

CONTENTS

PAGE

1. "Care" means "Enablement"	page 4
2. Introduction	page 6
3. How the Framework was Developed	page 7
4. What is Intermediate Care?	page 8
5. Multi-Agency Education	page 9
6. What is Capability?	page 9
7. The Essentials	page 10
8. Capability Framework for Staff Working across Intermediate Care Services	page 11
9. Using the Framework	page 11
10. References	page 21
11. Acknowledgements	page 22

1 “CARE” MEANS “ENABLEMENT”



In 2002, when I was 36, I contracted the blood poisoning form of meningitis. As a result, my lower arms and lower legs had to be amputated. After the acute phase of my care, I spent over six months in a specialised rehabilitation hospital. Now I'm supported in the community by my GP and NHS Lothian's prosthetics service. It might surprise you that by far the hardest stage of my rehabilitation was making the transition from hospital care to care at home.

Adjusting to being at home was physically, emotionally and psychologically draining. I felt as if all the progress I had made in hospital was slipping away from me. As a result, both my energy and my confidence levels dropped and that made it even harder to motivate myself to keep doing what I knew I was well able to do for myself - never mind try new things.

Although I still saw the same physiotherapists and the same prosthetist who had looked after me in hospital, there was no handover or coordination between the other hospital staff and the community personnel who took over from them. In the community I did have access to all the services I needed but there was no network or communication among them about me and in particular there was nobody with overall responsibility for making sure that I was okay. That made me feel vulnerable. From being used to having everything arranged for me, I suddenly had to work out for myself how physically (with limited mobility) to get to each rehabilitation location and how to pay for the journey. I also had to take instant responsibility for

deciding the extent to which I would access each service. If I stopped attending, I wouldn't be able to return without going through a referral procedure. I felt abandoned rather than empowered by the sudden loss of support.

So, just at the time when I was having to dig deep to cope with the physical demands of being at home alone, the psychological challenge of creating a new life and the emotional low of coming to terms with the contrast between what I had been pre illness and what I was now – the very time when I could have done with extra support - supervision and co-ordination simply stopped. The aim of this framework is to equip staff with the capability to promote smooth patient journeys through transitions of care so that people don't feel the joins and are actively enabled to cope with the challenge of change - as well as the challenge of their condition(s).

For some of my older fellow patients, (especially those with social problems or limited family support) it was even harder to cope following discharge from hospital. Going home meant loneliness and worry about money and the practicalities of day to day living. People are multi faceted social beings whose needs must be considered in the round. There's no point in only looking after the body because our motivation to push our bodies is so closely tied up with our emotional and psychological satisfaction with the way we are living our lives. Effective integration of social and health care services which take all aspects of the whole person into account is central to this framework.

Institutionalisation is the inevitable result of a hospital stay. It stifles drive and desire for autonomy - which are exactly what people need when they get home. The good news is that most human beings have amazing restorative inner resources and a natural inclination to achieve their full potential – whatever the limitations of their circumstances. It's your job, both in hospitals and in the community, to find, stimulate and nurture people's personal motivation to try to be the best they can be – and you can only do that if you really know the person. Person centred care underpins this framework.

The goal of intermediate care is maximum meaningful independence at home. The answer isn't mollycoddling because old-fashioned care alone will not stimulate personal motivation. You have to enable people to help themselves. In the context of intermediate care, “care” actually means “enablement”. The key to delivering effective, person centred enablement is to plan and coordinate care in a flexible way across the traditional boundaries between phases of care, between different health services and between health and social care services - and most of all, to engage the mind, body and spirit of the individual in that process. This framework will help you to develop your capability to do that.

Olivia Giles

Chair, National Implementation Group for the Adult Rehabilitation Framework in Scotland

Olivia Giles foreword elegantly sets out the need and the purpose of intermediate care. The framework that follows then sets out how we can better equip health care professionals to meet that purpose.

Key in this is the enabling of independence for those who need intermediate care. This requires sensitivity to an individual's capabilities and potential and a supportive, caring and whenever appropriate, challenging approach – which could be characterised as a cool head and a warm heart on the part of those for whom this capability framework has been developed. To get the balance right and develop a truly therapeutic relationship requires considerable skill. We, in Lanarkshire, recognise these challenges and have been supportive of the development work which has been undertaken so far and of the need for it to be developed further in the future. For now, I hope that the framework provides a significant step forward in improving intermediate care services.

Paul Wilson

Executive Director for Nurses, Midwives and Allied Health Professions
NHS Lanarkshire”



2

INTRODUCTION - A CHANGE IN APPROACH

This is the first time a capability framework has been developed by health and social care partners in Scotland. It focuses on Intermediate care, but the capabilities, knowledge and learning outcomes can be used for other care groups. This framework will also be an important step towards a capable community workforce that has the skills to support better health, better care for older people and people living with long term conditions. It will help build an integrated workforce that is fit for the future and helps people realise their full potential for health, independence and wellbeing.

Capable, Integrated and Fit for the Future was funded by NHS Education for Scotland (NES) and developed by NHS Lanarkshire in partnership with North and South Lanarkshire Councils. It highlights the capabilities needed by staff who work at the interface between hospital, home and community settings. It recognises that people who use these services need support from a wide range of professionals - specialist, generalist and support staff from different agencies. It describes the core skills and range of capabilities required. It also illustrates how to make the most of the contribution of the whole health and social care team by sharing learning, exchanging good practice and seeking new ways of working.

Changing Lives –Report of the 21st Century Social Work Review (2006) and the Better Health Better Care Action Plan (2007) set out a vision for care where professionals and partner organisations work collectively to help people become full partners in their own care. This approach requires us all to respond to each individual's needs, preferences and goals, and to do so with respect and compassion. Both documents encourage the development of tools that fully support staff as agents of change and improvement.

Better Health Better Care states "improvement can only be achieved through shared ambition and effective joint working".

In Planning Tomorrow's Workforce Today we need to take a more integrated approach to developing the capability of staff in the public and voluntary sectors.

This includes exploring new and extended roles for staff and more collaboration in creating development opportunities across care settings and sectors. Developing the workforce in acute, primary and community care settings is vital to delivering a shift towards community based services which are modern, safe and sustainable and give better and faster access to care locally.

3

HOW THE FRAMEWORK WAS DEVELOPED

The Capability Framework was developed with multi-agency staff who work with people and their carers across a wide range of intermediate care services. Between December 2006 and April 2007 focus group discussions were held with multi-agency staff from a variety of intermediate care services, exploring the competencies that exist now, the current challenges in delivering care within intermediate care services and the skills and capabilities staff need to undertake these roles. At the same time, two focus groups were held with people and their carers who have used intermediate care services. All the issues raised have driven the Capability Framework. NES and the Joint Improvement Team(JIT)supported national consultation on the draft framework through their professional and learning networks.



4

WHAT IS INTERMEDIATE CARE?

'Intermediate care' is simply enabling, rehabilitative and treatment services delivered through an integrated approach and in community settings. Intermediate care services effectively shift the balance of care from hospital to the community by acting as a bridge at key points of transition in the patient's journey from home to hospital and back home again and from illness to recovery.

Demographic changes will make intermediate care services even more important in the future. Over the next 25 years the proportion of the population aged over 80 years will increase to one in twelve, while one in four will be over 65 years.

In general, the older a person gets the more likely they are to suffer ill health and a long-term condition. Intermediate care is vital to tackling the challenges of ageing and rising numbers of people living with long-term conditions. These changes have significant implications for workforce education and training (Price 2004).

The Framework for Adult Rehabilitation in Scotland recommends jointly planned and commissioned intermediate care services which make the most of opportunities for rehabilitation in local communities.

Services can be provided in:

- **Individuals' own homes, sheltered housing and very sheltered housing complexes**
- **Day hospitals, day care and integrated day services**
- **Designated beds in local authority or independent provider care homes**
- **Designated beds in Community Hospitals**

Across the UK there are several definitions for Intermediate care. The Department of Health's Change Agent Team defined Intermediate Care as "A service provided on a short term basis at home or in a residential setting (usually about 6 weeks) for people who need some degree of rehabilitation and recuperation.

Its aims are to prevent unnecessary admission to hospital, facilitate early hospital discharge and prevent premature admission to residential care" (Making Connections 2006)

The Joint Improvement Team's Intermediate Care Learning Network (www.jit.org.uk) describes intermediate care in Scotland as care which substitutes for elements of acute hospital care, is delivered locally, and integrates a variety of services for people whose health and care needs are complex and / or changing at times of transition.

For the purpose of this Capability Framework, the Lanarkshire partners and people who use services agreed five key principles to underpin Intermediate Care.

These five key principles are:

Why: To increase opportunities for people to live independently in their own home.

Who: People who would otherwise face a long hospital stay or unnecessary delay in discharge from hospital; inappropriate admission or early readmission to hospital; or premature admission to long term institutional care

Where: If safe and practical, support people to remain or return to live in their own home with mainstream support or home based intermediate care services. Where that is not possible, provide Intermediate care locally in an appropriate primary or community care setting locally

What: Intermediate care applies a holistic assessment based on the single shared assessment (SSA) process. Care planning should be person centred around individualised goals and outcomes, with a programme of maintenance and regular review.

How: All professionals and support staff involved should work together as a team and use an enabling approach helping people build their confidence, independence and ability to self manage.



5

MULTI-AGENCY EDUCATION

With the rise in integrated services and roles changing so rapidly we need staff to be flexible and adaptable. Working out what skills are needed for a particular role is no longer easy. It is also difficult for education and training to reflect all the changes taking place in health and social care services (Price 2004). The range of roles undertaken by staff in health, social care and housing adds to this complexity.

But, a Capability Framework offers enough flexibility in education and training to allow staff to develop to meet the future demands of health and social care delivery. Capability effectively combines the competence needed to do the job today with the potential to develop more skills as job and circumstances change. A Capability Framework is therefore fit for now and fit for the future (Price 2004).

6

WHAT IS CAPABILITY?

This framework is based on the idea of capability. It is adapted from work undertaken by the Sainsbury Centre for Mental Health (2001), the Department of Health (2004), the Combined Sheffield Universities Interprofessional Learning Unit (2004) and NHS Education for Scotland's (NES) recent capability frameworks (2006).

Capability is the continued development of a practitioner's ability and potential. It is also essential to lifelong learning and personal and professional development.

- **competence describes what individuals know or are able to do in terms of knowledge, skills and attitudes at a particular point in time.**
- **capability describes how an individual can apply and adapt learning from experience and continue to improve his or her performance**

It is different from competence:

A Capability Framework is a broad outline of what practitioners should be able to do in practice.

It focuses on:

- **realising people's full potential**
- **developing the ability to adapt and apply knowledge and skills**
- **learning from experience**
- **envisaging the future and helping to making it happen**



7

THE ESSENTIALS

The following ten capabilities describe what capabilities staff of all grades and professional backgrounds should have or develop. There is no ranking of importance – all are equally important. These essential capabilities have been incorporated in the framework.

1. Work in partnership.

Develop and maintain constructive working relationships with people who use intermediate care services their carers and multi-professional colleagues to design, deliver and evaluate care and treatment across organisational, geographical and professional boundaries.

2. Respect diversity.

Provide care, support and treatment in ways that respect and value diversity in, for example, age, race, culture, disability, gender, spirituality and sexuality.

3. Practise ethically.

Recognise the rights of people and their carers, and provide information to increase understanding, inform choices and support decision-making. Provide care, support and treatment based on professional, legal and ethical codes of practice.

4. Challenge inequality.

Identify where care and support can be improved and devise solutions to give people and their carers access to the best quality care, regardless of their personal circumstances or where they live

5. Identify needs of people and their carers.

Work in partnership to identify health, well-being and social care needs of individuals and their carers.



6. Provide safe person-centred care.

Provide safe, effective and responsive care that meets the holistic needs of people and their carers within the parameters of the role and in accordance with professional codes of conduct and clinical governance.

7. Make a difference.

Continually undertake multi-agency review and evaluation to ensure best quality, evidence-based, values-based care that meets the individual needs of people and their carers is offered.

8. Promote rehabilitation approaches.

Recognise the relevance of rehabilitation for all individuals. Work in partnership with individuals, carers and multi-agency colleagues to set realistic goals, foster hope, and develop and evaluate realistic, sustainable programmes of rehabilitation that emphasise self care.

9. Promote self-care and empowerment.

Take active steps to work with, involve and support people in addressing their own health care needs, maximise their potential within the limits of their illness and enable them to live as independently as possible.

10. Pursue personal development and learning.

Keep up to date with changes in practice, seek opportunities to expand knowledge, skills and experience and participate in lifelong learning. Pursue personal and professional development for self and others through supervision and reflection in and on practice.



8

CAPABILITY FRAMEWORK FOR STAFF WORKING ACROSS INTERMEDIATE CARE SERVICE

Building on these essential capabilities the Capability Framework is presented under seven main headings:

- Knowledge for Practice
- Holistic Assessment
- The Multi-agency Approach
- Practising Ethically
- Care and Intervention.
- Spiritual Care
- Mental Health and Well Being

Each of the sections contains:

Capabilities - broad statements of intent

Practice learning outcomes - details of the knowledge, skills, attitudes and behaviours professionals should demonstrate in practice

Key content - a broad outline of the knowledge needed to achieve the practice learning outcomes to guide staff and reviewers

9

USING THIS FRAMEWORK

Who is the Framework For?

The Capability Framework is aimed at staff at all levels/ grades involved in the delivery of intermediate care in health and social care services. The framework applies to the individual staff member's role and remit. The focus of the document is intermediate care and as rehabilitation is a vital part of intermediate care it is also included. The framework is not, however, intended to be a comprehensive rehabilitation framework.

How can the framework be used?

The framework can be used to

- plan personal development
- develop education and training
- develop work based learning

The Capability Framework can be used in tandem with current personal development planning and review procedures – these differ across organisations. Staff should use this document with their reviewer/supervisor to reflect on their current practice, identify and prioritise areas for development and produce an action plan with regular progress reviews. Staff should continue to use existing documentation.

Domain	1. Knowledge for Practice
Capability	1.1 The health and social care worker continues to update their knowledge of new policy and research evidence on intermediate care services and uses this to develop effective, evidence-based care.

Practice Learning Outcomes	Key Content
1.1.1 Accesses relevant local and national policies and guidelines and works with other members of the multi-agency team use them in practice.	<p>Key government and local policies and guidelines relevant to intermediate care</p> <p>Common risk factors associated with poor health and well-being</p> <p>Key research findings</p> <p>Early warning signs to indicate change in needs / condition</p> <p>Common terminology associated with intermediate care</p> <p>Common professional and multi disciplinary assessments used in intermediate care</p> <p>Local pathways for care</p> <p>Awareness of psychological impact of using intermediate care</p> <p>Service Directory</p> <p>Informed Consent</p> <p>Consent to share</p> <p>Data protection</p>
1.1.2 Uses relevant research findings and works with other members of the multi-agency team to use them in practice.	
1.1.3 Recognises signs, which may indicate a change in someone's needs/health and then sources appropriate care.	
1.1.4 Outlines risk factors of poor health and wellbeing and uses health enhancement in their practice.	
1.1.5 Knows of and uses the common assessments used to assess individuals using intermediate care and the impact they can have on people and their carers.	
1.1.6 Uses pathways of care to help people and their carers understand what to expect from their care and treatment plan.	
1.1.7 Meets, through collaboration with others the information needs of people and their carers by explaining common terms used in intermediate care.	
1.1.8 Knows and uses communication & approaches for individuals with communication difficulties e.g. whose first language is not English, Deaf community.	
1.1.9 Knows of of the current range of resources/ services, accessible from different agencies and professionals that meet individual's needs.	
1.1.10 Works to current legislation on informed consent, data protection and information sharing between agencies.	

Domain	2. Holistic Assessment
Capability	2.1. The health and social care worker uses judgement and knowledge to assess the holistic needs of people and carers who use intermediate care services and provide and evaluate evidence-based care.

Practice Learning Outcomes	Key Content
2.1.1 Understands the theory and process of the Single Shared Assessment (SSA)	<p>Assessment of holistic needs</p> <p>Single Shared Assessment</p> <p>National Minimum Information Standards for Assessment, Care Planning and Review</p> <p>Common evidence based interventions</p> <p>Quality of life</p> <p>Common signs of impending emergencies</p> <p>Psychological issues: dealing with uncertainty, impact of new diagnosis, functional decline and disease progression.</p> <p>Rehabilitation/ Enabling approaches</p>
2.1.2 Involves carers and family at all stages of the assessment and care planning process, ensuring the individual is happy with this.	
2.1.3 Encourages individuals to identify priorities and talk about how they feel their illness/ condition affects them.	
2.1.4 Knows the likely impact of uncertainty in the patient pathway, especially at times of transition, and demonstrates skills and sensitivity when assessing the needs and concerns of individuals and their carers.	
2.1.5 Respects an individual's right to accept or refuse intervention.	
2.1.6 Helps discuss significant news and provides support for individuals and their carers to minimise distress.	
2.1.7 Identifies and responds sensitively to verbal and non-verbal cues from individuals and carers that may indicate psychological and spiritual distress.	
2.1.8 Collaborates with the multi-agency team to plan care based on best available evidence and national and local guidelines, ensuring consistent, safe and effective delivery.	
2.1.9 Provides interventions for individuals and carers that meet the holistic needs of Individuals and their carers.	
2.1.10 Uses evidence-based assessment tools to contribute to an individual's management plans and is aware of environmental and community impacts during the process.	
2.1.11 Works closely with specialist services to provide effective symptom management, psychosocial and supportive care for individuals and their carers.	
2.1.12 Identifies changes in the individual's behaviour or condition that may indicate a side effect of treatment or disease progression and seeks timely and appropriate advice.	
2.1.13 Identifies unpredicted or unusual symptoms that may indicate a developing health or social care emergency and then seeks advice quickly.	
2.1.14 Acts consistently on carer issues, monitors and evaluates interventions and records outcomes accurately.	
2.1.15 Gives information, advice and support on finance to people and their carers.	
2.1.16 Shows awareness of and contributes to providing benefit information to help maximise individuals income	

Domain	3. The Multi-Agency Approach
Capability	3.1 The health and social care worker actively contributes to a multi-agency team approach to ensure effective communication, continuity and consistency of patient and carer focused care across settings.

Practice Learning Outcomes	Key Content
<p>3.1.1 Is aware of all channels of communication in the multi-agency context and relates and relays information in and across care settings and to other agencies where useful.</p> <p>3.1.2 Recognises, respects and values the contributions of others in the multi-agency team, using sensitive, responsive and non-judgemental communication.</p> <p>3.1.3 Takes part in multi-agency team meetings, discussions and reviews and, where appropriate and takes the lead in initiating communications.</p> <p>3.1.4 Records and reports information consistently, within integrated records, offered to individuals and carers to ensure consistency and continuity of care.</p> <p>3.1.5 Uses protocols and data protection legislation to transfer care between agencies or services.</p>	<p>Contact details of key people in multi-agency intermediate care.</p> <p>Integrated Records</p> <p>Formal and informal communication channels and record keeping</p> <p>Communication skills: handling difficult questions; coping with different emotions such as shock, distress, anger and aggression; probing questions; clarifying; responding sensitively and empathetically; assertiveness.</p> <p>IT Systems</p>

Capability	3.2 The health and social care worker uses knowledge of the available roles and services within the multi-agency context to participate in care and initiate appropriate supportive services when required to ensure continuity and consistency of care.
-------------------	--

Practice Learning Outcomes	Key Content
<p>3.2.1 Fully understands and uses services provided by, the different organisations, including the Managed Clinical Networks (MCNs).</p> <p>3.2.2 Can access advice and support from relevant teams and services and promotes consistent care by referring people and their carers to other members of the multi-agency team and external agencies where appropriate.</p> <p>3.2.3 Identifies where access to and equity of services can be improved and works with the multi-agency team to address these issues.</p> <p>3.2.4 Promotes consistent care by helping individuals to source information and ask relevant questions for members of the multi-agency team.</p> <p>3.2.5 Recognises that information offered to people may need to be repeated and uses every opportunity to reinforce points.</p>	<p>Role and services provided by multi-professional teams and agencies.</p> <p>Role of Managed Clinical Networks and key people involved.</p> <p>Contact details and function of local and national sources of support and information, including support groups and sources of financial support.</p> <p>Patient information and education.</p> <p>Service Directory</p>

Domain	4. Practising ethically
Capability	4.1 The health and social care worker continues to develop their knowledge of culture, diversity, ethical, professional and legal frameworks and uses this knowledge to support clear interaction with people and their carers using intermediate care services.

Practice Learning Outcomes	Key Content
<p>4.1.1 Consistently engages with people and their carers in line with discrimination legislation. Recognises and respects their views, values and beliefs, and uses every opportunity to involve them as partners in care.</p> <p>4.1.2 Assesses information needs and works with the multi-agency team to provide people and their carers with helpful information and education.</p> <p>4.1.3 Helps individuals understand information that supports choice and decision making. Facilitates informed consent to proposed management measures.</p> <p>4.1.4 Always reflects on and evaluates the information and education provided for people and their carers to inform and develop future practice.</p> <p>4.1.5 Recognises that different value systems and beliefs may impact on how much individuals want to be partners in care and uses this knowledge to explore issues with people and their carers.</p> <p>4.1.6 Reflects on own values and beliefs and how they may affect his or her attitudes towards people and their carers.</p> <p>4.1.7 Uses effective verbal and written communication skills to share information with the multi-agency team about individuals' preferences and choices on participation in care where consent to share information has been provided.</p> <p>4.1.8 Identifies complexities associated with intermediate care for the individual that may have ethical implications, and acts to safeguard the best interests of people and their carers by seeking appropriate advice on their management.</p> <p>4.1.9 Uses knowledge of professional and legal accountability and responsibility to ensure safe and effective practice that meets the needs of people using intermediate care services and their carers.</p>	<p>Ethical and legal considerations including: accountability, duty of care</p> <p>Role development</p> <p>Patient and carer involvement choice and decision making, informed consent.</p> <p>Reflection and self-development.</p> <p>Cultural and diversity issues.</p> <p>Attitudes to ageing</p> <p>Professional codes of conduct</p> <p>Consent to Share Guidance</p> <p>Race Relations Act</p> <p>Fair to All</p>

Domain	5. Care and Intervention
Capability	5.1 The health and social care worker recognises the relevance of rehabilitation throughout the patient pathway and contributes to rehabilitation and follow-up planning for people using intermediate care services and their carers.

Practice Learning Outcomes	Key Content
<p>5.1.1 Works collaboratively with people, their carers and the multi-agency team to identify and negotiate appropriate rehabilitation goals.</p> <p>5.1.2 Uses knowledge of rehabilitation services to facilitate daily living, promote independence and maximise the person's potential.</p> <p>5.1.3 Works closely with the multi-agency team to ensure smooth transitions between different care settings by timely participation in formulating and implementing transfer/ discharge plans.</p> <p>5.1.4 Demonstrates skill in supporting individuals to return to everyday activities during and following treatment.</p> <p>5.1.5 Enables people and their carers to actively contribute to rehabilitation, recognising the person's right to take risks.</p> <p>5.1.6 Works collaboratively with the multi-agency team, the person and their carer to develop appropriate risk management strategies.</p>	<p>Principles of rehabilitation</p> <p>Goal Setting</p> <p>Local rehabilitation resources and services</p>

Capability	5.2 The health and social care worker works actively as part of the multi-agency team to improve general health and well being through empowering and supporting to self-manage their health.
-------------------	---

Practice Learning Outcomes	Key Content
<p>5.2.1 Consistently identifies opportunities to encourage or act to support individuals and their carers developing self-management strategies.</p> <p>5.2.2 Provides information and education relating to current conditions and potential symptoms and side-effects of treatments to support and empower individuals and their carers.</p> <p>5.2.3 Helps people and their carers access accurate information, advice and support that help enhance their self-management capabilities.</p> <p>5.2.4 Engages with people and their carers and provides opportunities to discuss their desire, abilities and role in self-management.</p> <p>5.2.5 Teaches, encourages and supports people to develop techniques to make the most of their general health and well-being.</p> <p>5.2.6 Teaches, encourages and supports people and their carers to anticipate, prevent and minimise side-effects and recognise when advice from health care professionals should be sought.</p> <p>5.2.7 Provides information about how to contact health care professionals and who to contact for specific advice and support.</p> <p>5.2.8 Provides support, advice, encouragement and appropriate education to empower informal carers to confidently support individuals</p>	<p>Principles of self management</p> <p>Local resources and services for self-care</p> <p>Teaching and patient education</p>

Capability	5.3 The health and social care worker continually develops, promotes and demonstrates understanding of and respect for those experiencing loss across different cultures and belief systems.
-------------------	--

Practice Learning Outcomes	Key Content
<p>5.3.1 Recognises the significance of loss, grief, hope and coping mechanisms for people from different cultures with diverse beliefs and values and uses this knowledge in practice.</p> <p>5.3.2 Works closely with the multi-agency team to help people and their carers in coming to terms with a new diagnosis, loss of function or changing roles within their family and community life.</p> <p>5.3.3 Sensitively applies physical, psycho-social, emotional and spiritual care for people who are dying and meets the needs of their carers.</p> <p>5.3.4 Recognises that bereavement may begin before death and prepares individuals for loss.</p> <p>5.3.5 Accesses and uses information and sources of support for bereaved carers, based on assessed need.</p> <p>5.3.6 Demonstrates skills in providing support and/or information sensitive to bereaved carers.</p> <p>5.3.7 Demonstrates sensitivity and empathy in interpersonal interactions with people who are dying and their carers.</p> <p>5.3.8 Uses nationally and locally recognised frameworks and pathways for end of life care.</p> <p>5.3.9 Is aware of individual experiences and values that may influence feelings when caring for people experiencing loss</p> <p>5.3.10 Demonstrates awareness of support mechanisms available for staff providing care to individuals experiencing loss</p>	<p>Nationally and locally approved frameworks for end of life care e.g. Liverpool care pathway, Macmillan Gold Standards Framework, Preferred place of death</p> <p>Care of the dying and bereaved.</p> <p>Grief and loss process.</p>

Domain	6. Spiritual and Religious Care
Capability	6.2 The health and social care worker helps the patient and carer identify areas of spiritual concern and/or strength and offers spiritual support through shared compassion.

Practice Learning Outcomes	Key Content
<p>6.2.1 Continues to grow awareness of personal spirituality and how that can be integrated into the delivery of care.</p> <p>6.2.2 Develops active listening skills to help patients and carers identify key fears, concerns, hopes and aspirations and those things that give meaning, purpose and fulfilment to their lives.</p> <p>6.2.3 Able to develop relationships with patients and carers based on shared respect and compassion.</p> <p>6.2.4 Able to enter the world of the patient and carer with empathy, offering spiritual support and companionship.</p> <p>6.2.5 Develops an awareness of personal areas of discomfort and limitations and when to refer to others.</p> <p>6.2.6 Uses reflective practice to seek deeper meaning from incidences, to grow in self awareness and empathise with those in their care</p>	<p>Awareness of the spiritual component of life and dealing with illness.</p> <p>Self-awareness and empathy</p>

Domain	7. Mental Health and Well Being
Capability	7.1 The health and social care worker recognises that mental health is vital to overall health and well-being and actively facilitates and promotes healthy living

Practice Learning Outcomes	Key Content
<p>7.1.1 Recognises the main areas that influence mental health and well being, particularly in later life, and incorporates effective responses in care assessment and planning to prevent mental ill health.</p> <p>7.1.2 Consistently promotes unconditional positive regard regardless of age, culture etc and values and respects older people's contribution.</p> <p>7.1.3 Consistently encourages and provides opportunities to people and their carers, to discuss aspects of their mental health which concern them.</p> <p>7.1.4 Works closely with the multi-agency team to identify possible mental health issues and calls on timely and appropriate advice from specialist services.</p> <p>7.1.5 Works with the multi-agency team to address mental health issues and uses appropriate legislation.</p> <p>7.1.6 Informs, encourages and creates opportunities for people with mental health issues to engage with helpful activities and make healthy lifestyle choices.</p> <p>7.1.7 Promotes lifelong learning opportunities for people using intermediate care services.</p>	<p>Effect of discrimination, relationships, physical health, poverty and participation in meaningful activity on mental health.</p> <p>Current mental health legislation</p> <p>Adults with Incapacity (Scotland) Act 2000</p> <p>Income maximisation</p> <p>Mental Health Act 2003</p> <p>UK Inquiry into Mental Health and Well-being in Later Life: Promoting Mental Health and Well-being in Later Life (2006)</p> <p>Age Concern and Mental Welfare Commission</p>

