, using experience and judgement to ensure high quality performance); values (the beliefs and ideals shared within a culture, about what is desirable and good); and knowledge (relevant to the area of work).

The competences described in this document should be used alongside occupation-specific competences, standards or capabilities. In many instances they will overlap, although there will be times that the end of life competences and knowledge are additional.
Core competences for effective delivery of end of life care

The Department of Health’s 2008 End of Life Care Strategy, which this document supports, sets out what adults reaching the end of their lives, and their carers*, can expect from the services provided to them. The National Institute for Clinical Excellence (NICE) draft End of Life Care Quality Standard, published for consultation in the spring of 2011 and due for final publication in the autumn of 2011, emphasises these expectations. The key points are summarised below.

1. A diagnosis that is arrived at as quickly as possible, with information about prognosis and treatment options explained sensitively, appropriately and in a jargon-free way.

2. Information that is provided as and when it is needed, in a format that is appropriate to their needs and abilities.

3. Regular assessment and care planning that includes discussion about current and future care, is person-centred, and takes account of practical, physical, psychological, spiritual, social and religious needs and preferences.

4. Support for carers and family members including children, recognising the impact of bereavement upon them.

5. Care and support delivered seamlessly, by multidisciplinary teams working together to meet identified needs.

6. Care and support that is delivered by practitioners who understand the person’s current medical condition, care plan and preferences.

7. Care and support that is delivered by workers who are competent, have the appropriate knowledge and have the right skills and attitudes needed to provide safe and effective care for people approaching the end of life.

8. Care and support that is available when it is needed, and at home if that is their preference.

9. Care and support that meets practical, physical, psychological, spiritual, social and religious needs and maximises independence and social participation for as long as is possible.

10. In the event of an unexpected crisis, prompt, safe and effective urgent care; at whatever time of day or night it is needed, appropriate to their needs and preferences.

11. Safe and timely transfers if they need to be moved, so that they receive care in the place most appropriate to their needs and preferences.

12. Specialist palliative care when it is needed, and that takes account of needs and preferences.

13. Timely identification of the last days of life, and care delivered at that time that is individualised to their needs and preferences and ensures access to, and administration of, prescribed medication.

14. Sensitive communication with carers and families who are newly bereaved, with timely verification and certification of death, information including details of any possible coroner involvement, and practical support appropriate to their needs and preferences.

15. Emotional and bereavement support appropriate to their needs and preferences, for people closely affected by a death.

* ‘Carer’ is used throughout to mean family and friends who provide care, as distinct from social care and health workers.
End of Life Care for All (e-ELCA) is an e-learning package developed to support the 2008 End of Life Care Strategy. It was developed by a partnership between the National End of Life Care programme, the Department of Health, the Association of Palliative Medicine and e-Learning for Healthcare. Four core modules for health and social care workers were launched in 2010 (advance care planning, assessment, communication skills and symptom management including comfort and wellbeing); as well as an introductory module and one on integrating learning. Following positive feedback, three more modules are now available:

- Social care related – supporting people to live and die well, palliative care social work, as assessment support and care planning, hospital social work, end of life care in homes and domiciliary care setting
- Bereavement
- Spirituality.

The integrating learning module includes condition-specific end of life care scenarios, critical situations, differing scenarios around dying (e.g. as a prisoner, as a homeless person), and care after death (‘last offices’). It also includes frameworks and tools such as DNACPR (‘Do not attempt cardio pulmonary resuscitation’), and the framework for advanced kidney disease. Curriculum workbooks to support e-learning and learning pathways covering primary care, social care and secondary care are also available.

All the NOS in the Skills for Health database are mapped against and indicatively linked to the NHS Knowledge and Skills Framework (KSF) dimensions. A worker can use evidence demonstrating competence against NOS as evidence he or she is meeting their NHS KSF profile.

The Qualifications and Credit Framework (QCF) has recently been launched to replace the former NVQ framework. Units within it can be linked to the competences, values and knowledge described here. QCF units, which are informed by national occupational standards, include some units specifically developed to support end of life care.

Social work training is currently being reviewed, and it is proposed that the NOS for social work be replaced by a ‘capabilities framework’, which can also be linked to the end of life competences.
Getting the most from the guidance

End of life care is the responsibility of a wide range of professions and occupational groups, working in a range of settings, undertaking a range of activities in co-ordinated and person-centred ways. This means that there can be no one single way to map the end of life competences against the requirements for each of these groups. Working in a truly person-centred way also means that the responsive, flexible and sensitive approaches taken by workers responding to changing needs results in the expectations placed upon workers changing over time. So an individual practitioner may need to be performing at different levels, undertaking different activities at different times.

This document has been produced to help guide people in thinking about the competences needed at the different points of the individual’s journey. It is intended not just for front line workers, but also for those people engaged in commissioning, developing and managing those services, including workforce development leads and trainers.

Information in this document can be used in many ways, including to:
- Support discussions as part of supervision
- Identify individual learning needs
- Shape training provision
- Influence workforce development plans
- Inform service development
- Shape job descriptions
- Influence commissioning
- Influence policy discussions
- Enable individuals and their carers to increase their understanding of what services and support they can expect.

The next sections outline some of the ways people undertaking specific tasks might find this guidance helpful. For many people, their jobs will incorporate several of these areas.

Commissioning

People commissioning services should ensure that workers delivering the care they have commissioned have appropriate training and support, and can demonstrate the necessary competences.

This can be achieved by developing a commissioning strategy that includes purchasing services with:
- Flexibility and choice, enabling individuals and their carers to be properly cared for and supported as their situations change
- Appropriate underpinning workforce development and training programmes to ensure that all workers have the required skills, values and knowledge to deliver personalised and sensitive end of life care services
- Workforce training and development programmes that incorporate the perspectives of people who use services and of carers, and that promote collaboration across agencies.
Sustained leadership and drive are needed both nationally and locally to ensure that appropriate actions are taken to support workforce and service development in end of life care. Part of the function of leadership and management is to ensure that the services provided achieve the standards set by the end of life principles and competences.

This guidance can be used to consider how to plan and deliver services, and the training and support provided to employees. This includes ensuring that systems are in place to identify and provide for the support needs of those working with people at the end of their lives.

The end of life care competences can be used to ensure services are consistent with what individuals and carers say they want, delivering personalised and flexible support. They can help in achieving better quality care, and contribute to meeting the Care Quality Commission (CQC) performance indicators and support employers in commissioning and delivering training.

The guidance can be used to:

- Provide benchmarks for best practice and service improvement, embedding the principles in corporate policies and governance frameworks
- Monitor and improve services, taking into account the views and experiences of the people who use end of life care services
- Work with independent and voluntary sector partners, as well as people who use services and carers, to develop a local workforce development strategy with a focus on raising knowledge and skill levels and providing career development opportunities
- Foster a common approach to end of life care across teams and organisations
- Provide a framework for workforce development, embedding the competences in performance management, and support new ways of working
- Ensure workers have the skills and support they need to work to the competences and principles.
- Design job roles, tasks and job descriptions.
- Commission learning that enables workers to deliver high quality end of life care.

Line managers have a particular responsibility to ensure that each worker for whom they are responsible is properly equipped and supported to deliver high quality end of life care. This guidance can be used to help:

- Identify learning and support needs related to working with a specific individual
- Discuss and agree personal development plans
- Link identified end of life care learning needs to the worker’s own occupational standards and training requirements
- Contribute to organisational discussions about workforce planning for end of life care.
Direct health and social care service delivery

Workers in health and social care, across both the public and independent sectors, all need training and support to ensure they are able to communicate and work effectively with people who are dying and with their carers. This guidance can help to increase job satisfaction by helping both paid and volunteer workers to meet individuals’ and carers’ needs and expectations.

The guidance can be used to:

- Identify skills gaps and support needs and ensure that these are met through personal and team development plans
- Discuss the skills and knowledge needed with supervisors and/or line managers to ensure shared understanding of the implications for the worker’s job role and working practice
- Challenge practice which is not consistent with the principles and the underpinning competences, values and knowledge.

Educators, trainers, workforce development managers

The end of life core competences should be an integral part of all education, training and support for those working in, or aspiring to work in, health or social care in settings or circumstances where they may be dealing with people at the end of their life. Education and training providers should consider reviewing training in relation to end of life care.

End of life care competences, values and knowledge underpinning the principles can:

- Help shape units of learning to be included in the Qualifications and Credit Framework.
- Design in-service training and assessment programmes.
- Develop undergraduate and postgraduate training and assessment programmes.
- Provide shared and agreed benchmarks of best practice.
- Address what people who use end of life services say they want from health and social care providers.
- Reflect what employers want their workforces to be able to do.
- Provide a framework to assess end of life care skills and competences.
- Support the commissioning of education and training to address workforce development needs.
Useful resources

www.dh.gov.uk

For a range of relevant documents including:

- Common core competences and principles for health and social care workers working with adults at the end of life (July 2009) This is also on the sites of the publishers of this present guide.
- End of Life Care Strategy (July 2008)
- The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process (October 2004).
- End of Life Care Strategy Quality Markers and measures for end of life care (June 2009)

www.e-lfh.org.uk/projects/e-elca

This site contains all of the e-learning sessions that have been developed to support the End of Life Care strategy, and is freely available. It is intended to be of use to all practitioners concerned with end of life care.

www.endoflifecareforall.org.uk

This site contains a subsection of the e-learning sessions developed for end of life care in e-ELCA. There are 12 basic sessions which are available on an open access basis.

www.education.gov.uk

Hosts the draft recommendations of the Social Work Reform Board, including Building a safe and confident future: One year on. Overarching professional standards for social workers in England (December 2010).

www.healthcareworkforce.nhs.uk

This site provides a range of tools for those working in the health care sector, including a Six Step Methodology to Integrated Workforce Planning and a Guide to Workforce Planning for Service Commissioners.

www.nice.org.uk

The National Institute for Health and Clinical Excellence has just completed a consultation on the draft quality standard for ‘End of Life Care for Adults’. The final standard should be available from autumn 2011.

More resources on the next page
Useful resources, continued

www.endoflifecareforadults.nhs.uk

This site includes a wide range of resources, some of which are also available on other sites included here. Guidance linked to specific competence areas is listed at the end of the relevant chapters.

- National End of Life Care Programme – Information for commissioning end of life care
- The route to success in end of life care – achieving quality for people with learning disabilities
- Care towards the end of life for people with dementia: an online resource guide

The National End of Life Care programme has also launched a series of publications under the ‘Route to Success’ banner, looking at end of life care in specific service areas:

- Hostels & homelessness  www.endoflifecareforadults.nhs.uk/publications/rts-hostels

www.skillsforcare.org.uk

This is the skills sector council for people working in social care. Its site includes the following useful documents.

End of Life Care Knowledge Set (revised 2010)

End of Life Care Learning and Development Pathway (2009)  This includes mapping against health and social care NVQs and NOS, as well as suggesting performance levels for particular roles.

Is it that time already?  (2009) Video produced with Housing 21 to accompany their EOL guide for workers in extra care housing schemes
www.skillsforcare.org.uk/qualifications_and_training/qualificationsandcreditframeworkQCF/what_is_changing.aspx

For details of the four QCF units developed to support end of life care.
www.skillsforcare.org.uk/qualifications_and_training/qualificationsandcreditframeworkQCF/supporting_materials.aspx

Two scenarios illustrating how QCF units can contribute to development of EoL workers (level 2 in residential care and level 3 in domiciliary).

The workforce strategy section of this site includes material on ‘workforce redesign’ about the workforce dimensions of service transformation.

www.skillsforhealth.org.uk

This is the skills sector council for people working in health care. The site includes full versions of the healthcare NOS.
An end of life care practice scenario: Using the framework at Cedar Lodge

Alec is an 87 year-old widower living at Cedar Lodge, a residential care home. He has lived in the home for the past two years, and during that time has had the same key worker, Amana. In total there are ten care workers and four domestic workers in the unit Alec lives in, plus additional agency workers.

Alec’s three children are all regular visitors to the home.

He has recently been diagnosed with renal failure, and his life expectancy is only a couple of months without dialysis. In the past Alec has made it clear that when his “time comes” he wants to be able to stay at Cedar Lodge, and “go quietly”. He has stated that she does not want any treatment that will prolong his life. This means he has chosen not to accept dialysis.

As well as input from his GP, Alec will be receiving regular support from specialist nurses to manage his symptoms and keep him comfortable. Day-to-day care and support will continue to be provided by Cedar Lodge care workers. Alec’s daughters and Martin will spend time with their father each day.

This is the first time since she began working at the home that Sue has been closely involved with someone who is dying, and she is both upset and anxious about caring properly for Alec.

As the home manager, and Amana’s line manager, Maggie is responsible for ensuring that Amana is properly trained and supported so that Alec’s needs and the needs of his family are properly addressed.

In discussion with her manager, Amana talks about her concerns, her feelings, and what she sees as the gaps in her expertise.

A planning meeting, involving Alec, his family, and health and social care workers has taken place, and a care and support plan has been put in place to help Alec to live comfortably at Cedar Lodge. This has included a discussion, led by Alec, about his wishes. He has made it clear that he does not want any medical intervention to prolong his life, and this has been recorded in an ‘advance care plan’. Alec’s two daughters are supportive but his son, Martin, has difficulty accepting the decision.
## Cedar Lodge: key issues identified by Amana and Maggie

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<tr>
<th>Amana (Key worker)</th>
<th>Maggie (Manager)</th>
<th>Action</th>
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<tr>
<td><strong>Issue:</strong> Alec is becoming very tired, spending more time resting. His skin is very fragile and the risk of skin breakdown has increased significantly.</td>
<td><strong>Issue:</strong> Alec understands that he is going to die. He needs to be able to talk to people about how he feels and what he wants to happen. Alec and Amana have a strong relationship, and Alec has made it clear that he does not want to have lots of new people around him at this stage of his life.</td>
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| Amana is an experienced and qualified care worker, but she and her colleagues need to be highly skilled in managing Alec’s skin so that it does not break down causing him additional distress. | Maggie wants to make sure that Amana has some additional training in this area so she feels confident and is able to take proper care of Alec’s skin. Maggie will ensure that all other members of the team are able to provide support consistent with this. | Maggie plans to work alongside Amana to demonstrate good skin care. This will give her the opportunity to observe Amana, and to demonstrate best practice. In doing this she will be able to reassure Amana about her practice. Maggie will also talk to the nurse specialists, to find out if there are any particular creams or equipment that will benefit Alec, or if they have any other advice. |

| Maggie also recognises that the team will need to be supported, and will look for ways to make sure that this happens. Maggie knows that Amana needs some additional training to help her dealing with the questions Alec may ask, and the things he wants to talk about. Maggie realises that the level of communication skills that Amana will need may be above the level for which she is currently trained. Some of the support & development that Amana needs is very practical, and Maggie expects that by talking to the doctors and nurses involved in Alec’s care the information about the progress of his condition will be relatively easy to gain. Maggie herself has done bereavement counselling so will be able to offer some guidance, but she is aware that Amana will need further training. | Maggie is aware of the importance of acknowledging and trying to meet Alec’s spiritual needs. (Overarching value A talks about practice that “…acknowledges the significance of spiritual, emotional and religious needs and support.”). She talks to Amana about this, and reassures Amana that she can talk to her if she feels upset whilst working with Alec. She plans to ensure that she makes time available for this. In order to give Amana more practical support she has been on the e-ELCA website and has found several helpful communication sessions, as well as a Spirituality module. Although Amana is very busy, and unlikely to complete these units in the short term, she has suggested that she should look at them. By making time to discuss with Amana what she has learnt through the e-learning afterwards, Maggie can help Amana deepen her learning and apply this to Alec’s situation. In addition to the Spirituality module, she plans to build these into Amana’s development programme. Maggie has identified the following e-ELCA units: |
Cedar Lodge: key issues identified by Amana and Maggie

**Issue:** Alec’s son, Martin, feels that his father should accept treatment to prolong his life. This is a cause of distress to Alec, and has led to friction between Martin and his sisters. Martin had also challenged workers at the home, suggesting that it is their job to get his father to change his mind.

- **Amana (Key worker):** Having already been challenged by Alec’s son, Amana is really worried about further encounters. She does not know what to say to Martin, and has noticed how this upsets Alec.

- **Action:** Amana recognises that ‘advance care plans’ and ‘care plans’ can be easily confused, and that it is important for everyone to have a good understanding of the difference. She thinks that if Amana is confident about this, it will help her when talking to Martin.

- **Maggie (Manager):** Maggie is very worried about this situation, and is particularly concerned about Amana’s ability to deal with it. On balance she feels that this is not something Amana should be responsible for, and that she should speak to Martin herself. She decides that Amana needs to be able to speak to Martin in a calm and positive way, but to direct him firmly to more senior workers who will work with him to help him come to terms with his father’s decision.

- **Action:** Maggie discusses Amana’s responses the next time this happens, and tells her to refer Martin to the senior on duty. Maggie is going to talk to all of the workers, so that everyone is clear about this.

- **Maggie and Amana also discuss Alec’s right to make his own decision, and the importance of his being supported by the team. Maggie, the senior team and Amana will all look at the eELCA module: Dealing with challenging relatives.

- **Action:** They discuss how they will work with all of the family, with reference to the end of life underpinning value “practice that acknowledges the differences and conflicts that may arise between the individual, their friends and family when making decisions; and is sensitive in helping all those concerned to reach a positive resolution.”

- **Maggie:** Maggie has checked the e-ELCA website and seen that there are several ACP modules. At this stage she plans to look through these herself, and to use this information to offer a short session with Amana and other workers, explaining what an ACP is and discussing how this will affect decisions about Alec as his disease proceeds.

**Issue:** Alec is in renal failure. No one else at Cedar Lodge has had renal failure in recent years, so there is very little understanding of the condition.

- **Amana (Key worker):** Amana feels that she needs to have some knowledge about renal failure and what to expect. She thinks that this will help her in her work, and will be useful when she is talking to Alec and to his son and daughters.

- **Action:** The specialist nurses have left some leaflets, which all workers will be asked to look at. Maggie has also found a relevant e-learning module (condition-specific case study: End-stage renal failure). She plans to undertake the module herself, and support Amana through doing it. Amana has offered to brief other members of the team on the contents as part of her development.

- **Maggie (Manager):** Maggie recognises that this is important for herself as well as for Amana.

- **Action:** Maggie explains that Amana needs to have some knowledge about renal failure and what to expect. She thinks that this will help her in her work, and will be useful when she is talking to Alec and to his son and daughters.
Wider workforce development issues for Cedar Lodge identified by Maggie

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<th>Issue</th>
<th>Workforce development solution</th>
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| Although death and dying are relatively frequent events at Cedar Lodge, workers had had very little training in this area. This is partly a funding problem, the funding that they have been able to attract has been linked to national qualifications such as NVQs and not one-off training programmes. | Maggie has decided to undertake a mapping exercise, to see how the end of life competences, knowledge and values link to the current QCF units [see appendix in this present guide]. She is hoping to find connections so that workers undertaking funded training can also have some end of life training. Once she has done this she will approach the training organisations that she works will and look at how they can integrate end of life care into their training modules. She will also look at the e-learning units to see how these can be integrated into learning opportunities. To help her in her thinking Maggie has looked at the new qualifications options for those working in residential care, particularly the level two diploma on the Skills for Care website. She has already noticed some useful connections, for example: **End of life competence** – communication skills **QCF end of life specific units:**  
  - HSC 3035 support individuals who are bereaved  
  - HSC 3048 support individuals at the end of life **QCF mandatory unit:** SHC 31 Promote communication in health, social care or children’s and young people’s settings **QCF optional unit:** HSC 3029 Support individuals with specific communication needs. |
| Amana has immediate needs with regard to her work with Alec, but she has very little time in which to undertake further training to support her practice. | In the short term Maggie has identified some e-learning modules that Amana can access, and has offered some practical support in the workplace. However, thinking about this has led Maggie to conclude that everyone working at Cedar Lodge needs a better understanding of working with people who are dying. She therefore plans to look in more detail at the e-learning units and identify some that she see as core to the work of the home. She will then build these into individual workers’ development plans, and commission or deliver some specific training sessions around these. She will integrate this with the more formal qualifications training that workers undertake, providing a range of blended learning opportunities for people. |
| Many of the people who live at Cedar Lodge may have clear ideas about how they wish to die, including what kinds of treatments, if any, they wish to have. Maggie realises that some residents may choose to begin these difficult and important conversations with the workers they know and trust. She therefore realises that she needs to introduce some training, and provide information, so that workers are prepared should such a conversation arise. | This is seen as a priority for Maggie. She decides to talk to the trainers based at her local hospice for advice, and potentially to work with them to develop and introductory programme for all workers at the home. She wants some training for everyone, including domestic workers, as she knows that residents will talk to the people they trust and get along with, whatever their role. She also plans to talk to the specialist nurses, to find out what protocols are already in place, so that workers at Cedar Lodge can work in a multidisciplinary way with colleagues from all backgrounds. |
| Maggie has spent some time looking at the end of life care competences, knowledge and values, and thinks that these need to inform future appointments. | The senior staff team have set aside one of their meetings to look at these in detail. From this they will consider:  
  - reviewing their person specifications  
  - looking at ways to ensure that workers are properly supported and enabled to develop the skills and knowledge that are important in delivering end of life care. |
3. **A framework of competences, values & knowledge**

3.1 **Communication skills**

Being able to work with people in a sensitive and insightful way, demonstrating a good understanding of the factors that can affect the quality and method of the interaction, is the basis of sound practice. For all of the competences listed below, practitioners should take account of the many factors that affect communication. These include:

- Sensory impairments
- Intellectual ability
- Language
- Culture
- Religion or similar beliefs, if any
- Age, in particular when working with young family members and children
- Levels of spiritual wellbeing and distress.

Good communication matters in every aspect of health and social care; the competences described below are of particular importance when working with people at the end of life.

**Competences**

A Communicate with a range of people on a range of matters in a form that is appropriate to them and the situation.

B Develop and maintain communication with people about difficult and complex matters or situations related to end of life care.

C Present information in a range of formats, including written and verbal, as appropriate to the circumstances.

D Listen to individuals, their families and friends about their concerns related to the end of life and provide information and support.

E Work with individuals, their families and friends in a sensitive and flexible manner, demonstrating awareness of the impact of death, dying and bereavement, and recognising that their priorities and ability to communicate may vary over time.

F Work with colleagues to share information appropriately, taking account of issues of confidentiality, to ensure that individuals receive the best possible care. Ensure that information is clear, and non-jargonistic, so that it can be fully understood by others.
Communication skills – Useful resources

www.act.org.uk

*GP workbook*

Although targeted at general practitioners this book includes really helpful guidance about communicating with children, young people and adults.

www.endoflifecareforadults.nhs.uk

*Talking about end of life care: right conversations, right people, right time*

This draws on the experience of a number of pilot sites to illustrate the importance of good communication, with the right people, at the right time, to a positive experience for patients. It also shows how good training and workforce development can be used to underpin good practice.

*The Disability Distress Assessment Tool (DisDAT)*

A tool produced by a partnership of organisations in the North East, to record the ways in which individuals with learning disabilities that affect their communication skills communicate distress and contentment. The tool was developed to support people with learning disabilities who have life-limiting conditions.

www.e-lfh.org.uk/projects/e-elca

This site contains all of the e-learning suites that have been developed to support the End of Life Care Strategy, and is freely available. It is intended to be of use to all practitioners concerned with end of life care. Details of modules can be found in the useful links in the Overview section of this document.

www.scie.org.uk

*Dignity in Care factsheet: communication*

Part of Scie’s Dignity in Care research and best practice programme; this is a useful poster outlining key ways to ensure good communication with individuals.

www.winstonswish.org.uk

Winston’s wish specialises in working with children and young people with terminally ill parents. The site has lots of helpful guidance about how to help children who have lost a parent or who have a parent with a terminal illness.
3.2 Assessment and care planning

Care plans (sometimes called support plans) document the aspirations, goals and priorities of the individual, and describe how they will be achieved, monitored and reviewed. They should be developed with the individual, and, where appropriate, their carers. They are plans for care in the present and the future, and are subject to regular review and change. Assessing and maximising the individual’s capacity (the ability to make a decision about a particular issue at the time it needs to be made, or to consent to a specific act) are essential aspects of the care planning process.

Care plans can be made on behalf of a person who lacks capacity, by involving those people closest to them (family, friends, carers, professionals) and taking account of any ‘advance decisions’ or ‘advance care plans’ that have been made. If an individual lacks the capacity to make decisions, the processes required by the Mental Capacity Act (2005) should be followed to ensure that the individual’s best interests are pursued (see Capacity, care planning and advance care planning document in resources at the end of this section).

Care plans differ from advance care plans because advance care plans are drawn up in anticipation of future loss of mental capacity, to be used when the individual can no longer actively contribute to the care planning process (see the advance care planning section in this guide). They can then be used to help with decisions to be taken at that time.

In some situations, where a carer provides a high proportion of the individual’s care, a carers’ assessment should be undertaken; this is the responsibility of the local authority.

Assessment and care planning are ongoing processes, incorporated in a cyclical process that includes the delivery of the plan (see Symptom Management, Maintaining Comfort and Wellbeing).

High quality, person-centred care planning and delivery matters in every aspect of health and social care; the competences described (next page) are of particular importance when working with people at the end of life.

**Assessment planning and delivery cycle**

- **assess:** by dialogue with relevant people
- **act:** provide care as agreed in the care plan, working in partnership with the individual and others
- **monitor:** continuous feedback from the individual and relevant people
- **review:** identify when circumstances or priorities change
Competences

A Understand the range of assessment tools and ways of gathering information and their advantages and disadvantages.

B Assess pain and other symptoms using assessment tools, pain history, appropriate physical examination and relevant investigation.

C Undertake/contribute to multi-disciplinary assessment and information sharing.

D Ensure that all assessments are holistic, including:
   - background information
   - current physical health and prognosis.
   - social and/or occupational wellbeing
   - psychological and emotional wellbeing
   - religious and/or spiritual wellbeing (recognising the differences between these two concepts and the person’s ability to maintain their preferred variations of their outward practice, such as prayer habits, diet, dress, etc.)
   - culture and lifestyle aspirations, goals and priorities
   - risk and risk management
   - the needs of families and friends, including carers’ assessments, and including children and young people.

E Regularly review assessments to take account of changing needs, priorities and wishes, and ensure information about changes is properly recorded.

Useful resources for assessment & care planning


For further information about carers’ assessments.

www.dh.gov.uk

End of life care and personalised care planning (information sheet 8). One in a series of factsheets to support people working with individuals with long term conditions.

www.endoflifecareforadults.nhs.uk

Capacity, care planning and advance care planning in life limiting illness: A Guide for Health and Social Care Staff

Gives clear guidance on the differences between care planning and advance care planning, as well as explaining the impact of loss of mental capacity and how to ensure that an individual’s best interests are maintained.

More assessment & care planning resources on next page
Useful resources continued

*Holistic common assessment of supportive and palliative care needs for adults requiring end of life care*

Step by step guide to undertaking holistic assessments to support care planning and delivery

*The differences between general care planning and decisions made in advance*

A succinct chart that describes the differences between care planning, advance care planning, advance decision to refuse treatment and DNACPR (‘Do not attempt cardio pulmonary resuscitation’). The chart included guides practitioners through the legal aspects of each, describes who is responsible for what and outline key actions to be taken.

[www.e-lfh.org.uk/projects/e-elca](http://www.e-lfh.org.uk/projects/e-elca)

This site contains all of the e-learning suites that have been developed to support the End of Life Care Strategy, and is freely available. It is intended to be of use to all practitioners concerned with end of life care. Details of modules can be found in the useful links in the Overview section of this document.

[www.winstonswish.org.uk](http://www.winstonswish.org.uk)

Winston’s wish specialises in working with children and young people with terminally ill parents. The site has lots of helpful guidance about how to help children who have lost a parent or who have a parent with a terminal illness.
3.3 Advance care planning

Advance care planning is a voluntary process of discussion and review to help an individual who has capacity to anticipate how their condition may affect them in the future, and if they wish, set on record their choices about care, treatment and/or decisions to refuse treatment in specific circumstances. It is undertaken at a time when the individual has capacity, to be used if that capacity is later lost. It is not the same as a care plan (see Assessment and Care Planning section) but should be used by professionals and families to review and update care plans if and when the individual no longer has the intellectual capacity to make decisions for themselves.

**Competences**

A Demonstrate awareness and understanding of advance care planning, and the times at which it would be appropriate.

B Demonstrate awareness and understanding of the legal status and implications of the advance care planning process; in accordance with the provisions of the Mental Capacity Act.

C Demonstrate awareness and understanding of the impact of culture and religion (or similar belief, if any) upon the choices people make.

D Show understanding of informed consent and demonstrate the ability to give sufficient information in an appropriate manner.

E Use effective communication skills when having advance care planning discussions as part of ongoing assessment and intervention.

F Work sensitively with families and friends to support them as the individual decides upon their preferences and wishes during the advance care planning process. Recognise the potential for conflicts arising from different religious, cultural or lifestyle perspectives and work with those involved to reach agreement.

G Where appropriate, ensure that the wishes of the individual, as described in an advance care planning statement, are shared (with permission) with other workers.

H When appropriate, know what the advance care planning statement contains, and how this will impact upon an individual’s care delivery.
Useful resources for advance care planning

www.endoflifecareforadults.nhs.uk

*Advance Decisions To Refuse Treatment: A Guide for Health and Social Care Professionals*

A guide to help health and social care professionals understand and implement the new law relating to advance decisions to refuse treatment (ADRT) contained in the Mental Capacity Act 2005.

**Capacity, care planning and advance care planning in life limiting illness: A Guide for Health and Social Care Staff**

Gives clear guidance on the differences between care planning and advance care planning, as well as explaining the impact of loss of mental capacity and how to ensure that an individual’s best interests are maintained.

**Planning For Your Future Care: A Guide**

A guide written for patients and people who use services, explaining what advance care planning means, and how, if they wish they can talk to people about making an advance care plan.

**The differences between general care planning and decisions made in advance**

A succinct chart that describes the differences between care planning, advance care planning, advance decision to refuse treatment and DNACPR (‘Do not attempt cardio pulmonary resuscitation’). The chart includes guides practitioners through the legal aspects of each, describes who is responsible for what and outline key actions to be taken.

www.e-lfh.org.uk/projects/e-elca

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www.scie.org.uk/publications/dementia/decisions/advance.asp

*Advance Care Planning Part* of the Dementia Gateway series, but a clear description that is of use in a range of situations.

www.westonhospicecare.org.uk/wiki/?page=advance_planning

Many hospices have information and pro formas to support discussions and produce advance care plans. This website contains an explanation of advance care panning, a form for individuals to use, and a form to help others who are making decisions on behalf of someone else.
3.4 Symptom management: maintaining comfort and wellbeing

The responsibility that a practitioner has in ensuring the wellbeing of individuals depends upon their particular role and expertise. For a social worker or social care practitioner the focus is likely to be on managing care and support. Workers who are more medically-based may, for example, have responsibility more for symptom management. However, there is significant overlap, and maintaining the physical and spiritual comfort and wellbeing of an individual is a shared responsibility, delivered through the appropriate multi-disciplinary partnership.

Maximising an individual’s wellbeing means looking at all of their concerns and goals, and working to manage and achieve these in accordance with their wishes (see Assessment and care planning). It incorporates far more than dealing only with medical concerns. Maintaining comfort and wellbeing may include, among other things, spiritual and emotional wellbeing, the ability to participate in activities that are important to the individual, or being at home.

High quality, person-centred service provision matters in every aspect of health and social care; the competences described below are of particular importance when working with people at the end of life.

**Competences**

A Be aware that symptoms have many causes, including the disease itself, its treatment, a concurrent disorder (including depression or anxiety) or other psychological or practical issues.

B Understand the significance of the individual’s own perception of their symptoms to any intervention.

C Understand that the underlying causes of a symptom will have an impact upon how care should be delivered.

D Understand the range of therapeutic options available, including drugs, hormone therapy, physical therapies, counselling or other psychological interventions, complementary therapies, surgery, community or practical support.

E In partnerships with others, including the individual, their family and friends, develop an end of life care plan which balances disease specific treatment with other interventions and support that meets the needs of the individual.

F In partnership with others, implement, monitor and review the end of life care plan.

G Understand the cultural and religious (or similar belief) issues that may impact on symptom management. Recognise the potential for conflicts between individuals and family members, arising from different religious, cultural or lifestyle perspectives and work with those involved to reach agreement.
Useful resources for symptom management

**www.e-lfh.org.uk/projects/e-elca**
This site contains all of the e-learning suites that have been developed to support the End of Life Care strategy, and is freely available. It is intended to be of use to all practitioners concerned with end of life care. Details of modules can be found in the useful links in the Overview section of this document.

**www.scie.org.uk**
*Dignity in Care factsheet: pain management in practice*
Part of Scie’s Dignity in Care research and best practice programme; this is a useful poster outlining key ways to recognise and support people who are in pain.

### 3.5 Overarching knowledge and values

At the heart of all practice, practitioners in whatever role need to have a good understanding of the underpinning knowledge needed to work with people at the end of their lives. They need also to work in ways that contribute to maximising the physical, spiritual and emotional wellbeing of those for whom they are caring. Social care and health professionals working with people at the end of life are bound by their own codes of practice or ethics, but in addition the knowledge and values below are related directly to end of life care.

#### Knowledge

In the context of end of life care, understanding and knowledge of:

- One’s own professional/role boundaries.
- Legal and ethical issues – adherence to legislation and advisory guidance, for example:
  - The Mental Capacity Act
  - The Mental Health Act
  - Advance Decisions to Refuse Treatments
  - DNACPR (‘Do not attempt cardio-pulmonary resuscitation’)
- Professional codes of practice or conduct and their impact on practice.
- The role and contribution of other workers and organisations to the individual’s care, and to leadership and innovation.

- The impact of one’s own beliefs on practice.
- The impact of the individual’s culture and beliefs, including any religious beliefs, on treatment both before and after death.
- Where appropriate to role, the responsibilities of caring for the person after death.
- Approaches to risk assessment, management and taking.
- Theories of change, loss and bereavement and how these impact upon people.
- Social models of care and person-centred approaches.
Values

Practice that:

A Is person-centred, recognising the circumstances, concerns, goals, beliefs and culture of the individual, their family and friends, and acknowledges the significance of spiritual, emotional and religious needs and support.

B Acknowledges the differences and conflicts that may arise between the individual, their friends and family when making decisions; and is sensitive in helping all those concerned to reach a positive resolution.

C Is sensitive to the support needs of family and friends, including children and young people, both as part of end of life care and following bereavement.

D Demonstrates awareness of the importance of contributing to evaluation and change of services, participating as appropriate, and of involving the people who use them in that process.

E Recognises and takes responsibility for one’s own learning and continuing professional development, and contributes to the learning of others.

Useful resources

www.dh.gov.uk/publications

Bereavement care services: a synthesis of the literature (Jan 2011)
Spirituality Care at the End of Life a systematic review of the literature (Jan 2011)

www.endoflifecareforadults.nhs.uk

For a wide range of information, guidance and links to other useful sites.

www.endoflifecareforadults.nhs.uk/publications/guidance-for-staff-responsible-for-care-after-death

For guidance to help workers responsible for care after death.

www.e-lfh.org.uk/projects/e-elca

This site contains all of the e-learning suites that have been developed to support the End of Life Care strategy, and is freely available. It is intended to be of use to all workers concerned with end of life care.

The suites include condition-specific end of life scenarios, critical situations and differing scenarios around dying, for example as a prisoner and as a homeless person, as well as care after death (also known as ‘last offices’) and various frameworks and tools such as DNACPR and the framework for advanced kidney disease.
Appendix  End of life care core competences values & knowledge: links between health and social care QCF units and social care induction standards

The following pages link the end of life care core competences, values and knowledge to the social care Common Induction Standards and to health and social care (HSC) QCF units. It provides a framework for trainers or those involved with commissioning and developing training to work across the two sets of competences making logical connections. It is not an exhaustive list, and as new QCF units are developed there will be other units that could be connected.

There are a small number of units that are specific to end of life care; these are in shaded cells in the tables.

Under each standard are the units that relate most closely to end of life care, and the numbers in the brackets refer to the specific criteria within that unit that link to the end of life care competences.

By looking for the links between end of life care training and development and other HSC units, people developing programmes (whether or not leading to a qualification) will be able to:

1. Ensure that the required end of life care training is included in the curriculum.

2. Demonstrate that workers are competent across the relevant aspects of end of life care as well as their more generic learning.

3. Ensure that end of life care training is delivered in a way that incorporates HSC units and enables workers to demonstrate their learning towards achieving those units.

Employers and those commissioning training will be able to “pick and mix” to ensure that employees have the right range of training and development for their circumstances.

For example, by looking at the end of life competences, a manager in a residential home for older people may realise that it is important that all workers are comfortable about responding to a resident who wants to talk about the fact that they are dying. Therefore, when creating an induction programme she may want to ensure that everyone has some understanding of communicating with people who are dying; so one of the communication sessions is designed to cover this topic.
**Communication skills**

A Communicate with a range of people on a range of matters in a form that is appropriate to them and the situation.

B Develop and maintain communication with people about difficult and complex matters or situations related to end of life care.

C Present information in a range of formats, including written and verbal, as appropriate to the circumstances.

D Listen to individuals, their families and friends about their concerns related to the end of life and provide information and support.

E Work with individuals, their families and friends in a sensitive and flexible manner, demonstrating awareness of the impact of death, dying and bereavement, and recognising that their priorities and ability to communicate may vary over time.

F Work with colleagues to share information appropriately, taking account of issues of confidentiality, to ensure that individuals receive the best possible care. Ensure that information is clear, and non-jargonistic, so that it can be fully understood by others.

<table>
<thead>
<tr>
<th>Common Induction Standards</th>
<th>QCF level 2</th>
<th>QCF level 3</th>
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<tbody>
<tr>
<td><strong>STANDARD 1 ROLE OF HEALTH &amp; SOCIAL CARE WORKER</strong></td>
<td><strong>HSC 2022 CONtribute to the Care of a Deceased Person</strong></td>
<td><strong>HSC 3035 Support Individuals Who are Bereaved</strong></td>
</tr>
<tr>
<td>3. The importance of working in partnership with others (.1)</td>
<td>2. Be able to contribute to supporting those who are close to the individual (.2)</td>
<td>3. Be able to support individuals to express their responses to loss (.1.2)</td>
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<tr>
<td><strong>STANDARD 3 COMMUNICATE EFFECTIVELY</strong></td>
<td><strong>HSC028 Handle Information in Health and Social Care Settings</strong></td>
<td><strong>HSC 3048 Support Individuals at the End of Life</strong></td>
</tr>
<tr>
<td>1. Importance of effective communication in the work setting (.1.2.3)</td>
<td>3. Be able to handle information in accordance with agreed ways of working (.1.2)</td>
<td>4. Be able to provide support to individuals and key people during end of life (.1.2.4.6)</td>
</tr>
<tr>
<td>2. Meeting the communication and language needs, wishes and preferences of individuals (.1.2)</td>
<td><strong>SHC21 INTRODUCTION TO COMMUNICATION IN HEALTH, SOCIAL CARE OR CHILDREN’S AND YOUNG PEOPLE’S SETTINGS</strong></td>
<td>5. Understand how to address sensitive issues in relation to end of life care (.1)</td>
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<td>3. Overcoming difficulties in promoting communication (.1.2.3.4)</td>
<td>1. Understand why communication is important in the work setting (.1.2.3.)</td>
<td><strong>HSC3029 Support Individuals with Specific Communication Needs</strong></td>
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<td>2. Be able to meet the communication and language needs, wishes and preferences of individuals (.1.2.3.)</td>
<td>1. Understand specific communication needs and factors affecting them (.1.2.3.4.5.6)</td>
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<td>3. Be able to reduce the barriers to communication (.1.2.3.4)</td>
<td>2. Be able to contribute to establishing the nature of specific communication needs of individuals and ways to address them (.1.2.3)</td>
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<td>3. Be able to interact with individuals using their preferred communication (.1.2.3.4)</td>
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<td>4. Be able to promote communication between individuals and others (.1.2.3.4)</td>
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</table>
| **SSOP2.2 SUPPORT EFFECTIVE COMMUNICATION WITH INDIVIDUALS WITH A SENSORY LOSS** | 1. Know different methods that can support communication with individuals with sensory loss (.1.2.3)  
2. Be able to use different methods of communication with individuals with sensory loss (.1.2.3)  
3. Understand how the environment impacts on communication with individuals with sensory loss (.1.2)  
4. Be able to utilise the environment for effective communication with individuals with sensory loss (.1) | **HSC038 PROMOTE GOOD PRACTICE IN HANDLING INFORMATION IN HEALTH AND SOCIAL CARE SETTINGS**  
2. Be able to implement good practice in handling information (.1) |
| **HSC 3038 WORK IN PARTNERSHIP WITH FAMILIES TO SUPPORT INDIVIDUALS** | 2. Be able to establish and maintain positive relationships with families (.1)  
5. Be able to exchange and record information about partnership working with families  
7. Be able to provide feedback about support for families | |
| **SHC31 PROMOTE COMMUNICATION IN HEALTH, SOCIAL CARE OR CHILDREN’S AND YOUNG PEOPLE’S SETTINGS** | 1. Understand why effective communication is important in the work setting (.1.2.)  
2. Be able to meet the communication and language needs, wishes and preferences of individuals (.1.2.3.4)  
3. Be able to overcome barriers to communication (.1.2.3.4.) | **SSOP3.2 PROMOTE EFFECTIVE COMMUNICATION WITH INDIVIDUALS WITH SENSORY LOSS**  
1. Understand the importance of effective two way communication (.1.2.3)  
3. Be able to support the individual with communication (.1.2.3.4) |
Assessment and care planning

A  Understand the range of assessment tools and ways of gathering information and their advantages and disadvantages.

B  Assess pain and other symptoms using assessment tools, pain history, appropriate physical examination and relevant investigation.

C  Undertake/contribute to multi-disciplinary assessment and information sharing.

D  Ensure that all assessments are holistic, including
- Background information
- Current physical health and prognosis.
- Social and/or occupational wellbeing
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- Religious and/or spiritual wellbeing (recognising the differences between these two concepts and the person’s ability to maintain their preferred variations of their outward practice, such as prayer habits, diet, dress, etc.)
- Culture and lifestyle aspirations, goals and priorities
- Risk and risk management
- The needs of families and friends, including carers’ assessments, and including children and young people.

E  Regularly review assessments to take account of changing needs, priorities and wishes, and ensure information about changes is properly recorded.

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<td><strong>HSC035 SUPPORT INDIVIDUALS WHO ARE BEREAVED</strong></td>
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<td><strong>STANDARD 3 COMMUNICATE EFFECTIVELY</strong></td>
<td><strong>HSC2025 THE ROLE OF THE HEALTH AND SOCIAL CARE WORKER</strong></td>
<td>5. Understand the role of specialist agencies in supporting individuals who are bereaved (.2)</td>
</tr>
<tr>
<td>1. Importance of effective communication in the work setting (.1.2.3)</td>
<td>3. Be able to work in partnership with others (.1.2.4)</td>
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<tr>
<td>2. Meeting the communication and language needs, wishes and preferences of individuals (.1.2)</td>
<td><strong>HSC026 IMPLEMENT PERSON CENTRED APPROACHES IN HEALTH &amp; SOCIAL CARE</strong></td>
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<tr>
<td>3. Overcoming difficulties in promoting communication (.1.2.3.4)</td>
<td>1. Understand person-centred approaches for care and support (.1.2.3)</td>
<td>1. Understand the application of person-centred approaches in health and social care (.1)</td>
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<td>2. Be able to work in a person-centred way (.1.2)</td>
<td>2. Be able to work in a person-centred way (.1.2.3)</td>
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<td>5. Be able to support the individual’s right to make choices (.2.3)</td>
<td>5. Be able to support the individual’s right to make choices (.3)</td>
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<tr>
<td><strong>STANDARD 4 EQUALITY &amp; INCLUSION</strong></td>
<td>2. Provide inclusive support (.2)</td>
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<tr>
<td><strong>STANDARD 7 PERSON-CENTRED SUPPORT</strong></td>
<td>1. Promote person-centred values in everyday work (.1.2)</td>
<td>2. Be able to implement good practice in handling information (.1.3)</td>
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<td>5. Supporting an individual's rights to make choices (.1)</td>
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<td>6. Promoting spiritual and emotional well-being (.1.2.3)</td>
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<tr>
<td><strong>HSC028 HANDLE INFORMATION IN HEALTH AND SOCIAL CARE SETTINGS</strong></td>
<td>1. Understand the need for secure handling of information in health and social care settings (.1.2)</td>
<td>2. Be able to implement good practice in handling information (.1.3)</td>
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<td>2. Know how to access support for handling information (.1)</td>
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<td><strong>HSC2003 PROVIDE SUPPORT TO MANAGE PAIN AND DISCOMFORT</strong></td>
<td>2. Be able to assist in minimising individual's pain or discomfort (.1.2)</td>
<td>3. Be able to contribute to the planning of care or support (.4)</td>
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<td>3. Be able to monitor, record and report on the management of individuals' pain or discomfort (.1.2.3)</td>
<td>4. Be able to support the implementation of care plans (.3)</td>
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<td>5. Be able to monitor care plans (.1.2.3)</td>
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<td>6. Be able to facilitate a review of care plans and their implementation (.1.2.3.4.5)</td>
</tr>
<tr>
<td><strong>HSC3029 SUPPORT INDIVIDUALS WITH SPECIFIC COMMUNICATION NEEDS</strong></td>
<td>6. Be able to review an individual's communication needs and the support provided to address them (.1.2.3)</td>
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</tr>
<tr>
<td><strong>HSC3038 WORK IN PARTNERSHIP WITH FAMILIES TO SUPPORT INDIVIDUALS</strong></td>
<td>4. Be able to work with families to access support in their role as carers (.1)</td>
<td>5. Be able to exchange and record information about partnership work with families (.1.2)</td>
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<td>6. Be able to provide feedback about support for families (.1.2.3.4)</td>
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Advance care planning

A Demonstrate awareness and understanding of advance care planning, and the times at which it would be appropriate.
B Demonstrate awareness and understanding of the legal status and implications of the advance care planning process; in accordance with the provisions of the Mental Capacity Act.
C Demonstrate awareness and understanding of the impact of culture and religion (or similar belief, if any) upon the choices people make.
D Show understanding of informed consent and demonstrate the ability to give sufficient information in an appropriate manner.
E Use effective communication skills when having advance care planning discussions as part of ongoing assessment and intervention.
F Work sensitively with families and friends to support them as the individual decides upon their preferences and wishes during the advance care planning process. Recognise the potential for conflicts arising from different religious, cultural or lifestyle perspectives and work with those involved to reach agreement.
G Where appropriate, ensure that the wishes of the individual, as described in an advance care planning statement, are shared (with permission) with other workers.
H When appropriate, know what the advance care planning statement contains, and how this will impact upon an individual’s care delivery.

<table>
<thead>
<tr>
<th>Common Induction Standards</th>
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<tbody>
<tr>
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<td><strong>HSC 3048 SUPPORT INDIVIDUALS AT THE END OF LIFE</strong></td>
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<tr>
<td>3. The importance of working in partnership with others (.1)</td>
<td>3. Be able to work in partnership with others (.1.2.3)</td>
<td>1. Understand the requirements of legislation and agreed ways of working to protect the rights of individuals at the end of life (.1.2)</td>
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<td><strong>STANDARD 3 COMMUNICATE EFFECTIVELY</strong></td>
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<td>2. Understand factors affecting end of life care (.1.2.3.4)</td>
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<td>1. Importance of effective communication in the work setting (.1.2.3)</td>
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<td>3. Understand advance care planning in relation to end of life care (.1.2.3.4)</td>
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<td>2. Meeting the communication and language needs, wishes and preferences of individuals (.1.2)</td>
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<td>4. Be able to provide support to individuals and key people during end of life care (.1.2.3.4.6)</td>
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<td>3. Overcoming difficulties in promoting communication (.1.2.3.4)</td>
<td>3. Be able to establish consent when providing care or support (.1.2)</td>
<td>5. Understand how to address sensitive issues in relation to end of life care (.1.3.4)</td>
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<td><strong>STANDARD 7 PERSON-CENTRED SUPPORT</strong></td>
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<td><strong>HSC036 PROMOTE PERSON-CENTRED APPROACHES IN HEALTH AND SOCIAL CARE</strong></td>
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<td>1. Promote person-centred values in everyday work (.1.2)</td>
<td>1. Understand the need for secure handling of information in health and</td>
<td>1. Understand the application of person-centred approaches in health and</td>
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<td>2. Working in a person-centred way (.1.2.3)</td>
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<td>5. Supporting an individual's rights to make choices (.1)</td>
<td>2. Know how to access support for handling information (.1)</td>
<td>2. Be able to work in a person-centred way (.1.2.3)</td>
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<td>6. Promoting spiritual and emotional well-being (.1.2.3)</td>
<td>3. Be able to handle information in accordance with agreed ways of working</td>
<td>3. Be able to establish consent when providing care or support (.1.2)</td>
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<td>4. Be able to implement and promote active participation (.2.3)</td>
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<td>**HSC 038 PROMOTE GOOD PRACTICE IN HANDLING INFORMATION IN HEALTH AND</td>
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<td>2. Be able to implement good practice in handling information (.1.2.3)</td>
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<td><strong>HSC 3020 FACILITATE PERSON-CENTRED ASSESSMENT, PLANNING, IMPLEMENTATION</strong></td>
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<td>1. Understand the principles of person-centred assessment and care planning</td>
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<td><strong>HSC3029 SUPPORT INDIVIDUALS WITH SPECIFIC COMMUNICATION NEEDS</strong></td>
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<td>3. Be able to interact with individuals using their preferred communication (.4)</td>
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<td>5. Know how to support the use of communication technology and aids (.1.2.3)</td>
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<tr>
<td><strong>HSC3033 SUPPORT INDIVIDUALS DURING A PERIOD OF CHANGE</strong></td>
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<td>1. Understand reasons for and responses to change</td>
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<td>2. Be able to establish and maintain positive relationships with families (.3)</td>
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<td>3. Be able to plan shared approaches to the care and support of individuals with families (.1.2.3.4.5)</td>
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<td>5. Be able to exchange and record information about partnership work with families (.1.2)</td>
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</table>
Symptom management: maintaining comfort and wellbeing

A  Be aware that symptoms have many causes, including the disease itself, its treatment, a concurrent disorder (including depression or anxiety) or other psychological or practical issues.

B  Understand the significance of the individual’s own perception of their symptoms to any intervention.

C  Understand that the underlying causes of a symptom will have an impact upon how care should be delivered.

D  Understand the range of therapeutic options available, including drugs, hormone therapy, physical therapies, counselling or other psychological interventions, complementary therapies, surgery, community or practical support.

E  In partnerships with others, including the individual, their family and friends, develop an end of life care plan which balances disease specific treatment with other interventions and support that meets the needs of the individual.

F  In partnership with others, implement, monitor and review the end of life care plan.

G  Understand the cultural and religious (or similar belief) issues that may impact on symptom management. Recognise the potential for conflicts between individuals and family members, arising from different religious, cultural or lifestyle perspectives and work with those involved to reach agreement.

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<td><strong>HSC2003 PROVIDE SUPPORT TO MANAGE PAIN AND DISCOMFORT</strong></td>
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<td>1. Understand approaches to managing pain and discomfort (.1.2.3)</td>
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<td>2. Be able to assist in minimising individuals’ pain or discomfort (.1.2.3.4.5)</td>
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<td>1. Understand the application of person-centred approaches in health and social care (.1)</td>
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<tr>
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<td>1. Understand the principles of person-centred assessment and care planning (.1.2.3)</td>
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<td>2. Working in a person-centred way (.1.2.3)</td>
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<td>2. Be able to facilitate person-centred assessment (.1.2.3.4.5)</td>
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<td><strong>HSC3038 WORK IN PARTNERSHIP WITH FAMILIES TO SUPPORT INDIVIDUALS</strong></td>
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</table>
**Overarching values and knowledge**

**Knowledge**

In the context of end of life care, understanding and knowledge of:

- One’s own professional/role boundaries.
- Legal and ethical issues – adherence to legislation and advisory guidance, for example:
  - The Mental Capacity Act
  - The Mental Health Act
  - Advance Decisions to Refuse Treatments
  - DNACPR (‘Do not attempt cardio pulmonary resuscitation’)
- Professional codes of practice or conduct and their impact on practice.
- The role and contribution of other workers and organisations to the individual’s care, and to leadership and innovation.
- The impact of one’s own beliefs on practice.
- The impact of the individual’s culture and beliefs, including any religious beliefs, on treatment both before and after death.
- Where appropriate to role, the responsibilities of caring for the person after death.
- Approaches to risk assessment, management and taking.
- Theories of change, loss and bereavement and how these impact upon people.
- Social models of care and person-centred approaches.

**Values**

Practice that:

A  Is person-centred, recognising the circumstances, concerns, goals, beliefs and culture of the individual, their family and friends, and acknowledges the significance of spiritual, emotional and religious needs and support.

B  Acknowledges the differences and conflicts that may arise between the individual, their friends and family when making decisions; and is sensitive in helping all those concerned to reach a positive resolution.

C  Is sensitive to the support needs of family and friends, including children and young people, both as part of end of life care and following bereavement.

E  Demonstrates awareness of the importance of contributing to evaluation and change of services, participating as appropriate, and of involving the people who use them in that process.

F  Recognises and takes responsibility for one’s own learning and continuing professional development, and contributes to the learning of others.
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<td>HSC035 SUPPORT INDIVIDUALS WHO ARE BEREAVED</td>
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<tr>
<td>1. Responsibilities and limits of your relationship with an individual (.1.2)</td>
<td>1. Know the factors that affect how individuals are cared for after death (.1.2)</td>
<td>1. Understand the effects of bereavement on individuals (.1.2)</td>
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<tr>
<td>2. Working in ways that are agreed with your employer (.1.2.3)</td>
<td>2. Be able to contribute to supporting those who are close to the individual (.1.2.3.4)</td>
<td>2. Understand the principles for supporting individuals who are bereaved (.1.2.3)</td>
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<tr>
<td>3. The importance of working in partnership with others (.1.2.3)</td>
<td>3. Be able to contribute to preparing deceased individuals prior to transfer (.1.2)</td>
<td>3. Be able to support individuals to express their responses to loss (.1.2)</td>
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<td><strong>STANDARD 2 PERSONAL DEVELOPMENT</strong></td>
<td>HSC024 PRINCIPLES OF SAFEGUARDING AND PROTECTION IN HEALTH &amp; SOCIAL CARE</td>
<td>4. Be able to support individuals who are bereaved (.1.2.3.4.5.6)</td>
</tr>
<tr>
<td>1. Competence in your own work role within the sector (.1.2.3)</td>
<td>2. Know how to respond to suspected or alleged abuse (.1.2.3)</td>
<td>5. Understand the role of specialist agencies in supporting individuals who are bereaved (.2)</td>
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<tr>
<td>2. Reflective practice (.1.2)</td>
<td>3. Understand the national and local context of safeguarding and protection from abuse (.1.2.3.4)</td>
<td><strong>HSC 3048 SUPPORT INDIVIDUALS AT THE END OF LIFE</strong></td>
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<td>4. Understand ways to reduce the likelihood of abuse (.1)</td>
<td>1. Understand the requirements of legislation and agreed ways of working to protect the rights of individuals at the end of life (.1.2)</td>
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<tr>
<td>4. Producing a personal development plan (.1.2.3)</td>
<td>5. Know how to recognise and report unsafe practices (.1.2.3)</td>
<td>2. Understand factors affecting end of life care (.1.2.3.4)</td>
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<tr>
<td>5. Using learning opportunities and reflective practice to contribute to personal development (.1.2.3.4)</td>
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<td>4. Be able to provide support to individuals and key people during end of life care (.1.2.3.4.6)</td>
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<td>4. Understand principles and practice relating to confidentiality (.1.2.3.4)</td>
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<td>5. Understand how to address sensitive issues in relation to end of life care (.1.3.4)</td>
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<td>2. Be able to work in ways that are agreed with the employer (.1.2.3)</td>
<td>8. Be able to support individuals through the process of dying (.1.2.3)</td>
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<td>3. Be able to monitor, record and report on the management of individuals’ pain or discomfort (.1.2.3)</td>
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<td>3. Be able to assist an individual to sleep (.1.2)</td>
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<td>1. Understand requirements for handling information in health and social care settings (.1.2)</td>
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<td>2. Be able to carry out own responsibilities for health and safety (.1.2.3.4.5.6)</td>
<td>3. Be able to support others to handle information (.1.2)</td>
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<td>4. Be able to apply principles and practices relating to confidentiality at work (.1.2.3.4)</td>
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<tr>
<td>HSC3033 SUPPORT INDIVIDUALS DURING A PERIOD OF CHANGE</td>
<td>1. Understand reasons for and responses to change (.1.2.3)</td>
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</tr>
<tr>
<td>HSC3038 WORK IN PARTNERSHIP WITH FAMILIES TO SUPPORT INDIVIDUALS</td>
<td>1. Understand partnership working with families (.2.3.4)</td>
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<tr>
<td>2. Be able to establish and maintain positive relationships with families (.1.3)</td>
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<td>3. Be able to plan shared approaches to the care and support of individuals with families (.3)</td>
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<td>7. Be able to provide feedback about support for families (.2.3)</td>
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<tr>
<td>SHC31 PROMOTE COMMUNICATION IN HEALTH, SOCIAL CARE OR CHILDREN’S AND YOUNG PEOPLE’S SETTINGS</td>
<td>4. Be able to apply principles and practices relating to confidentiality (.1.2.3)</td>
<td></td>
</tr>
<tr>
<td>SSOP3.2 PROMOTE EFFECTIVE COMMUNICATION WITH INDIVIDUALS WITH SENSORY LOSS</td>
<td>2. Understand different methods that can support communication with individuals with sensory loss (.1.2)</td>
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<tr>
<td>4. Evaluate the effectiveness of methods of communication used to support an individual with sensory loss (.1.2.3.4.5)</td>
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</tbody>
</table>