

Common Core Principles

and competences for
social care and health
workers working with
adults at the end of life



Common core principles and competences for social care and health workers working with people at the end of life
2nd edition

Published by Skills for Care, West Gate, 6 Grace Street, Leeds LS1 2RP
Skills for Care, West Gate, 6 Grace Street, Leeds LS1 2RP www.skillsforcare.org.uk
Skills for Health, 1st Floor, Goldsmiths House, Broad Plain, Bristol BS2 0JP www.skillsforhealth.org.uk

© Skills for Care & Skills for Health 2014

Skills for Care and Skills for Health are pleased to acknowledge the contracted work of Melissa Balman in researching and compiling this publication

Copies of this work may be made for non-commercial distribution to aid social care workforce development. Any other copying requires the permission of the publishers. 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; NHS, independent and third sector.

Bibliographic reference data for Harvard-style author/date referencing system:

Short reference: Skills for Care & Skills for Health [or SfC&SfH] 2014

Long reference: Skills for Care & Skills for Health. (2014) Common core principles and competences for social care and health workers working with people at the end of life (2nd edition).
www.skillsforcare.org.uk www.skillsforhealth.org.uk

Introduction



People nearing the end of their life often need specialist care and support that is provided by experts working in the field. Increasingly though, people working in social care and health who are not specialists in this area find themselves working with people who are dying. This document, while relevant for everyone, is aimed at those non specialist workers¹ that sets out the principles for working with adults at the end of their life, and describes the underpinning competences, knowledge and values they should have. Used alongside occupation-specific guidance, these 'common core principles' form a framework to guide managers and workers, helping to define the additional knowledge and competences needed when supporting someone who is dying.



1. The majority of these workers will be from health and social care organisations, but many other people may be included, such as faith leaders, community workers, or people working in housing or education.



Principle 2

Communication is straightforward, appropriate and timely and is delivered sensitively, taking account of the circumstances, needs and abilities of the person and their carers. Communication reflects an understanding of, and respect for, the person's cultural and spiritual needs.

Communication is appropriate to the circumstances and needs of the person, recognising the range of factors, such as dementia, learning disability, illness or emotional state, which have an impact on communication.

Workers are knowledgeable about how religious or cultural customs and beliefs, or their absence, may impact upon ways of communicating.

Listening skills are used to recognise cues from people and their carers, and open questions are used to them all to express themselves freely if they wish to.

Workers recognise the changing ability and desires of the person, their family and friends to communicate, and adapt their own communication style accordingly.

Where children and young people are among the family and friends, workers are aware of



Principle 3

End of life care is provided through integrated working, with practitioners collaborating to ensure seamless care and support at the point of delivery. Needs are met in ways that are appropriate to the person, rather than being service-led. Workers maintain ongoing communication so that care and support is properly co-ordinated and responsive to changing circumstances and priorities.

Workers have a good understanding of, and respect for, the services provided by their colleagues in other disciplines, and work in partnership with them to meet the needs of the person, their family and friends.

Care and support are delivered in a co-ordinated way and information is shared in a timely and appropriate manner, recognising the range of communication needs and requirements of people, their families and friends, including children and young people.

People are seen within the context of their own communities, being supported to continue to participate in and contribute to them as they wish.

Networks and partnerships are used to identify resources, information and support systems that will benefit people, their families and friends.



Principle 5

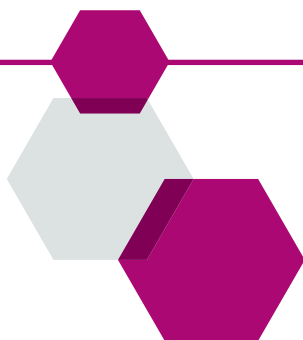
Regular reviews and effective communication ensure that care and support is responsive to the needs and changing circumstances of people, and their carers. Forward planning, including advance care planning, facilitates well-coordinated, organised and delivered care and support.

Care is organised around the needs and circumstances of the person, and is delivered in a co-ordinated manner across services. It is delivered in a way that demonstrates respect for the person, their family and friends, maintaining their dignity at all times. Workers are sensitive to circumstances and their changing nature, and care is delivered accordingly.

Workers support families and friends to take on caring responsibilities where that is desired, but recognise and accept that they may choose not to undertake this role. The rights of carers to be assessed have been strengthened with the introduction of the Care Act in April 2015. Within the Care Act, there is a new single duty for local authorities to undertake a carer's assessment based on whether a carer may appear to have needs for support, either currently or in the future. Carers will be entitled to services and support where their needs meet the national eligibility criteria.

Where conflict arises between the person, their family and friends about the chosen end of life pathway, or advance care plan, the worker is able to work sensitively, and as appropriate to their role, with all parties, to work towards a resolution. This may involve contacting mediation or advocacy services in highly complex situations.

The concerns, fear and anxieties of people, their families and friends are recognised and responded to.



Principle 7

Employers provide appropriate learning and development opportunities for workers to ensure that they are properly equipped to work with people at the end of life. Workers are encouraged to take responsibility for their own learning.

Employers are aware of the ways in which adults learn, and the cultures in which they learn best, and ensure that workers are supported in developing their skills and confidence when working with people who are dying and their families and friends. They recognise the link between a well-trained workforce, an open approach to organisational learning, and excellence in the care and support they provide.

Workers recognise that effective work with people depends upon well-developed knowledge and skills and appropriate attitudes. Good use is made of supervision and other learning and development opportunities to reflect on practice and identify end of life care learning needs. They recognise the limitations of their own practice, seeking support when appropriate.

Workers recognise the importance of all members of the workforce, providing help, support and guidance to each other.

Skills for Care has developed end of life care qualifications in conjunction with a wide range of employers to equip workers to not only recognise end of life situations but to manage them more effectively. They are aimed at all learners in social care and health with an interest in end of life care and also build on these common core competences and principles for end of life care.

To find out more about the end of life care qualifications, visit the Skills for Care website www.skillsforcare.org.uk/endoflifecare.



Competences, underpinning values and knowledge



1. Competences

1.1 Communication skills

Communication is at the heart of every aspect of end of life care. It is important that all workers feel able to talk to people about the things that matter to them, and are knowledgeable about who else to involve if they are unable to deal with any concerns or questions from people or their carers.

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 dif cult 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 people, their families and friends about their concerns related to the end of life and provide information and support.
- e. Work with people, their families and friends in a sensitive and exible 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 con dentiality, to ensure that people receive the best possible care. Ensure that information is clear, and non-jargonistic, so that it can be fully understood by others.

1.2 Assessment and care planning

Assessment is the process of identifying the strengths, needs, wants, and aspirations of people. In end of life care, assessment and care planning (sometimes called support planning) is likely to include medical therapeutic interventions alongside meeting the person's other needs (such as social aspirations, spiritual or religious needs, and interests).

Some assessment is formal, using tools or forms, but much assessment takes place informally, during conversations. It is important that information gathered in this way is still included in care plans, and shared appropriately.

All care planning should be person-centred, with the person always at the heart of any care or support.

Listening to people and their carers, and encouraging them to participate in discussions and decision-making helps to ensure that plans meet their needs as they see them.

Care plans relate to the present and the future, and should be regularly reviewed to meet changing needs, circumstances or priorities. They are not the same as 'advance care plans' (ACPs) which are discussed in 1.4, and are plans made by the person to be acted upon at a later stage to guide care if they have lost capacity. If a person no longer has capacity to make decisions about their care, the ACP may be used by those closest to them to guide decisions about care, including treatment. If a person lacks the capacity to make decisions, the processes required by the Mental Capacity Act (2005) should be followed to ensure that the person's best interests are pursued.

Competences

- a. Work in a person-centred way, listening to and taking account of the wishes of the person and their carers. Recognise people as experts in their own lives.
- b. Understand the range of assessment tools and ways of gathering information including conversation, and know

- c. Be aware of the range of therapeutic options available, including drugs, hormone therapy, physical therapies, counselling or other psychological interventions, complementary therapies, surgery, community or practical support.
- d. In partnership with others, including the person and their carers, develop an end of life care plan which balances disease-specific treatment with care and support that meets the needs and wishes of the person.
- e. Know when a person requires specialist support and ensure that appropriate practitioners are informed.
- f. Ensure that any plan is regularly reviewed and updated to meet changing needs, wishes and priorities, including managing pain and other symptoms.

1.4. Advance care planning

An advance care plan (often called ACP) is a very specific kind of plan. It is drawn up with the person and their carers if that is appropriate, for use only if the person is no longer able to speak for themselves. In the plan the person may talk about the kinds of treatment, if any, they wish to be given, or they may talk about how they want to be treated as they die, for example following their religious or cultural beliefs. The plan can be amended by the person at any time they wish. The plan may be recorded in any format that the person wishes; for example, it could be a video.

If a situation arises where the person cannot say what they want, what they have said in the plan is used to make decisions on their behalf. It is therefore important that anyone who may find themselves in that position is aware of the plan and what it says. For example, some people make it very clear that they do not wish to be admitted to hospital at the end of their

2. Underpinning values

a.

Skills for Care
West Gate
6 Grace Street

