LOROS
Hospice Care for Leicester, Leicestershire & Rutland

NHS England

End of Life Care Education Standards

East Midlands End of Life Care Education Standards

A framework of education standards for all those involved in the care of a person approaching the end of life

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Prepared by: East Midlands Strategic Clinic Network's End of Life Group jointly with LOROS Hospice, Leicestershire

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Suzanne Horobin at suzanne.horobin@nhs.net

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Executive summary

Death and dying affects us all whether professionally, or through our own experience as consumers of healthcare. In order to support this experience it is essential that we are equipped with the right level of skill, knowledge and attitudes to deliver high quality care, but also support ourselves and others within our own community.

This document provides a framework of education standards for anyone involved in the care of those at the end of life. The standards can be used to confirm levels of knowledge and skills, to develop new programmes of education and to inspire new learning and education provision.

The framework covers the knowledge and skills that members of the public in the East Midlands need to make informed choices about their future care and the care of those important to them. Health and social care professionals are also members of the public inevitably exposed to dying in a personal capacity, as well as professionally and need access to support, education and the opportunity to engage with others to meaningfully navigate this experience. The structure of the framework builds on this recognition.

The framework describes five distinct groups; from the general population of the East Midlands to those working within specialist palliative care, whose work is entirely focused on the care of people at the end of their lives. The standards build on each other and follow the patient journey from planning for, and recognition of dying, to care after death and include care of the patient and those important to them. For the purpose of this framework, 'end of life' refers to adults who are likely to die within the next twelve months

For each group there are two parts 'skills' and 'knowledge'. We have used descriptors such as discuss, appraise and debate, to articulate the standard of performance required and to enable measurement of each standard. This framework aims not to be prescriptive about competencies or approaches to training; rather it is a locally developed reference tool which aims to provide standards that training can be developed around.

The framework has been developed collaboratively by Health Education East Midlands, LOROS Hospice Leicestershire and the East Midlands Strategic Clinical Network. It draws on work done already in this area and aims to complement the End of Life Care Core Skills Education and Training Framework (Health Education England, Skills for Health and Skills for Care, 2017). It should also be used in reference to the Ambitions for Palliative and End of Life Care (National Palliative and End of Life Care Partnership, 2015).

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1 How to use these standards

Education Groups

The education standards have been developed and set against five specific groups from A to E. These groups correlate with the tiers used by Skills for Health and Skills for Care.

This group reflects Tier 3 of the EoLC Skills Training Framework.

A. **Specialist Palliative Care Professionals**: Palliative Medicine clinicians, nurses and allied professionals who demonstrate the highest levels of end of life care skills and knowledge, through specialist training. This level includes all of the common core competences for the care and support for the dying person and those closest to them in the last days and hours of life.

These two groups are described as Tier 2 in the EoLC Skills Training Framework.

B. **Adult Health and Social Care Professionals who are *frequently* involved in the care of the dying and those important to them:** GPs, district nurses, paramedics, consultants and medical staff, ward nurses including other specialist nurses and hospice nurses, and social care staff. They need to be enabled to develop or apply existing skills and knowledge to the principles and competences for the care and support of the dying person and those closest to them in the last days and hours of life. They may require additional specialist training.

C. **Adult Health and Social Care Professionals who are *infrequently* involved in the care of the dying and those important to them**: Ancillary staff, ward clerks, reception staff, porters, transport staff, and some nurses, allied health professionals and care assistants who are very infrequently involved in care of the dying. They will require a good basic grounding in the principles and competences for the care and support for the dying person and those closest to them in the last days and hours of life, alongside knowledge of where to seek expert advice or refer on to as needed.

These two groups are described as Tier 1 in the EoLC Skills Training Framework.

D. **People approaching the end of life:** their families, carers and those important to them. Including volunteers and informal carers e.g. partners, family members and volunteers

E. **The general population of the East Midlands**: the general public, adults, young adults and children.

There is a section for each of these five groups within this document. Within each section the standards are listed to follow an individual journey at the end of life; from the recognition that death is approaching and the discussions that should take place, to care in the last days of life and in the period after death for families and those important to the person. This step-wise approach is based on the original End of Life Care Pathway, as set out in the End of Life Care Strategy (DH 2008), it comprises of **six steps** and was developed to help anyone providing health and social care to people nearing the end of life. The standards build on each other and should be considered in a step wise fashion starting at the beginning, recognising that at the simplest level, we are all members of the public and consumers of care.

Within each section there are two parts; these describe the **skills** that the learner should be able to demonstrate, as a result of the **knowledge** they should obtain through training provided. Examples of **learning outcomes** are given for each standard.

The modules from the e-learning programme End of Life Care for All (e-ELCA) have been mapped against these standards (Appendix 1).

At the end of the framework are additional resources that support these standards and should be considered for further reading.

This framework does not describe measures of competency nor prescribe a training approach. These should be locally developed based on expectations in practice. What is described is the underpinning standards that training programmes across the East Midlands should meet in order to deliver high quality care to people at the end of their lives.

Who are these standards aimed at?

These standards are aimed at those staff in all settings who commission or who develop and design training programmes, by setting out clear expectations of what training should deliver.

In addition this framework outlines the knowledge that informal carers and members of the public would benefit from, as well as understanding their role in seeking and accessing support within their own communities.

This framework aims to complement the End of Life Care Core Skills Education and Training Framework (Health Education England, Skills for Health and Skills for Care, 2017) by providing a locally adapted and accessible reference point for ease of use.

2 Core Education Standards

Group E - The general population of the East Midlands

Step	Knowledge	Skills
Discussion as the end of life approaches	Recognises the need to talk openly and honestly about death, dying and bereavement and to make plans for the end of life Identifies reliable sources of information e.g. Dying Matters website, Child Bereavement UK	Discusses their own end of life plans and is able to talk openly and honestly about death, dying and bereavement Engagement in activities that support openness about death, dying and bereavement e.g. Dying Matters Week, making a will, organ donation, collaborative work between schools and hospices
Examples of learning outcomes	1. Discuss the importance of talking openly and honestly about death, dying and bereavement and planning for the end of life 2. Is able to talk openly and honestly about death, dying and bereavement and makes plans for the end of life	
Assessment, care planning and review	Identifies local services to support the dying person and those important to them and how to access these services Describes their own role in supporting and promoting local services that support the dying person and those important to them State what they are entitled to expect as they reach the end of their lives	Is able to access services appropriate to their own needs Engagement in the activities of local services and in their future development
Examples of learning outcomes	1. Is able to name local services that are available to people approaching the end of life and those important to them 2. Is empowered to engage in the future development of these services	
Co-ordination of care	Aware of the local directory of services that support the person in the last year of life and those important to them	Responds compassionately to those members of the community who are dying, facing bereavement or who are bereaved

Step	Knowledge	Skills
	Able to identify the services that might support the dying person and those important to them	Empowered to direct self and others to locally available services
Examples of learning outcomes	1. Is able to list some of the members of the team who may be involved in the care of people approaching the end of life 2. Is enabled to fulfil their role as a compassionate member of their community	
Delivery of high quality care	Relate knowledge of healthy living - nutrition, exercise, smoking cessation and regular health checks - to positive outcomes in quality of life and longevity State some of the long term conditions, other than cancer, that are life limiting	Respond with compassion to people living with a chronic condition and those important to them Respond to opportunities to support people living with life limiting conditions e.g. volunteering, being a good neighbour, donating to charity
Examples of learning outcomes	1. Is able to list some of the conditions, other than cancer, that are life limiting 2. Is enabled to make positive lifestyle choices to improve their chance of health into old age	
Care in the last days of life	Recall some of the changes that might be seen in someone who is dying List some of the teams and people who might be involved in supporting the dying person and those important to them Describes some of the local and national approaches to engage in positive discussion about end of life e.g. Dying Matters awareness week, Able to access information about withdrawal/ denial of treatments, assisted suicide and euthanasia and principles of double effect	Respond with compassion to the dying person and those important to them Respond to opportunities to support the dying person and those important to them e.g. being a good neighbour, being available to them
Examples of learning outcomes	1. Is able to list some of the changes that might be seen in a dying person 2. Is able to state some of the ways in which they can support the dying person and those closest to them	

Step	Knowledge	Skills
Care after death	Recall what to do and who to contact in the event of an expected death including: • Tissue donation • Who to contact when death occurs at home • Registering the death • Funeral arrangements	State who to contact in the event of an expected death and how and when to contact them
	Describe what the physical and emotional needs of the bereaved person might be	Identify the various options for funeral arrangements, dependent upon culture and faith, that are available, e.g. the option of not using a funeral director
	Describe the responses that children have to bereavement and how to talk to them about the person who has died	Is able to normalise death and bereavement within the conscience of the general population
	Describe some of the ways in which bereavement may affect someone close to the person who has died	State where to go for help and support following bereavement
Examples of learning outcomes	1. Is able to describe what to do when someone dies 2. Is able to state where to find help and support following bereavement	

Group D - People who are approaching the end of life

Step	Knowledge	Skills
Discussions as the end of life approaches	Describes what information and services are available to the dying person and those important to them and understands how to access these Recognises the importance of expressing wishes and being empowered to have difficult conversations, including topics that people may want to talk about at end of life Is able to locate written resources that are available in clear language e.g. the NCPC booklet 'What to expect when someone important to you is dying'	Is able to select and access services and feels empowered to make decisions and choices about care and access information sources appropriate to their needs Is able to approach their health care professional and feels empowered to discuss with them their wishes and preferences for care at the end of life Is able to raise other topics that may be of concern to someone who is approaching the end of life
Examples of learning outcomes	1. Is empowered to express their wishes and concerns 2. Is able to access resources and services that support people approaching the end of life and those closest to them	
Assessment, care planning and review	Describes what information and services are available to the dying person and those closest to them and understands how to access them Recognises the choice that they have in planning their care Can state who is involved in the planning and review of their care or the care of someone important to them	Is able to select and access services and feels empowered to make decisions and choices about their care Is able to access information sources appropriate to their needs, including information about Advance Care Planning Can describe their own physical, emotional, social and spiritual needs
Examples of learning outcomes	1. Is empowered to make choices about the care they receive 2. Is able to access resources and services that support people approaching the end of life and those important to them	

Step	Knowledge	Skills
Co-ordination of care	State and locate the services that are available to them over 24 hours, 7 days a week Recognises their own role in the co-ordination of care and is empowered to make decisions and choices Aware of personal health budgets and how to access these	Is able to access services over 24hours, 7 days a week appropriate to their needs Able to self-direct health and social care provision
Examples of learning outcomes	1. Is empowered to make choices about the care they receive 2. Is able to access resources and services that support people approaching the end of life and those closest to them regardless of the time of day or day of the week	
Delivery of high quality care	Recognises their rights to care and services available to them including personal health budgets State the likely progression of their life limiting condition, or that of the person that they are close to Recognises the progression of a life limiting condition and impact on the physical, emotional, spiritual & financial needs of the person affected	Locate and access the information and services available to meet their personal needs at a time and at a level that best suits them
Example learning outcomes	1. Is empowered to make choices about the care they receive 2. Discuss the likely progression of their life limiting condition	
Care in the last days of life	Describe what to expect in the last days of life State who to contact for support in the last days of life Locate written resources that support the dying person and those closest to them e.g. NCPC 'What to expect when someone important to you is dying'	Locates services that support the dying person over a 24 hour/7-day period. Confidently discuss what is important to them at the end of life Confidently discuss with the dying person what is important to them at the end of life
Example learning outcomes	1. Is empowered to fulfil their choices for their care as they die 2. Discuss what to expect when someone is dying	

Step	Knowledge	Skills
Care after death	Recall what to do and who to contact in the event of an expected death including: • Tissue donation • Who to contact when death occurs at home • Registering the death • Funeral arrangements • Administering the estate Describe what the physical and emotional needs of the bereaved person might be Describe the responses that children have to bereavement and how to talk to them about the person who has died Recall the local directory of services available to the bereaved person after the death of a person Recall how to raise care concerns/ complaints Recognise/recall the difference between normal grief reaction and ongoing distress	Identify when there is a need for professional support in bereavement Locate sources of support for adults and children when bereavement is complex Discusses with children their experience of bereavement, their feelings and needs
Examples of learning outcomes	1. Is enabled to seek a variety of sources of support to meet their individual bereavement needs 2. Discuss what to expect when someone is bereaved	

Group C - Adult Health and Social care professionals who are infrequently involved in the care of the dying and those important to them.

Step	Knowledge	Skills
Discussions as the end of life approaches	Recognises the emotional and information needs and concerns of the person approaching the end of life and those important to them Describes how the local Electronic Palliative Care Co-ordination System (or local equivalent) is used Describes the referral process to specialist palliative care teams Recognises the need for the dying person approaching the end of life and those important to them, to explore questions about their care Recognises the needs of people who cannot communicate easily, either because English is not their first language or because they have a sensory, physical or mental impairment	Communicates with the person approaching the end of life and those important to them in an honest way and offers clear information and support Listens and responds sensitively to the emotional needs of the person approaching the end of life and those important to them Listens and responds sensitively to questions and concerns regarding the individualised plan of care, providing information where able to do so but also acknowledging own limitations and referring onto the appropriate member of the care team Respond to the needs of people who cannot communicate easily, either because English is not their first language or because they have a sensory, physical or mental impairment, with understanding including giving additional time and assistance Locates specialist help for the above group, including interpreter services, or communication aids if required Checks understanding of information or explanations given. Proactively provides information in simple, appropriate, straight forward language without using euphemisms e.g. ‘passed away

Step	Knowledge	Skills
Examples of learning outcomes	1. Understands the aims, principles and policies of end of life care and can identify when a person is at end of life 2. Is able to open conversations with people approaching the end of life and those important to them providing clear information and support	
Assessment, care planning and review	Recognises the need for an individualised plan of care that supports the dying person and those important to them Describes their own role in assessing, planning and reviewing the care of the dying person (if any) Defines what Advance Care Planning is and describes their role in this process Relates how the Mental Capacity Act (2005) and its code of practice, guide the planning of care Recognises the need to support the wellbeing of those important to the dying person. Identifies and describes a range of health conditions for which end of life care may be provided	Participates in and contributes to the assessment, planning and review of the care of the dying person Listens and responds sensitively to questions and concerns regarding the individualised plan of care, providing information where able to do so acknowledging the limitations of their knowledge and referring onto the appropriate member of the care team where necessary Proactively elicits and encourages questions about the plan of care Responds sensitively to questions and concerns relating to Advance Care Planning and refers to an appropriate member of the care team where necessary Demonstrates care delivery within the guidance of the Mental Capacity Act e.g. around decision making Clearly explains the facilities available to those important to the dying person within their care environment
Examples of learning outcomes	1. Discuss the principles of holistic care planning and Advance Care Planning 2. Is able to describe their role in delivering a holistic plan of care	
Co-ordination of care	Describes their legal and professional responsibilities in the collection, recording and safekeeping of data	Demonstrates acknowledgement and respect of the wishes of the dying person and those important to them

Step	Knowledge	Skills
	Explain the process for referral in relation to organ and tissue donation State which agencies and teams may be involved in the care and support of the dying person and those important to them Discuss the importance of documenting all aspects of care Describes the role and purpose of an Electronic Palliative Care Co-ordinating System (EPaCCS) and can describe the local approach	Establishes who the dying person wishes information regarding their condition to be shared with and acknowledges and documents their wishes Ensures that the dying person understands what information is being shared and how this will be used and shared Acknowledges the wishes of the dying person in relation to organ and tissue donation and refers appropriately in response to these wishes Documents and communicates conversations with the dying person with respect to their wishes and preferences Identifies and documents changes in the dying persons condition and reports these to the relevant care team Documents and reports any emotional distress of the dying person or those important to them
Examples of learning outcomes	1. Is able to describe their role in the co-ordination of care across the multidisciplinary team 2. Is able to list some of the wishes and preferences regarding their care and support that a dying person might have	
Delivery of high quality care	Identify situations when specialist and/or senior support is required to provide a holistic assessment of care of the dying person Identify situations when the delivery of care and treatment is beyond their competence and referral to specialist and/or senior support is required	Documents and informs key professionals involved in the care of the dying person and those important to them in relation to: • Symptom recognition • Side effects of medications • Anxieties, worries and concerns • Emotional distress • Cultural, spiritual and /or religious needs • Changes in condition

Step	Knowledge	Skills
	Describe the need and process for referral to specialist services Describe the need and process for regular reviews Discuss the importance of timely communication and sharing of information between the dying person and those important to them and those involved in their care and support	Actively promotes the maintenance of privacy and dignity of the patient Complies with professional guidelines for documentation Responds to and acts on any changes in care in a timely way Responds to and supports communication of a review with the dying person and those important to them within the parameters of their role
Examples of learning outcomes	1. Identify situations where specialist /or senior support is required 2. Describe the side effects of medications that are regularly used in the symptom management of the dying person	
Care in the last days of life	Describe and recognise the physical symptoms that may be present when a person is dying. Including: • Pain • Nausea and vomiting • Breathlessness • Noisy breathing • Agitation • Confusion • Dry mouth • Constipation • Urinary retention	Confidently: • Recognises that a person may die within the next few hours or days • Communicates this clearly to the dying person and to those important to them (where appropriate) • Ensures that decisions made and actions taken are in accordance with their needs and wishes • Recognises any anxieties, worries or concerns that the dying person and those important to them have • Ensures that needs and wishes are reviewed regularly and decisions and actions revised accordingly • Explores the needs of those important to the dying person Respects the needs of those important to the dying person and ensures that they are met as far as possible

Step	Knowledge	Skills
	Describe and recognise the psychological symptoms that may be present when a person is dying: • Worries e.g. how will I die? • Concerns e.g. how will you know when I am dead? • Anxieties e.g. who will look after my pet? Explain the rationale for the use of a McKinley syringe pump (or equivalent) and discuss the principles that underpin its use Illustrate how the dying person and those close to them can be involved in decisions about treatment and care Describes situations in practice where there is a need to escalate care and seek support	Competent use and monitor of a McKinley T34 syringe pump (or its equivalent) and follows the policies for its use, if relevant to role Completes the care plan for the use of a McKinley T34 syringe pump (or equivalent) as per local policy, if relevant to role Support the dying persons care needs in the following areas: • To eat and drink as long as they wish to do so and as long as there is no serious risk of harm, having explained such risks/alternatives • Oral care, including consideration of the use of moisture gels and lip salves • Moving and handling as per the manual handling assessment (including the use of bed rails as appropriate) • Hygiene needs, including hair care and shaving • Skin integrity with consideration of the need for pressure relieving equipment Monitors symptoms and the effectiveness of symptom management interventions Recognises and responds to changes in the condition of the dying person and communicates these changes to relevant staff Demonstrates correct use of prescribing guidance Effectively reviews individual plans of care and support for the dying person in the last days and hours of life and escalate when senior review is needed

Step	Knowledge	Skills
Examples of learning outcomes	1. Effectively manage the physical and psychological symptoms that may be present in the dying person 2. Apply the concept of 'Total Pain' to the management of pain in the dying person	
Care after death	Reiterates the process for organ and tissue donation Discuss the opportunities for those important to the deceased to be involved in their care after death	If present at the time of death accurately records details of the death e.g. the time of death, who was present, any known or suspected infection any relevant devices that are in situ such as cardiac defibrillators. Works in accordance with "care of the body after death" policies, respecting any known wishes expressed in the Advance Care Plan and cultural, faith and spiritual needs
	Registered Nurse or Paramedic Discuss the responsibilities of a Registered Nurse or Paramedic in confirming /verifying that a person has died	Registered Nurse or Paramedic Confirms that death has occurred following local and national guidance e.g. Care after death: registered nurse verification of expected death guidance (Hospice UK 2017) Refers to the coroner as necessary Delivers the "first steps of bereavement care" with the dignity of the deceased as their first priority in accordance with local policies and procedures and best practice guidance e.g. Care after death: Guidance for staff responsible for care after death (second edition. Hospice UK 2015)
Examples of learning outcomes	1. Effectively manage the care of the patient after death 2. Discuss a range of faith and cultural practices relating to the care of the deceased person	

Group B - Adult Health and Social care professionals who are frequently involved in the care of the dying and those important to them.

Step	Knowledge	Skills
Discussions as the end of life approaches	Recognises and can discuss the need to involve the dying person and those important to them as much as possible in decisions about their individualised plan of care	Offers the dying person and those important to them (with permission), honest conversations, clear information and support
	Identifies local Electronic Palliative Care Co-ordination System (or local equivalent) and can discuss how this is used to communicate the individualised plan of care	Employs the local Electronic Palliative Care Co-ordination System (or local equivalent) to communicate the individualised care plan and named responsible clinician with all involved in the person's care across a variety of care environments
	Recognises and can discuss the importance of sharing information with appropriate health and social care providers involved in the care and support of the person approaching the end of life and those important to them	Effectively communicates the senior clinical handover from in–hours to out of hours regarding the individualised plan of care
	Recognises and can discuss the need to explore questions from the dying person, their family or those important to them	Effectively communicates the individualised plan of care and support for the dying person to other key professionals involved in the person's care
		Provides clarity in verbal and written handovers between professionals and across shifts & care settings to ensure continuity of care and communication with the dying person and those important to them

Step	Knowledge	Skills
	Senior staff at band 7 and above: Have a working knowledge of the aims and principles of end of life care to confidently and sensitively discuss key information and negotiate with the dying person and those important to them	**Senior staff at band 7 and above:** Develops and maintains communication with people about difficult and complex matters or situations related to end of life care Confidently recognises the emotional needs of the dying person and those important to them and respond in a flexible and sensitive way to these needs
	Other registered professionals: Recognise the need to develop and maintain communication about difficult matters or situations related to care of the patient approaching the end of life and those important to them.	**Other registered professionals:** Confidently recognise the emotional needs of the person approaching the end of life and those closest to them and respond to them on a flexible and sensitive way Sensitively negotiate with the dying person their care needs and discuss with them, and those important to them, key information
	HCA and patient facing support staff: Discuss the emotional needs and concerns of the person approaching the end of life and those important to them Discuss how to respond to these needs in a flexible and sensitive way List other health and social care agencies who may be involved in the care and support of the dying person and those important to them	**HCA and patient facing support staff:** Respond confidently and sensitively to the emotional needs of the dying person and those important to them Listens, acknowledges and responds to the concerns raised by the dying patient and those important to them in a flexible and sensitive manner Signpost appropriately to other health and social care professionals

Step	Knowledge	Skills
Examples of learning outcomes	1. Competently use the local electronic palliative care coordination system (EPaCCS) 2. Is able to hold conversations about advance care planning with people approaching the end of life and those closest to them, demonstrating understanding of the various factors and influences that can affect an individual's end of life choices	
Assessment, care planning and review	Recognises the need to seek a second opinion if there is a continuing difference in opinion about the dying persons treatment or care Recognises and discusses the need for Advance Care Planning and the need for review and re-evaluation of that plan of care Discusses and debates the need to explore questions from the dying person, their family or those important to them .	Initiates Advance Care Planning early in the last year of life, according to the wishes and preferences of the dying person Reviews regularly the individualised plan of care as the patient approaches the end of life in response to changes in the patient's condition or circumstances e.g. decisions around treatment when further deterioration occurs Review any Advance Care Plan/Advance Decision to Refuse treatment (ADRT) in line with the MCA (2005) and its code of practice Confidently negotiate with the dying person and those important to them in relation to their needs and care e.g. the changing need for nutrition and hydration Confidently and sensitively act as a keyworker for the dying person and those important to them as appropriate to their role Confidently recognises the emotional, physical, social and spiritual needs of the person approaching the end of life and those important to them and responds in a flexible and sensitive way to these needs

Step	Knowledge	Skills
		Actively includes the dying person and those important to them in agreeing an individualised care plan, making it clear if they are being informed about, consulted about, involved in or taking particular decisions about treatment and care
Examples of learning outcomes	1. Discuss the aims and principles of Advance Care Planning and apply these to the holistic plan of care of the dying patient 2. Confidently produce a plan of care that involves the dying person and those close to them	
Co-ordination of care	Describe the agencies and teams involved in the rapid discharge/transfer of care including transfer between care settings in an emergency situation Relates the emotional needs of the dying person to their plan of care in relation to complex situations	Demonstrates confidence in establishing where the dying person wishes to be cared for directly with the person or within the 'best interests' framework Responds to and rapidly facilitates discharge /transfer of care including in the event of an emergency Identifies and manages the potential risks caused by multiple sets of documentation Awareness and use of local electronic Palliative Care Co-ordination System (EPaCCS) to communicate care plan and named responsible clinician, with all agencies and multi-disciplinary teams involved in the care of the dying person Demonstrates and role models confidence and sensitivity in negotiating a flexible plan of care for the dying person in complex situations, including recognition of the emotional needs of that person
Examples of learning outcomes	1. Discuss the aims and principles of Advance Care Planning and apply these to the holistic plan of care of the dying patient 2. Confidently produce a plan of care that involves the dying person and those important to them	

Step	Knowledge	Skills
Delivery of high quality care	Describes the changes in condition that should be anticipated in the dying person and discuss the possible responses to these changes	Formulates a plan of care following holistic assessment of the needs of the dying person, where possible, in collaboration with that person and those important to them to identify their hopes and goals
	Discuss reversible causes and when active treatment should be considered	Initiate and manage conversations with the dying person regarding their preferences at the end of life, utilising Advance Care Planning (ACP) in compliance with the MCA (2005) and its code of practice
	List and describe specialist services and identify when it might be appropriate to refer to these services	Provides clarity in verbal and written handovers between teams and individuals across shifts and settings (e.g. community to acute care) to ensure consistent care of, and communication with the dying person and those important to them
	Appraise the effectiveness of symptom management interventions and discuss how their effectiveness might be evaluated and how to respond when interventions are ineffective	Ensures that a senior clinician is informed of or included in any review of the dying person
		Proactively communicate any change in care plan (including the rationale for change) to the dying person, those important to them and to the teams and individuals involved in their care
	.	Competently respond to changes in medication regimes using local prescribing guidance and the safe use in practice of the McKinley T34 Syringe pump (or other device delivering a continuous subcutaneous infusions) as appropriate and relevant to role

Step	Knowledge	Skills
Examples of learning outcomes	1. Describe the rationale for use of a syringe driver 2. Describe the anticipated changes in the dying person and their own role in responding to these changes	
Care in the last days of life	Discuss the need for anticipatory prescribing and the use of different forms of drug administration e.g. patches and pumps Describe the potential side effects of medications commonly used in the symptom management of the dying person and how these may be alleviated Demonstrate understanding of the decision making process when commencing a syringe driver and the importance of communicating this to the dying person and those important to them (where appropriate) Discuss the cultural and faith needs of the dying person and those important to them as they approach death and at the time of death Appraise and debate the challenges and ethical issues regarding nutrition and hydration and the importance of keeping the dying person & those closest to them at the centre of the decision-making process Appraise and debate the use of clinically assisted nutrition and hydration, including the benefit vs burden to the dying person	Assess, manage and document the following physical symptoms that may be experienced by the dying person: • Pain • Nausea and vomiting • Breathlessness • Noisy breathing • Confusion • Dry mouth • Constipation • Urinary retention Initiate, prescribe or administer (as appropriate) anticipatory prescribing of medications for specific/potential symptoms Observe and manage potential side effects of medication Review the response to medications and treatment options and evaluate the dying person's response to these Confidently communicate to the dying person and those important to them the rationale for use of a syringe driver and respond to any questions and concerns that they may have

Step	Knowledge	Skills
	Discuss the importance of the environment to the dying person and those important to them and how their wishes might be met .	Ensure that personal care is delivered to the dying person that meets their hygiene and elimination needs i.e. insertion of a urinary catheter as appropriate Assess, manage and review the cultural and faith needs of the dying person and those important to them before death or at death Complete and review assessments of the nutrition and hydration needs of the dying person and manage these needs appropriately Record clinical decisions regarding the withdrawal, withholding or commencement of clinically assisted nutrition and hydration Create an environment that promotes the maintenance of privacy and dignity and is appropriate to the wishes of the dying person and those important to them Is able to engage the patient and/or those important to them about the appropriateness of intervention where there is possible reversibility and any consequence of this e.g. wrist fracture, sepsis
Examples of learning outcomes	1. Debate the concept of 'a good death' 2. Formulate a holistic plan of care for the management of agitation and delirium in the dying person	
Care after death	Discuss how their own experience of death and dying, their own stress and bias, may affect their response to the bereaved person Identify those who may be at a risk of complicated grief responses e.g. children,	Sensitively discusses with the bereaved the deceased persons wishes to donate organs or tissue where appropriate Sensitively and candidly (without the use of euphemism) informs those close to the deceased

Step	Knowledge	Skills
	people bereaved by a traumatic death, people with learning disabilities, those who have suffered multiple bereavements Discuss and critique theories of loss and grief, and how they might be used to underpin the support of the bereaved person Describes the legal issues regarding consent to organ/tissue donation Doctors: Understand the law and the statutory codes of practice, governing completion of death and cremation certificates	person that death has occurred (having previously identified how and when they wish to be informed) Offers compassionate level one psychological support to those close to the deceased Doctors: Certifies an expected death in a timely way in accordance with local procedure and guidelines for death Is prepared to answer questions from those close to the patient about reporting procedures and post-mortems, or to suggest other sources of information and advice
Examples of learning outcomes	1. Discuss how the care of the deceased person may impact upon the bereavement experience of those close to the deceased 2. Identify those groups who may be at risk of complicated grief	

Group A - Specialist Palliative Care Professionals

Step	Knowledge	Skills
Discussions as the end of life approaches	Recognises and appraises the necessity for discussions around prognosis and Advance Care Planning, including when such discussions need to take place and who needs to be involved in these discussions	Initiates, leads and supports discussions regarding the prognosis and individualised care planning for the dying person with sensitivity and confidence; ensures shared decision making
	Recognises the need to communicate the uncertainties around prognostication at the end of life and identifies who this needs to be communicated to	Is able to sensitively communicate, and discuss with compassion and candour, the uncertainties of prognostication at the end of life
	Recognises and appraises the need to provide open and honest communication regarding the needs and preferences of those approaching the end of life and the needs of those important to them	Identifies those who need to be involved in the discussions about the individualised care planning of the dying person, putting this person at the centre of the discussion; is able to confidently explore and answer their questions and the questions of those important to them
	Applies the theoretical models of grief, loss and bereavement and how the person approaching the end of life, and those important to them, might be affected, and how emotions may manifest themselves	Is able to identify and address communication problems raised by the dying person and those important to them
	Has a working knowledge of the theoretical models and skills that underpin effective communication with the dying person and those important to them	Initiates and manages complex conversations with the person approaching the end of life regarding their preferences for end of life care. Is able to explore and answer specific questions regarding the individualised plan of care including: • Current clinical situation • Agreeing aims & expectations of care being provided • Levels of intervention and/or /treatment implications

Step	Knowledge	Skills
	Is able to locate aids to communication, including translations services and equipment to support communication. Recognises the importance of sharing information with appropriate health and social care providers involved in the care and support of the person approaching and the end of life and those important to them. Describes how to communicate with children and can signpost to resources for children experiencing the death of someone close to them. Has a working knowledge of the legal and ethical frameworks related to decision making at the end of life. This includes the Mental Capacity Act (2005) and Advance Care Planning and the application of its code of practice, choice, consent and power of attorney	• Clinical uncertainties • Issues of supporting nutrition and hydration • Management of symptoms and medication that may be required *The above should be utilising Advance Care planning (ACP) in compliance with the Mental Capacity Act (2005) and its code of practice* Role models sensitive communication to actively seek the wishes of the person approaching the end of life regarding organ /tissue transplantation and DNACPR decisions; and documents and communicates these decisions to others Utilises local Electronic Palliative Care Co-ordination System (or local equivalent) to communicate the individualised plan of care Ensures that decisions re ACP are documented and shared with the appropriate health and social care providers involved in the care and support of the dying person, their family or those important to them Develops and maintains communication with people about difficult and complex matters or situations related to end of life care. Recognising and taking into account the impact of culture, faith and life choices and is non-judgmental, genuine, empathetic, collaborative and supportive in their communication
Examples of learning outcomes	1. Discuss the aims, principles and policies of end of life care and can identify and communicate to others, when a person is at end of life	

Step	Knowledge	Skills
	2. Is able to hold conversations about Advance Care Planning with people approaching the end of life and those important to them, demonstrating understanding of the various factors and influences that can affect an individual's end of life choices	
Assessment, care planning and review	Appraises which decisions need to be made 'on the spot' to ensure the safety and comfort of the affected person and those which can and must wait for a review by the senior doctor who has responsibility for the person's treatment and care e.g. transfer of care to an acute setting Able to prioritise care delivery based on complexity of patient and carer need Evaluate their role in providing specialist support to the care team, the dying person and those close to them in exploring questions regarding a holistic plan of care including: • Current clinical situation • Agreeing aims and expectation of care being provided • Levels of intervention and/or /treatment limitations • Recognising clinical uncertainties • Issues of supporting nutrition and hydration • Symptoms and medications required • Recognising the need for and timing of referral to other specialist services	Provides specialist support to Initiate, review and evaluate the individualised plan of care and considering the views of the wider multi professional team alongside the wishes of the dying person Provides leadership to manage complex situations within the remit of the MCA, 2005 and its code of practice Manage complex situations to negotiate the plan of care with the dying person or act in the best interests of the dying person in the absence of mental capacity Apply clinical judgement to be able to formulate a plan of care following holistic assessment of the dying person's needs, including the identification of their hopes & goals; where possible this is done in collaboration with the dying person and those important to them Apply a range of assessment tools to identify an individual's pain and /or distress, including those with cognitive impairment Utilises patient reported outcome measures (PROMs) eg iPOS and patient feedback to evaluate care Encourages shared decision making with patient when developing plans of care Appraise the circumstances in which life-prolonging treatment can be stopped or withheld

Step	Knowledge	Skills
Examples of learning outcomes	1. Discuss the aims and principles of Advance Care Planning and integrate these into the individualised planning of care of the dying person 2. Demonstrate the ability to plan for situations of clinical uncertainty in collaboration with the dying person and the wider clinical team	
Co-ordination of care	Critiques and evaluates their role in supporting other agencies and multidisciplinary teams involved in the care and support of the dying person Reviews Advance Care Plans, and Advance Decision to Refuse Treatment (ADRT) in relation to the Mental Capacity Act (MCA) 2005 and its code of practice Identify resources for bereaved children Describes how to recognise dying and the changes in the plan of care that need to be anticipated to support the dying person in the last days and hours of life	Proactively provides specialist support to other agencies and multidisciplinary teams supporting the care needs and wishes of the dying person Role models sensitive communication to actively seek the wishes of the dying person in relation to organ/tissue donation Communicates with and supports children who have been bereaved and/or signposts them to resources to support them Demonstrates confidence in negotiating an individualised plan of care with the dying person and those important to them Anticipates and recognises changes in the dying persons condition in the last days and hours of life and evaluates the plan of care in response to these changes
Examples of learning outcomes	1. Understands the aims and principles of Advance Care Planning and can integrate these into the planning of care of the dying person 2. Demonstrates the ability to plan for situations of clinical uncertainty in collaboration with the dying person and the wider clinical team	
Delivery of high quality care	Critique their own role in the assessment and management of the complex physical, psychological, social and spiritual needs of the dying person and those important to them	Assess and manage the following complex physical symptoms: • Pain • Nausea and vomiting • Breathlessness • Noisy breathing • Agitation and confusion • Dry / sore mouth

Step	Knowledge	Skills
		• Constipation • Urinary retention
	Describes and compares a broad range of disease processes including long term conditions and cancer	Is able to assess for differential diagnosis, recognise reversible processes and appraise appropriate, alternative treatment Supports the transfer of care delivery across clinical settings
	Comprehensive understanding of Advance Care Planning including capacity, advance decisions to refuse treatment and role of advocates	Demonstrates expert level of knowledge in relation to symptom management (minimum BSc)
	Appraise the role of specialist palliative care in relation to long term conditions and cancer	Supports the delivery of care based upon shared decision making with the patient regardless of the ethical challenges that an unwise decision made by the patient may present e.g. a decision by the patient to continue with therapies when there is no evidence base to support this
	Debates the legal and ethical challenges in palliative care including those relating to nutrition & hydration and best interests decision making	Confidently lead the review of existing medications, current symptoms and medication /treatment options
	Appraise and debate how the individual psychological, cultural, spiritual and religious needs of the dying person and those important to them can be met	Lead the review of medications to prescribe or stop (including anticipatory medications); document and communicate reasoning whilst involving the dying person and those important to them
	Relate how individual cultural needs should be considered and acted upon before death, at death and after death	Acts as a competent and knowledgeable resource in the application and use of a continuous subcutaneous infusion (CSCI) e.g. McKinley T34 syringe driver and where appropriate, deliver training on its use

Step	Knowledge	Skills
		Role model high quality palliative care and provide peer support to colleagues (e.g. in the management of complex nutrition and hydration and appropriate decision making) whilst keeping the dying person and those important to them at the centre of the decision-making process Delivers specialist training and education to others Acts as a keyworker for the dying person and those closest to them
Examples of learning outcomes	1. Competently make decisions within the MCA (2005) and its code of practice and best interest decision guidance to make decisions if a person lacks capacity regarding nutrition and hydration 2. Develop a plan of care with the patient and those important to them considering their specific cultural or faith needs before death or at death	
Care in the last days of life	Recognise and appraise the need for and timing of referral to specialist services Appraise the need for regular specialist palliative review of the dying person Recognises dying, where dying may be reversible and appropriateness of intervention Recognises dying within a range of disease processes including long term conditions and frailty	Supports the care delivery and management of symptoms by junior tier 1 staff and tier 2 and tier 3 staff Provides peer support and education for staff who are infrequently and frequently involved in the care of the dying and those important to them Ensures regular review of the dying person and those closest to them and responds to the review through amendment or continuation of the plan of care Provides specialist review to support the care delivery and management of the dying person
Examples of learning outcomes	1. Review and audit the standard of pain management for patients dying with dementia 2. Evaluate the effectiveness of clinical supervision within a team	

Step	Knowledge	Skills
Care after death	Recognise and appraise the need for and timing of referral to specialist bereavement services Critiques grief theories and how they might underpin the care of the person experiencing complex grief	Provides informal clinical supervision and support to staff who are involved in the care of the dying Provides psychological support to people experiencing complex grief Undertakes a bereavement risk assessment
Examples of learning outcomes	1. Investigate the provision of bereavement support for those experiencing complex grief 2. Debate the concept of a 'good death'	

3 Additional Resources to support these standards

Child Bereavement UK *'Support for bereaved children'.*
Available at:
http://childbereavementuk.org/for-families/support-for-bereaved-children/

Department of Constitutional Affairs (2007), *Mental Capacity Act 2005 Code of Practice* Available at:
https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

Department of Health (2008), *End of Life Care Strategy: Promoting high quality care for all adults at the end of life*. Available at:
https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life

Department of Health (2016), *Our Commitment to you for end of life care: The Government Response to the Review of Choice in End of Life Care* Available At:
https://www.gov.uk/government/publications/choice-in-end-of-life-care-government-response

Dying Matters: "*Why should we develop compassionate communities?"*
Available at:
http://www.dyingmatters.org/sites/default/files/user/documents/Resources/Community%20Pack/1-Introduction-1.pdf

General Medical Council (2013), *Treatment and care towards the end of life: good practice in decision making.* Available at:
http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_care.asp

Greater Manchester, Lancashire and South Cumbria Strategic Clinical Network's Palliative and End of Life Care Education and Training Group (2014). *Recommended Core Education Standards for Care and Support for the Dying Person in the Last Days and Hours of Life.* Available at:
http://www.gmecscn.nhs.uk/attachments/article/109/RecommendedCoreEducationStandardsforCareandSupportfortheDyingPerson.pdf

Hospice UK. (2015) *Care after death: Guidance for staff responsible for care after death. Second edition.* Available at:
https://www.hospiceuk.org/what-we-offer/publications?cat=72e54312-4ccd-608d-ad24-ff0000fd3330

Hospice UK (2017*)Care after death :Registered Nurse Verification of Expected Adult Death* Available at:
https://www.hospiceuk.org/what-we-offer/publications?cat=72e54312-4ccd-608d-ad24-ff0000fd3330

Leadership Alliance for the Care of Dying People (2014), *One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/323188/One_chance_to_get_it_right.pdf

National Institute for Health and Care Excellence (2011), *NICE quality standards: End of life care for adults (qs130).* Available at: https://www.nice.org.uk/guidance/qs13

National Council for Palliative Care (2015), *Every moment counts: A narrative for person centred care for people near the end of life*. Available at: https://www.nationalvoices.org.uk/sites/default/files/public/publications/every_moment_counts.pdf

National Council of Palliative Care (2014) *Life after death.* Available at: http://www.ncpc.org.uk/sites/default/files/LifeAfterDeath.pdf

National Council of Palliative Care (2014). *Planning your future care.* Available at: http://www.ncpc.org.uk/sites/default/files/planning_for_your_future_updated_sept_2014%20%281%29.pdf

National Council of Palliative Care (2015). *What to expect when someone important to you is dying.* Available at: http://www.ncpc.org.uk/sites/default/files/user/documents/What_to_Expect_FINAL_WEB.pdf

National Palliative and End of Life Care Partnership (2015), *Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020*. Available at: http://endoflifecareambitions.org.uk/

Office for National Statistics (2015), *National Survey of Bereaved People (VOICES)* Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthcaresystem/bulletins/nationalsurveyofbereavedpeoplevoices/england2015

Skills for Care & Skills for Health (2014), *Common Core Principles and Competences for Social Care and Health Workers Working with Adults at the End of Life (2nd edition)* Available at: http://www.skillsforcare.org.uk/Documents/Topics/End-of-life-care/Common-core-principles-and-competences-for-social-care-and-health-workers-working-with-adults-at-the-end-of-life.pdf

The Choice in End of Life Care Programme Board (2015), *What's important to me: A Review of Choice in End of Life Care* Available at: https://www.gov.uk/government/publications/choice-in-end-of-life-care

Together for Short Lives '*Difficult conversations for young adults'* Available at: http://www.togetherforshortlives.org.uk/families/information_for_families/7836_difficult_conversations_for_young_adults

4 Appendix

End of Life Care for All e-learning modules mapped to groups

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
00_01Introduction to e-learning for end of life care						
00_02 Relationship Between Palliative Care and End of Life Care	C	C	C	C	C	C
01_01 Introduction to principles of ACP		B,C				
01_02 Cultural and Spiritual Considerations in ACP	B,C	B,C	B,C	B,C		
01_03 Benefits and risks of ACP to patients, families and staff		B,C		B,C		
01_04 ACP in practice: using end of life care tools	B,C	B,C				
01_05 Advance Decisions to Refuse Treatment: Principles	B	B				
01_06a Advance Decisions to Refuse Treatment in Practice	B	B				
01_07 Mental Capacity Act - Aims and Principles	A,B	A,B				

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
01_08 Mental Capacity Act in practice	A,B	A,B	A,B	A,B		
01_09 Approaching ACP when capacity is uncertain, fluctuating or likely to deteriorate	A,B	A,B	A.B	A,B		
01_10 ACP and different trajectories	A,B	A,B		A,B	A,B	
01_11 Introduction to conducting conversations about advance care planning	A,B	A,B				
01_12 How to get started and get the timing right	A,B	A,B				
01_13 How to handle patients' questions and concerns	A,B	A,B				
01_14 How to Document Conversations About Advance Care Planning	A,B	A,B				
01_15 How to Negotiate Decisions Which May be Difficult to Implement	A,B	A,B				
01_16 How to review previous ACP decisions	A,B	A,B				
01_17 Developing ACP in your organisation	A,B	A,B				

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
01_18 Developing your practice: clinical supervision, further reading.	A,B	A,B				
02_01 Introduction to principles of assessment in end of life care: Part 1		B,C				
02_02 Introduction to principles of assessment in end of life care: Part 2		B,C				
02_03 Assessment of Physical Symptoms		B,C		B,C		
02_04 Assessment of physical function		B,C		B,C		
02_05 Assessment of psychological well-being		B,C		B,C		
02_06 Assessment of Social and Occupational Well-being		B,C		B,C		
02_07 Assessment of spiritual wellbeing		B,C		B,C		
02_08 Context of assessment: cultural and language		B,C		B,C		
02_09 Bereavement assessment and support						B
02_10 Carer assessment and support		B		B		B

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
02_11 Assessing through proxies		A				
02_12 Assessing those with fluctuating mental capacity		A				
02_13 Assessing Urgent Situations with Limited Information	B	B	B			
02_14 Assessment of dying phase and after-death care					C	C
02_15 First assessment: meeting the patient		B,C	B,C	B,C		
02_16 Identifying the patient's goals and priorities		B,C	B,C	B,C		
02_17 Documentation, communication and coordination		B,C	B,C	B,C		
02_18 Following up Assessments and Evaluating Outcomes		B,C	B,C	B,C		
02_19 Uses and limitations of assessment tools		B,C	B,C			
03_01 The importance of good communication	C,D,E					
03_02 Principles of communication	C,D,E					

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
03_03 Communicating with ill people	C,D					
03_04 Talking with Ill People Considering the Surrounding Environment	C,D					
03_05 Culture and Language in Communication	C,D					
03_06 Communication skills for administrative staff, volunteers and other non-clinical workers	B,C,D					
03_07 Self-awareness in communication	B,C,D,E					
03_08 Understanding and Using Empathy	B,C,D,E					
03_09 Skills which facilitate good communication	B,C,D					
03_10 Things which block good communication	B,C,D					
03_11 Face to face communication skills	B,C,D					
03_12 Telephone communication	B,C,D					
03_13 Written communication skills	B,C,					

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
03_14 Information Giving	A,B					
03_15 Breaking Bad News	A,B					
03_16 Communicating with non-English speaking patients	A,B,C					
03_17 Communicating with people with speech and hearing difficulties	A,B,C					
03_19 Request for organ and tissue donation	A,B,C					
03_18 Communicating With Children and Young People	A,B					
03_20 Request for euthanasia	A,B					
03_21 Legal and Ethical Issues Embedded in Communication	A,B					
03_22 Am I Dying How Long have I Got Handling Challenging Questions	A,B					
03_23 "Please Don't Tell My Husband" - Managing Collusion	A,B					
03_24 "How dare you do this to me!" - managing anger	A,B					

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
03_25 “I don’t believe you, I’m not ready to die!” Managing Denial	A,B					
03_26 What Will it Be Like Talking About the Dying Process	A,B					
03_27 "Why can't I stay here" "I don't want to stay here" - when preferred place of care cannot be met	A,B					
03_28 "I'm not loveable anymore" - discussing intimacy in end of life care	A,B					
03_29 "Why me?" - discussing spiritual distress	A,B					
03_30 Discussing 'Do Not Attempt CPR' Decisions	A,B					
03_31 Discussing food and fluids	A,B					
03_32 Silence: The Withdrawn Patient	A,B					
03_33 Distress: the crying patient	A,B					
03_34 Dealing With Challenging Relatives	A,B					

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
03_35 Challenging communication with colleagues	A,B					
04_01 General approach to assessment of symptoms		B,C				
04_02 Agreeing a plan of management and care		B,C				
04_03 Communicating the Plan of Management and Care			B,C	B,C		
04_04 Individual preferences and cultural influences on symptom management		B,C	B,C	B,C		
04_05 Influence of Transition Points and Crises on Decision-Making in Symptom Management		A,B		A,B		
04_06 Recognising Your Own Limitations in Symptom Management		A,B		A,B		
04_07 Assessment of Pain		A,B		A,B		
04_08 Principles of pain management		A,B		A,B		
04_09 Drug management of pain: core knowledge		A,B		A,B		

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
04_10 Opioids in pain management: advanced knowledge		A,B		A,B		
04_11 Managing Different Types of Pain		A,B		A,B		
04_12 Assessment of breathlessness		A,B		A,B		
04_13 Drug management of breathlessness		A,B		A,B		
04_14 Non-drug management of breathlessness		A,B		A,B		
04_15 Causes of nausea and vomiting		A,B		A,B		
04_16 Assessment of nausea and vomiting		A,B		A,B		
04_17 Management of nausea and vomiting		A,B		A,B		
04_18 Assessment of Constipation		A,B		A,B		
04_19 Management of constipation		A,B		A,B		

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
04_20 Management of Bleeding		A,B		A,B		
04_21 Management of seizures		A,B		A,B		
04_22 Recognising and Managing Malignant Spinal Cord Compression		A,B		A,B		
04_23a Recognising the Last Months and Days of Life and Verifying Death					B,C	
04_23b Symptom Management for the Dying Adult					B,C	
04_24 Managing Death Rattle					B,C	
04_25 Agitation and Restlessness in the Dying Phase					B,C	
04_26 Managing distress during the dying phase					B,C	
04_27 Using Syringe Drivers				A,B		
04_28 Non-drug intervention in symptom management				A,B,C		
04_29 Symptom Management in People with Learning Difficulties or Mental Health Problems				A,B,C		

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
04_30 Symptom Management Complicated by Coexisting Conditions	A.B			A,B		
04_31 Management of symptoms associated with wounds	A,B			A,B		
04_32 Assessment of Mood		A,B		A,B		
04_33 Assessment and Management of Anxiety		A,B		A,B		
04_34 Management of Depression		A,B		A,B		
04_35 Assessment and Management of Agitation		A,B		A,B		
04_36 Recognising and managing fatigue		A,B	A,B	A,B		
04_37 Assessment and management of weight loss and loss of appetite		A,B	A,B	A,B		
04_38 Management of Sore Mouth and Other Oral Problems		A,B	A,B	A,B		
04_39 Assessment of physical and cognitive deterioration in function		A,B	A,B	A,B		

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
04_40 Management of physical deterioration		A,B	A,B	A,B		
04_41 Management of Cognitive Deterioration		A,B	A,B	A,B		
05_01 Initiating Conversations about End of Life Care: COPD	B	B				
05_02 Initiating conversations about EoLC: cancer	B	B				
05_03 Initiating Conversations about End of Life Care: Dementia	B	B				
05_04 Initiating conversations about EoLC: long term neurological conditions	B	B				
05_05 End-stage Cardiac Disease	B	B	B	B	B	
05_06 Case Study Motor Neurone Disease	B	B	B	B	B	
05_07 Case study: COPD	B	B	B	B	B	
05_08 Case study: End-stage Renal Disease	B	B	B	B	B	
05_09a End of Life Care for People with Dementia	B	B	B	B	B	

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
05_09b Case study: dementia	B	B	B	B	B	
05_10 Ambulance Called to Home	B	B	B	B	B	
05_11 Scenario: terminal agitation - patient in a care home	B	B	B	B	B	
05_12 Dying in Acute Hospitals	C	C	C			
05_13 When the dying process is protracted or unexpectedly fast	C	C	C	C	C	
05_14 Sudden unexpected death	C			B,C	C	C
05_15 Dying As A Prisoner	B,C	B,C	B,C	B,C	B,C	
05_16 Dying as a homeless person	B,C	B,C	B,C	B,C	B,C	
05_17 Dying in Intensive Care	B	B	B	B	B	B
05_18 Treatment and Care Towards the End of Life Good Practice in Decision	**B DOCTORS**	**B DOCTORS**	**B DOCTORS**	**B DOCTORS**	**B DOCTORS**	**B DOCTORS**
05_19 Care After Death Introduction to Care After Death						B,C

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
05_20 Care After Death II Providing Personal Care After Death						A,B,C
05_21 A Unified DNACPR Policy	A,B	A,B	A,B		A,B	
05_22 Using the NHS Continuing Healthcare Fast Track Pathway Tool		B,C				
05_23 Framework for End of Life Care in Advanced Kidney Disease		A,B	A,B			
Sessions for social workers and social care workers						
06_01 Supporting People to Live and Die Well		B,C	B,C		B,C	
06_02 Palliative Care Social Work	B,C	B,C	B,C			
06_03 Assessment in End of Life Care	B,C	B,C		B,C		
06_04 Support and Care Planning at End of Life	B,C		B,C			
06_05 Hospital Social Work			A,B	A,B		
06_06 End of Life Care in Care Homes and Domiciliary Care Settings	B,C	B,C	B,C	B,C	B,C	B,C

STANDARD	1.Discussion as the end of life approaches	2. Assessment care planning and review	3. Co-ordination of care	4. Delivery of high quality care	5.Care in the last days of life	6.Care after death
07_01 Talking about death and dying	A,B,C,D,E					
07_02 Assessment of Carers' Needs		B,C				B,C
07_03 Practical Support After a Bereavement						A,B,C
07_04 Sudden Death and Bereavement					A,B,C	A,B,C
07_05 Emotional Support and Signposting	B,C,D,E					
07_06 Children and Bereavement	A,B,C					A,B,C
08_01 Spirituality and the philosophy of end of life care				A,B,C		
08_02 Understanding and assessing spiritual need and distress		A,B				
08_03 Spiritual care and the models of spiritual intervention	A,B	A,B	A,B		A,B	
08_04 Spiritual resources and quality of life		A,B				
08_05 Spirituality and the multidisciplinary team		A,B	A,B	A,B		
08_06 Spirituality in the community		A,B	A,B			

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Suzanne Horobin at suzanne.horobin@nhs.net