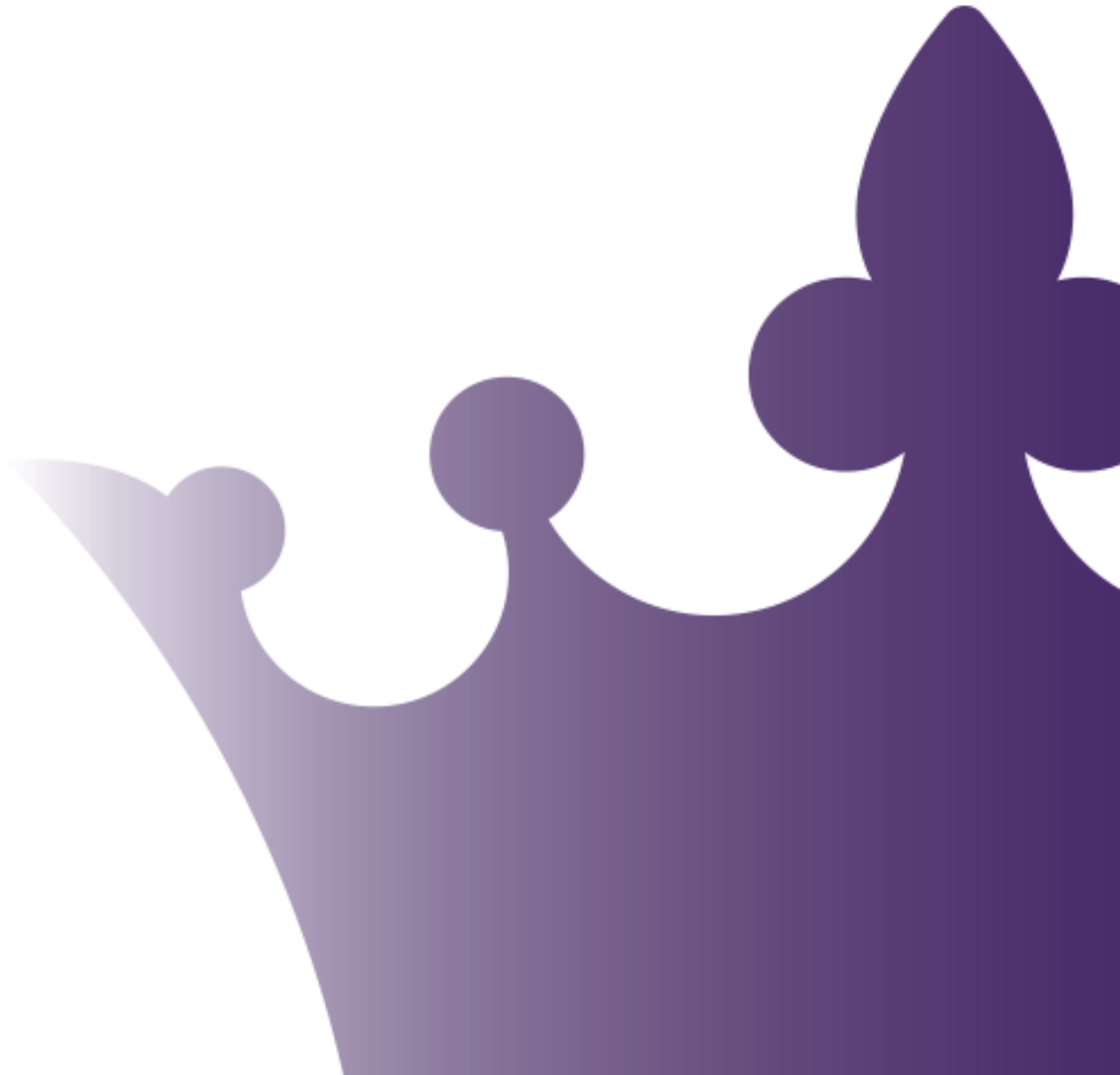
SFJ Awards Level 3 Diploma in Principles of Health and Social Care Specification

Regulation No: 603/1395/X



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Introduction

This specification is intended for trainers, centres and candidates. General information regarding centre approval, registration, Odyssey Online (SFJ AWARDS's candidate management system), assessment papers, certification, reasonable adjustments, special consideration, appeals procedures, are available from the website. This document should be read in conjunction with the SFJ AWARDS QMS Centre guide available from the website.

Version Number

Please ensure that you have the latest and most up-to-date version of documents. Please check the website for the most up-to-date version. To check which version you have please see the footer which will give you the version number.

Version 2.0	Head office address updated.
	Data protection references updated in line with GDPR.
Version 3.0	Assessment/ additional requirements sections updated to recognise audio recording as an acceptable alternative to video recording for the learner interview and identification check.
	Additional requirements section updated to clarify the workbook documentation requirements.
	Unit guidance updated in accordance with the above changes.
	SFJ AWARDS Assessment workbook updated in accordance with the above changes.

This regulated qualification was developed in partnership with Living Autism

About this Qualification

The 90 Credit SFJ AWARDS Level 3 Diploma in Principles of Health and Social Care is a knowledge only qualification aimed at the following:

- Individuals with an interest in health and social care
- Individuals who intend to work within a health and social care setting
- Individuals who are currently working within a health and social care setting
- Individuals unable to adhere to the demands of a competency based health and social care apprenticeship

The qualification content is applicable to a wide variety of health and social care job roles, including but not limited to; residential settings, primary care environments, day services, personal assistance and domiciliary services. It provides learners with formal recognition of their health and social care knowledge.

In the seven mandatory units, all learners will cover content general to the full range of health and social care career paths. The purpose behind this is to increase the possible breadth of knowledge application, post successful qualification attainment, thereby permitting the greatest degree of career flexibility without additional qualification requirements. The mandatory content includes health and social care facing principles of; Health, Safety and Infection Control, Person-Centred Care, Communication, Safeguarding and Duty of Care, Equality, Diversity and Rights, Teamwork and Multidisciplinary Working and Record Keeping.

The seven optional units provide learners with the opportunity to choose those areas relevant to their particular setting/area of interest, thereby tailoring the qualification to individual needs. The optional content includes health and social care facing principles of; Medication Handling and Awareness, Behaviour that Challenges and Positive Behavioural Support, Dementia Care, End of Life Care, Caring for Autistic Spectrum Conditions, Learning Disability Care and Epilepsy Care.

Objective

Supporting a role in the workplace

Purpose

B. Prepare for further learning or training and/ or develop knowledge and/ or skills in a subject area
B2. Develop knowledge and/ or skills in a subject area

Sector

1.3 - Health and Social Care

Structure

Rules of Combination: To achieve this 90 credit knowledge only qualification, learners must successfully complete the seven mandatory units (totalling 70 credits) and optional units totalling **a minimum** of 20 credits.

No of units	Unit Number	Unit Title	Level	Estimated TQT*	Estimated GLH**	Estimated Credit
Mandatory Units Group (70 Credits Required):						
1	D/615/6723	Principles of Health, Safety and Infection Control in Health and Social Care	2	200	150	20
2	Y/615/6719	Principles of Person-Centred Care in Health and Social Care	3	150	100	15
3	L/615/6717	Principles of Communication in Health and Social Care	3	100	75	10
4	F/615/6715	Principles of Safeguarding and Duty of Care in Health and Social Care	3	100	75	10
5	A/615/6714	Principles of Equality, Diversity and Rights in Health and Social Care	3	50	25	5
6	M/615/6712	Principles of Teamwork and Multidisciplinary Working in Health and Social Care	3	50	25	5
7	K/615/6711	Principles of Record Keeping within Health and Social Care	2	50	25	5
Mandatory Unit Total			3	700	475	70
Optional Units Group (20 Credits Required):						
8	H/615/6710	Principles of Medication Handling and Awareness	3	100	75	10
9	M/615/6709	Principles of Behaviour that Challenges and Positive Behavioural Support	3	100	75	10
10	K/615/6708	Principles of Dementia Care	3	100	75	10
11	H/615/6707	Principles of End of Life Care	3	100	75	10
12	D/615/6706	Principles of Caring for Autistic Spectrum Conditions	3	100	75	10
13	Y/615/6705	Principles of Learning Disability Care	3	50	25	5
14	R/615/6704	Principles of Epilepsy Care	3	50	25	5
Optional Unit Total			3	600	425	60
Qualification Total			3	900	(600-625)	90

Total Qualification Time (TQT)*

This is an estimate of the total length of time it is expected that a learner will typically take to achieve and demonstrate the level of attainment necessary for the award of the qualification i.e. to achieve all learning outcomes.

TQT is comprised of Guided Learning Hours (GLH) and an estimate of the number of hours a learner is likely to spend in preparation, study or any other learning including assessment, which takes place as directed by, but not under the supervision of a lecturer, supervisor or tutor. If a credit value is assigned to a qualification it is determined by TQT, as one credit corresponds to 10 hours of learning.

Guided Learning Hours (GLH)**

It is the responsibility of training centres to decide the appropriate course duration, based on their learners' ability and level of existing knowledge. It is possible, therefore, that the number of GLH can vary from one training centre to another according to learners' needs.

GLH are all times when a member of provider staff is present to give specific guidance towards the learning aim being studied on the programme. This definition includes examinations, lectures, tutorials, and supervised study. It does not include hours where supervision or assistance is of a general nature and is not specific to the study of the learners.

Delivery

Guided Learning Hours are (600-625). The course may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Assessment

Each unit within this knowledge only qualification is assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. All assessment criteria of the selected units must be met in order to achieve the qualification and this qualification is not graded, successful learners achieve a pass.

Following the assessment of each workbook, centres are required to conduct an audio/ video recorded learner interview and identification check. For further information, please refer to the additional requirements section below.

Additional Requirements

1. English Language Competency

It is the centre's responsibility to ensure that each learner is sufficiently competent in the use of the English language up to and including Level 2. Centres must ensure that learners have sufficient language skills before putting the learners forward and retain evidence of this for quality assurance purposes.

Contribution to Workbook:

Centres are required to confirm the English language competency of each learner within the relevant section of their workbook.

2. Photo ID

It is the centres responsibility to check the learners' identity. A copy of the learner's photo identification, checked and countersigned by the tutor or assessor, must be retained securely and in accordance with the relevant data protection legislation for quality assurance purposes.

Contribution to Workbook:

Centres are required to attach a countersigned copy of the learner's photo identification within the relevant section of their workbook.

3. Learner Interview and Identification Check

For each learner, an interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording.

Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Contribution to Workbook:

As part of the declarations section for each unit, the interviewer is required to confirm that an audio/ video recorded learner interview was conducted, including the format of this interview (face-face vs video conference). The interviewer must also confirm that photographic identification was checked and verified for every non- consecutive interview, specifying the type of identification that was reviewed (passport/ driving licence etc.). Finally, the interviewer must confirm that both they and the learner stated their full names within the audio/ video recording, as this will be considered as part of the external quality assurance process.

4. Plagiarism Check

Completed submissions must be assessed for plagiarism in line with centre policies and procedures. For additional guidance, please refer to the plagiarism section below.

Contribution to Workbook:

Both the assessor and learner are required to sign a declaration of authenticity for each unit within the workbook.

Age Range and Geographical Coverage

This qualification is approved for learners aged 16+ in England

Learner Entry Requirements

There are no formal entry requirements. However, learners should be able to work at level 2 or above and provide evidence to confirm this ability. Centres must ensure that learners have sufficient language skills before putting the learners forward and retain evidence of this for quality assurance purposes.

Progression

Learners can progress to other qualifications or apprenticeships within the same sector. Examples include competency based apprenticeships and leadership and management qualifications.

Tutor Requirements

1. Trainer Requirements:

i) A recognised teaching qualification: e.g. Level 3 Award in Education and Training, Level 3 NVQ Certificate in Learning and Development, Level 4 NVQ Certificate in Learning and Development, Level 4 Certificate in Education and Training, IHCD Instructional Methods, Level 5 Diploma in Education and Training, CIPD Level 5 Intermediate Certificate in Learning and Development, PTLLS (12 credits), DTLLS, Postgraduate Certificate in Education (PGCE), Postgraduate Certificate in Higher Education (PGCHE) etc.
ii) A minimum of three years' experience within the sector ***(OR)*** qualifications in health and social care at level 4 or above
iii) Relevant CPD

2. Assessor Requirements:

i) Requirements identical to those of trainer (above)

OR

i) A formal assessing qualification: e.g. Level 3 Award in Assessing Vocationally Related Achievement, Level 3 Certificate in Assessing Vocational Achievement etc. ***(OR)*** to be working towards a relevant assessing qualification, including those listed previously*
ii) A minimum of three years' experience within the sector ***(OR)*** qualifications in health and social care at level 4 or above
iii) Relevant CPD

3. Internal Verifier (IV) Requirements:

i) Requirements identical to those of trainer (above)
ii) An IV qualification such as the Level 4 Award in the Internal Quality Assurance of Assessment Processes and Practice, the Level 4 Certificate in Leading the Internal Quality Assurance of Assessment Processes and Practice etc. ***(OR)*** to be working towards a relevant IV qualification, including those listed previously*.

**Those tutors who are working towards a specific, role essential qualification must be supervised by a member of staff who does hold the relevant qualification.*

Those assigned any one of the above three roles may fulfil no other tutor role, besides that of their primary function, at any one time.

Centre Requirements

Centres must be approved by SFJ AWARDS in order to offer this qualification and be able to provide the learner with all necessary equipment, facilities and resources required to enable completion of this qualification. Centres must have access to adequate audio and/ or video recording equipment and file storage facilities as part of these requirements.

Plagiarism Guide to Centres, Assessors, Examiners and Learners

Learners commit plagiarism when they copy, very closely imitate, paraphrase or cut and paste someone else's work, ideas, and/ or language and present it as their own.

It is the tutor's responsibility to explain to each learner the concept and consequences of committing plagiarism. Tutors must develop policies and procedures to reduce the likelihood of plagiarism occurring and to ensure the validity of all submitted work.

What are the Consequences of Plagiarism?

Plagiarism is not permitted. If detected, plagiarism will lead to a zero mark and possible suspension from SFJ AWARDS registration.

Unit 1: Principles of Health, Safety and Infection Control in Health and Social Care D/615/6723

Estimated TQT:	200
Estimated GLH:	150
Credit	20
Level	2

Unit Description:

This unit covers the underpinning knowledge of health, safety and infection control in health and social care. The unit develops the learner's knowledge and understanding of health and safety responsibilities, moving and handling safely, fire safety, causes and transmission of infection and infection prevention/control related; roles, responsibilities, legislation, policies, systems/procedures, risk assessments and PPE. Learners will also develop an understanding of hazardous substances, waste management practices, the value of good personal hygiene, environmental cleaning, decontamination processes, procedures for responding to accidents/ sudden illnesses and stress management techniques.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand own responsibilities, and the responsibilities of others, relating to health and safety within a health and social care work setting	1.1	Identify health and safety legislation relevant to a health and social care work setting	Health and safety legislation relevant to a health and social care work setting: E.g. Health & Safety at Work Act (1974), Health and Social Care Act (2008), Management of Health and Safety at Work Regulations (1999), Manual Handling Operations Regulations (1992), Health and Safety (First Aid) Regulations (1981), Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) (1995) and Control of Substances Hazardous to Health Regulations (COSHH) (2002).
	1.2	Explain the purpose of policies and procedures relating to health and safety	Purpose of policies and procedures relating to health and safety: E.g. Details of agreed ways of working and approved codes of practice, ensuring safety as far as is reasonably practicable (and in line with risk assessments) and provides for standardisation and best practice.
	1.3	Explain the main health and safety responsibilities of: • The employer and manager(s) • All individuals in the work setting	Responsibilities of employers and managers for health and safety: E.g. Information provision regarding; risks to health and safety from working practices, changes that may harm or affect health and safety, how to do the job safely, what is done to protect health and safety, how to get first-aid treatment and what to do in an emergency. Additionally the responsibility of employers to provide staff training to do the job safely; protection (e.g. special clothing, gloves or masks) and health checks (e.g. vision testing).

			Responsibilities of all individuals in the work setting: E.g. The responsibility to take care of own health and safety, understanding and applying relevant legislation and agreed ways of working, responsibility to undertake relevant training and updating as required, the importance of cooperating with others on health and safety, importance of the correct use of anything provided for health, safety or welfare (e.g. protective clothing and other specialised equipment), understanding the advantages and disadvantages of undertaking own responsibility in health and safety issues and to be mindful of health and safety issues in relation to; observation, practice, reporting and recording procedures.
	1.4	Explain how to support others to understand and follow safe working practices	How to support others to understand and follow safe working practices: E.g. Ensure that others understand the need to follow safe working practices, ensure that others access relevant training, support others to put into practice the guidance and procedures, share relevant information relating to any changes, ensure that others are familiar with procedures for reporting incidents and monitor and supervise safe working practices.
	1.5	Explain the purpose of risk assessments in relation to health and safety	The purpose of risk assessments in relation to health and safety: E.g. The importance of risk-assessment for protecting self and others from danger or harm, the need to comply with the law, identifying what could cause harm, taking precautions to prevent harm, the importance of minimising accidents, injuries and ill health and reducing the risk of individuals being injured at work.
	1.6	Identify tasks in the work setting that should not be carried out without special training	Tasks in the work setting that should not be carried out without special training: E.g. Use of specialist equipment, first aid, administering medication, healthcare /clinical procedures, food handling and food preparation.
	1.7	Explain the importance of monitoring and reporting potential hazards and risks	The importance of monitoring and reporting potential hazards and risks: E.g. Agreed ways of working, vigilant monitoring required for effective risk identification, value of early reporting, documentation of risks, risk reduction, protection through prevention, safeguarding, liability policy/ procedure maintenance and fitness for purpose.
	1.8	Explain the importance of ensuring that others are aware of own whereabouts	The importance of ensuring that others are aware of own whereabouts: E.g. Safety of self, safety of others, planned assistance of others (e.g. own role

			in assistance of another during an emergency), fire safety, building security and emergency incident management.
	1.9	Explain how to access additional support or information regarding health and safety	How to access additional support or information regarding health and safety: E.g. HSC/E documentation/ information (e.g. Health and safety law: What you should know), HSC/E documentation associated contact details for further information or support and local Health and Safety Representatives or Officers.
2. Understand the importance of moving and handling equipment and other objects safely within a health and social care work setting	2.1	Identify legislation that relates to moving and handling	Legislation that relates to moving and handling: E.g. The Health and Safety at Work Act (1974), The Manual Handling Operations Regulations 1992 (as amended in 2002) and The Lifting Operations and Lifting Equipment Regulations 1998 (as amended).
	2.2	Explain principles for safe moving and handling	Principles for safe moving and handling: E.g. The key principles of; avoid (e.g. the need for hazardous manual handling) assess (e.g. the risk of injury from any hazardous manual handling), reduce (e.g. the risk of injury from hazardous manual handling), the importance of assessment (e.g. the task, load, working environment and own capability), reducing the risk of injury (e.g. musculoskeletal disorders: avoiding hazardous manual handling), the importance of correct posture and technique, working in teams (e.g. the importance of a co-ordinated approach and good communication), using mechanical aids where necessary (e.g. a hoist), changing the task or approach where necessary, the importance of following appropriate systems and agreed ways of working, making proper use of equipment provided for safe practice, taking care to ensure that activities do not put others at risk and reporting any potentially hazardous handling activities.
3. Know how to promote fire safety within a health and social care work setting	3.1	Describe practices that prevent fires from starting	Practices that prevent fires from starting: E.g. Identifying potential fire hazards in the health and social-care workplace, understanding how fires start (e.g. the fire triangle of ignition, fuel and oxygen), preventing fires from starting (e.g. the danger from lit cigarettes, naked flames, hot surfaces, faulty electrical equipment), the importance of regular checks on electrical equipment (e.g. PAT testing), the importance of staff training and vigilance in the workplace and risk-assessment procedures.
	3.2	Explain practices that prevent fires from spreading	Practices that prevent fires from spreading: E.g. Preventing fires from spreading through safe practices; safe storage of flammable materials (e.g.

			waste materials, paper, wood, furnishings, flammable liquids), keeping fire doors shut and checking smoke detectors regularly.
	3.3	Explain emergency procedures to be followed in the event of a fire in the work setting	Emergency procedures to be followed in the event of a fire in the work setting: E.g. Understanding how to raise the alarm if a fire is discovered (e.g. operating a fire alarm system), agreed procedures for alerting all individuals in the work setting, knowledge of basic firefighting procedures (e.g. use of different fire extinguishers, fire blankets or other fire safety equipment), understanding procedures for evacuation (e.g. using designated routes, not using lifts, closing all doors, special evacuation procedures for very young children and those with mobility or other difficulties including use of an evac-chair), knowledge of evacuation routes and assembly points, agreed procedures for checking on the presence of all individuals in the work setting, the importance of staff training and regular evacuation drills.
	3.4	Explain how and why clear evacuation routes are maintained at all times	How and why clear evacuation routes are maintained at all times: E.g. Keeping fire exits and doorways clear, not storing furniture or other equipment in the way of evacuation routes and keeping stairwells or designated special evacuation areas clear at all times. Unclear evacuation routes will delay or prevent evacuation and cause possible injury or loss of life.
4. Understand the causes of infection	4.1	Identify the differences between bacteria, viruses, fungi and parasites	Differences between bacteria, viruses, fungi and parasites: E.g. Bacteria are microscopic organisms some types of which are pathogenic; bacteria are made up of just one cell and are capable of reproducing themselves. Viruses are pathogenic microscopic organisms; viruses cannot multiply on their own and so invade a 'host' cell. Pathogenic fungi are yeasts and moulds which can infect humans. Parasites are organisms that live on other organisms. Major differences between all four categories include; structure, growth, infection mechanism(s), effects and treatments.
	4.2	Identify common illnesses and infections caused by bacteria, viruses, fungi and parasites	Common illnesses and infections caused by bacteria, viruses, fungi and parasites: E.g. List not exhaustive but includes: Bacteria; Chlamydia, Clostridium Difficile Toxin Diphtheria, Scarlet Fever, Tuberculosis. Virus; HIV, Hepatitis A/B/C, Herpes, Chickenpox, Measles, Norovirus. Fungi; Ringworm, Tinea Pedis (athlete's foot), Candida (Thrush). Parasites; Scabies, Threadworms, Lice.

	4.3	Describe what is meant by 'infection' and 'colonisation'	What is meant by 'infection' and 'colonisation': E.g. Infection; the organism is present and is causing illness. Colonisation; the organism is present in or on the body but is not causing illness.
	4.4	Explain what is meant by 'systemic infection' and 'localised infection'	What is meant by 'systemic infection' and 'localised infection': E.g. Systemic infection: The infection caused by a pathogen has spread through the body to several organs in different systems of the body (e.g. digestive, respiratory or circulatory systems). Localised infection: An infection that is confined or restricted to a specific location of the body (e.g. an infected wound).
	4.5	Identify poor practices that may lead to the spread of infection	Practices that may lead to the spread of infection: E.g. Lack of/ poor hand hygiene, lack of/ poor cleaning procedures, lack of/ incorrect use of personal protective equipment (PPE) (e.g. gloves and aprons), contaminated bed linen/ clothing, infected food handlers, lack of/ poor personal hygiene, non-approved clothing and jewellery, incorrect food hygiene practices and incorrect waste storage and/ or disposal.
5. Understand the transmission of infection within a health and social care work setting	5.1	Explain the conditions needed for the growth of micro-organisms	Conditions needed for the growth of micro-organisms: E.g. Pathogenic micro-organisms require the following; moisture, nutrients, temperature and time to grow.
	5.2	Explain the ways an infective agent might enter the body	Ways an infective agent might enter the body: E.g. The respiratory tract (e.g. nose, windpipe, lungs); airborne pathogens such as those causing coughs and colds can be inhaled. Broken skin; one of the functions of the skin is to provide protection against infection, if skin is broken (e.g. by bites, scratches, puncture wounds or dryness) this provides a route for infection to enter the body. The digestive tract; infected products such as food and drink can be swallowed, often affecting the bowels or stomach. The urinary tract and reproductive system; infections may remain localised or enter the bloodstream; one of the problems with catheterisation is the possibility of bacteria being carried into the urinary tract during the catheterisation procedure.
	5.3	Identify common sources of infection	Common sources of infection: E.g. Contaminated food /water, humans (e.g. incubatory carriers, in- apparent infections, convalescent carriers, chronic carriers), animals, bodily fluids, contaminated environmental surfaces and airborne.

	5.4	Explain how infective agents can be transmitted	How infective agents can be transmitted: E.g. Direct contact (e.g. actual contact with an infected person), indirect contact (e.g. contact with contaminated surfaces touched by the infected person/ where droplets of body fluid have landed), inhalation (e.g. airborne micro-organisms including those from coughs and sneezes), ingestion/ consumption (e.g. contaminated food/ water/ surfaces), parental, breaks in the skin or urinary tract, vector-borne (e.g. parasite bites), sexual contact, vertical transmission and mother to child transmission. Hands play a large part in spreading infection.
	5.5	Identify factors that will increase the likelihood of infection occurring	Factors that will increase the likelihood of infection occurring: E.g. Immune status, pre-existing medical conditions, age; very young or old, not being immunized, open wounds or entry points, poor practices, poor personal hygiene, shared facilities (care homes, hospitals, nurseries), physical wellbeing, psychological wellbeing, nutritional status, medical interventions and specific medical therapies.
6. Understand roles and responsibilities in the prevention and control of infection within a health and social care work setting	6.1	Explain employees' roles and responsibilities in relation to the prevention and control of infection	Employees' roles and responsibilities in relation to the prevention and control of infection: E.g. Personal, organisational and legal responsibilities, responsibilities to self, colleagues, employer, clients and visitors; acting to prevent spread of infection, reviewing own practice, differing roles when working in different contexts, following policies, procedures and agreed ways of working, attending required training, following cleaning schedules, completing cleaning records, maintaining good personal hygiene, reporting infection control issues, appropriate use of provided Personal Protective Equipment (PPE), safe disposal of waste, reporting of any concerns and seeking advice when unsure.
	6.2	Explain employers' responsibilities in relation to the prevention and control of infection	Employers' responsibilities in relation to the prevention and control of infection: E.g. Personal, organisational and legal responsibilities, responsibilities to self, colleagues, employer, clients, visitors; establishing, maintaining and updating procedures, assessing risk, identifying and acting upon training needs, knowledge of relevant policies, monitoring/ training staff, providing PPE and monitoring the work environment
7. Understand legislation and policies relating to prevention and control of infections within a health and social care work setting	7.1	Identify legislation and regulatory body standards which are relevant to the prevention and control of infection	Legislation and regulatory body standards which are relevant to the prevention and control of infection: E.g. Health and Safety at Work Act (1974), Control of Substances Hazardous to Health Regulations (2002), Reporting of Injuries, Diseases and Dangerous Occurrences regulations

			(1995), Environmental Protection Act (1990), Personal protective equipment work regulations (PPE) (1992), Safe Disposal of Clinical Waste (1992) Hazardous Waste Regulations (2005), Safe Management of Healthcare Waste (2006), Health Act (2006), Health & Social Care Act (2008), The Environmental Protection (Duty of Care) Regulations (1991), Food Safety Act (1990), The Management of Health and Safety at Work (Amendment) Regulations (1994), The Public Health (Control of Diseases) Act (1984), The Public Health (Infectious Diseases) Regulations 1988 (as updated in 2010), Regulatory Body Standards (e.g. NICE, Universal Blood and Body Fluid Precautions, Skills for Health Infection Control Core Competencies, The Quality Standards for Health and Social Care (2006), Care Quality Commission and Public Health England).
	7.2	Identify local and organisational policies relevant to the prevention and control of infection	Local and organisational policies relevant to the prevention and control of infection: E.g. Health and safety policies, organisational infection control policies and other local and organisational policies related to role including; PPE, management of occupational exposure, staff induction and training guidelines, infection control policies, risk assessment, monitoring and audits, Standard Infection Control precautions (SICP), Local and national initiatives (e.g. in England), Essential Steps to safe clean care and Saving Lives (2005).
8. Understand systems and procedures relating to the prevention and control of infections within a health and social care work setting	8.1	Identify procedures and systems relevant to the prevention and control of infection	Procedures and systems relevant to the prevention and control of infection: E.g. Hand hygiene following the Ayliffe technique, cleaning schedules, waste disposal, decontamination of equipment and management of linen.
	8.2	Explain the potential impact of an outbreak of infection on: • The organisation • Employees • Service-users	The potential impact of an outbreak of infection on the organisation: E.g. Cost implications, staff sickness levels, reduction in patient and public confidence, litigation, not delivering regulatory standards, disruption to routines and services, increased mortality and morbidity and cancellation of services. The potential impact of an outbreak of infection on employees: E.g. Loss of confidence in organisation, loss of earnings, fear of risk of infection and infecting family members. The potential impact of an outbreak of infection on service-users: E.g. Risk to service-user, additional illness, increase time in recovery, increase length of stay, loss of earnings, potential death, extended incapacity and distress to service-user and their network.

9. Understand the use of risk assessments in relation to the prevention and control of infections within a health and social care work setting	9.1	Define 'hazard'	Hazard: E.g. Any source of potential damage, harm or adverse health effects on something or someone
	9.2	Define 'risk'	Risk: E.g. Likelihood of a hazard to cause harm.
	9.3	Explain the process of carrying out a risk assessment	The process of carrying out a risk assessment: E.g. HSE 5 Steps; Identify hazard, determine who could be harmed and how, evaluate the risk, record the findings, implement the actions, review the impact of the actions; ongoing process, responsibility of organisation and individuals and requires role allocation.
10. Understand the importance of using Personal Protective Equipment (PPE) in the prevention and control of infections within a health and social care work setting	10.1	Identify different types of PPE	Types of PPE: E.g. Single use items: Gloves, aprons, gowns and masks. Multiple use items: uniforms, goggles, face shields and visors.
	10.2	Explain the reasons for use of PPE	Reasons for use of PPE: E.g. Protect, prevent or control spread of infection. Prevention of cross contamination/ cross infection between persons (e.g. staff to service-user, service-user to staff, between staff members, between service-users and to and from visitors/ family members).
	10.3	Identify regulations and legislation relating to use of PPE	Regulations and legislation relating to use of PPE: E.g. Personal Protective Equipment Regulation (1992), Control of Substances Hazardous to Health Regulations (2002) and Health & Safety at Work Act (1974).
	10.4	Describe employees' responsibilities regarding the use of PPE	Employees' responsibilities regarding the use of PPE: E.g. Responsibility to select and use PPE as instructed, check PPE before and after use, report damage or other issues and to store in facilities and as instructed.
	10.5	Describe employers' responsibilities regarding the provision of PPE	Employers' responsibilities regarding the provision of PPE: E.g. Providing PPE appropriate for range of activities carried out, training and instructing staff in use, maintenance of condition, replacing damaged or worn equipment and establish reporting procedures.
	10.6	Describe best practice for the application and removal of PPE	Best practice for the application and removal of PPE: E.g. With reference to policies and procedures of organisation and manufacturer's guidelines; hands to be washed prior to application and removal of gloves, safe disposal of PPE and use of new PPE equipment per service-user/ activity.
	10.7	Describe best practice for the disposal of used PPE	Best practice for the disposal of used PPE: E.g. With reference to policies and procedures of organisation and manufacturer's guidelines; disposal method dependent upon item and item usage (e.g. non-clinical /clinical

			waste, single use/ multiple use items), includes waste bins, hazardous waste and laundry.
11. Understand hazardous substances and waste management practices within a health and social care work setting	11.1	Identify hazardous substances that may be found in the work setting	Hazardous substances that may be found in the work setting: E.g. List not exhaustive but includes: Cleaning materials (e.g. disinfectant, surfactants, and bleach), clinical and bodily waste, medicines and/ or drugs.
	11.2	Identify the different categories of waste and the associated risks	The different categories of waste and the associated risks: E.g. Waste; Non- clinical/ clinical waste, disposable personal protective equipment, used needles/ sharp instruments and food waste. Risks; injuries, infections (e.g. onsite and/ or to the public).
	11.3	Explain how to dispose of different types of waste	How to dispose of different types of waste: E.g. Sorting of waste, designated bins for different types, dealing with biological spillages, reduction of risks linked with correct disposal, correct procedures and arrangements for collection.
	11.4	Explain how waste should be stored prior to collection	How waste should be stored prior to collection: E.g. Colour coded disposal bags/ bins, sharps bins, correct procedures for disposal/ collection and use of specialist services/ disposal methods where appropriate (e.g. incineration).
	11.5	Identify legal responsibilities in relation to waste management	Legal responsibilities in relation to waste management: E.g. Use of approved contractors, record keeping, working within COSHH guidelines and other legislation; Controlled Waste (Amendment) Regulations (1993), Environmental Protection Act (1990), Environmental Protection Hazardous Waste Regulations (England and Wales) (2005) and the Public Health (Control of Diseases) Act (1984).
	11.6	Explain how to reduce the risk of sharps injury	How to reduce the risk of sharps injury: E.g. Provision of sharps boxes which comply with safety standards, locating sharps containers close to where sharps are used, training, internal procedures for good practice, risk assessment of work practices, EU directive on non-re-sheathing and safe disposal of used sharps boxes.
12. Understand the importance of good personal hygiene in the prevention and control of infections within a health and social care work setting	12.1	Explain the principles of good personal hygiene	Principles of good personal hygiene: E.g. Clean and short fingernails, frequent showers, restrictions on makeup/ jewellery, appropriate hair (e.g. clean, tied back, covered etc.), adherence to uniform policy/ requirements, clean clothes or uniform and regular handwashing

	12.2	Explain best practice for hand washing	Best practice for hand washing: E.g. Six stages of hand-washing (Ayliffe Technique): Stage One; palm to palm, Stage Two; right palm over back of left hand- change hands repeat, Stage Three; palm to palm with fingers interlaced, Stage Four; backs of fingers to opposing palms with fingers interlocked, Stage Five; rotational rubbing of right thumb clasped in left palm- change hands repeat, Stage Six; rotational rubbing, backwards and forwards with clasped fingers of hand in left palm- change hands repeat.
	12.3	Explain when and why hand washing should be carried out	When and why hand washing should be carried out: E.g. At the start of work, at the end of work period, before and after any contact with service-users or bodily fluids, after handling used laundry and clinical waste, after using the toilet, following the removal of disposable gloves, before and after handling food, before eating food, after blowing nose, coughing or sneezing. Aims to reduce risks of cross contamination or infection via microorganisms carried on hands and transferred to and from items, service-users or the environment.
	12.4	Identify types of products that should be used for hand washing	Types of products that should be used for hand washing: E.g. Soaps, antibacterial liquid soaps, antiseptic lotions for after washing and alcohol based cleansers if water is not available etc.
13. Understand how to maintain a clean environment to prevent the spread of infection within a health and social care work setting	13.1	Summarise the general principles for environmental cleaning	General principles for environmental cleaning: E.g. Objectives of cleaning to reduce risk/ spread of infection by removing dirt and microorganisms. Definitions of; cleaning, deep cleaning, disinfection, sterilization and decontamination and when each is used, procedures for each type of work area and work surfaces (e.g. washbasins, floors, walls etc.) and the safety of staff, service-users and visitors while cleaning is carried out.
	13.2	Explain the purpose of cleaning schedules	Purpose of cleaning schedules: E.g. To maintain a clean and safe environment and reduce the risk of infection. Covers; procedures, timing/ frequency of cleaning and what, when and how to clean.
	13.3	Explain why cleaning equipment is colour coded	Why cleaning equipment is colour coded: E.g. To reduce risk of cross-contamination, control infection, promote awareness through standardisation, promote compliance with relevant health and safety legislation and promote adherence to national code.
14. Understand the principles and steps of the decontamination process within a health and social care work setting	14.1	Explain the three steps of the decontamination process	Three steps of the decontamination process: E.g. Cleaning to remove soiling/ debris, processes for dealing with hazardous spillages (e.g. blood, vomit), disinfection (application of chemicals which reduce the level of

			microbial contamination after cleaning) and sterilisation (technique used to kill all remaining microorganisms; autoclave, dry heat etc.)
	14.2	Explain how and when cleaning agents are used	How and when cleaning agents are used: E.g. Cleaning agents (e.g. detergents used to mobilise dirt, debris and soiling to increase efficiency of cleaning), importance of using correct dilution and temperature and safe use and storage in accordance with the Control of Substances Hazardous to Health (COSHH) Regulations (2002).
	14.3	Explain how and when disinfecting agents are used	How and when disinfecting agents are used: E.g. Importance of using correct dilution/ temperature, safe use and storage (COSHH), importance of using the correct product for different types/ levels of likely contamination, using after cleaning and the likelihood disinfecting agents will be inactivated by gross contamination with dirt/ debris/ organic material etc.
	14.4	Explain why personal protective equipment (PPE) is used during the decontamination process	Why personal protective equipment (PPE) is used during the decontamination process: E.g. To protect individuals carrying out the decontamination from chemical agents, to avoid re-contamination of cleaned/ sterile areas or instruments and to ensure legislative adherence.
	14.5	Explain the concept of risk in dealing with specific types of contamination	The concept of risk in dealing with specific types of contamination: E.g. Level of risk affects chance of infection and relates to type of contamination; low risk (e.g. bathrooms, washbasins, hoists, surfaces and furnishings), medium risk (e.g. toilets, spillages of body fluids, infectious individuals) and high risk (e.g. re-usable equipment etc.).
	14.6	Explain how the level of risk determines the type of agent that should be used to decontaminate	How the level of risk determines the type of agent that should be used to decontaminate: E.g. Low risk; water and detergent only, medium risk; disinfectants, high risk; sterilizing agents/ techniques used after cleaning.
	14.7	Describe how cleaning equipment should be cleaned and stored	How cleaning equipment should be cleaned and stored: E.g. Importance of cleaning equipment after use to maintain it in good condition, avoid harbouring contamination or promoting microbial growth, method dependent upon equipment type, storing safely to avoid accidents (e.g. tripping) and correct storage of all cleaning agents in accordance with COSHH to avoid chemical hazards (e.g. spillages, ingestion etc.).
	15.1	Identify different types of accidents and sudden illness that may occur in own work setting	Different types of accidents and sudden illness that may occur in own work setting: E.g. Accidents (e.g. slips and trips, falls, manual handling, needle

15. Understand procedures for responding to accidents and sudden illness			stick injuries, burns and scalds, injuries from operating machinery or specialised equipment, electrocution, accidental poisoning etc.) and sudden illness (e.g. heart attack, diabetic coma, seizure).
	15.2	Explain procedures to be followed if an accident or sudden illness should occur	Procedures to be followed if an accident or sudden illness should occur: E.g. Understanding the importance of procedures to be followed if an accident or sudden illness should occur, knowing how to ensure and maintain safety for individuals concerned and others (e.g. clearing the area, safely moving equipment if possible etc.), remaining calm, knowing how to send for help, knowing how to assess individuals for injuries, understanding when to administer basic first aid if necessary and if trained to do so, understanding the importance of staying with the injured/ sick individual until help arrives, knowing how to observe and note any changes in an individual's condition, understanding how to provide a full verbal report to relevant medical staff or others, understanding how to complete a full written report and relevant documentation (e.g. accident report, incident report etc.), understanding the policies, procedures and agreed ways of working for the work setting.
16. Know how to manage stress	16.1	Describe common signs and indicators of stress	Common signs and indicators of stress: E.g. Physical signs and symptoms (e.g. aches and pains, nausea, dizziness chest pain, rapid heartbeat), emotional signs and symptoms (e.g. moodiness, irritability or short temper, agitation, inability to relax, feeling overwhelmed, sense of loneliness and isolation, depression or general unhappiness), cognitive signs and symptoms (e.g. memory problems, inability to concentrate, poor judgement, constant worrying) and behavioural signs and symptoms (e.g. eating more or less, sleeping too much or too little, neglecting responsibilities, using alcohol, cigarettes or drugs to relax and nervous habits like nail-biting).
	16.2	Describe signs that indicate own stress	Signs that indicate own stress: E.g. Individual answers but may include elements from 16.1.
	16.3	Describe factors that tend to trigger own stress	Factors that tend to trigger own stress: E.g. Individual answers, examples include; work factors (e.g. changes in routine, dealing with difficult situations, pressure to meet targets, interpersonal relationships, expectations from managers, demands of working unsocial hours, taking on special projects etc.), personal factors (e.g. financial problems, relationship or family problems, major life changes, bereavement, injury or

			illness etc.) and understanding how these factors can trigger own stress singly or in combination.
	16.4	Describe strategies for managing stress	Strategies for managing stress: E.g. Recognising individual stressors, applying a range of coping strategies (e.g. internally or externally-focused, emotional or solution-focused) including; relaxation techniques (e.g. time-out, massage, yoga, aromatherapy, listening to music), physical activity and exercise (e.g. going for a run, joining a gym), social strategies (e.g. meeting up with friends and family, volunteering or helping with community work), logical strategies (e.g. making lists, prioritising), creative strategies (e.g. music, painting or other artistic pursuits) or faith based strategies (e.g. religion or other beliefs) and comparing and contrasting different strategies and their effectiveness to inform future stress management.

Unit 1: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit is linked to: HSC27, HSC29, HSC32, HSC218, HSC219, HSC220, HSC230, HSC246, IPC1, IPC2, IPC3, IPC4, IPC6, IPC7, GEN3 and K5. There are some relationships between this unit and those of other standards such as Key Skills, Functional Skills and Skills for Life.

Unit 2: Principles of Person-Centred Care in Health and Social Care Y/615/6719

Estimated TQT:	150
Estimated GLH:	100
Credit	15
Level	3

Unit Description:

This unit covers the underpinning knowledge of person-centred care in health and social care. The unit develops the learner's knowledge and understanding of; the concept and role of person-centred care, potential barriers to person-centred care, person-centred risk assessments, the role of learning and development activities, the role of active participation, person-centred approaches to assessment and planning and how to support the implementation and review of person-centred care plans.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the concept and role of person-centred care within health and social care	1.1	Explain the meaning of person-centred care	The meaning of person-centred care: E.g. A flexible needs based approach that places the service-user being cared for at the heart of their own care (e.g. leads to the development of a personalised care strategy that recognises and responds to the uniqueness of the service-user; specific needs, strengths, weaknesses, aims, goals, ambitions, preferences, values, situation etc.).
	1.2	Explain the importance of recognising and adhering to a service-users individual needs	The importance of recognising and adhering to a service-users individual needs: E.g. Underpins implementation of person-centred care; essential for the delivery of a dynamic care strategy tailored to the service-user and has significant positive impacts upon progression and wellbeing.
	1.3	Explain factors that contribute to the wellbeing of individuals	Factors that contribute to the wellbeing of individuals: E.g. Multitude of person-dependent factors including; diet (e.g. improved immunity, weight control and general health), rest/ sleep (e.g. improved concentration, improved learning, memory consolidation and energy restoration), exercise (e.g. improved fitness, general health, weight control and improved learning and memory), social (e.g. improved engagement, social ability and perceptions of self-worth), financial (e.g. control and financial security), stimulation based (e.g. work, education and leisure; impacts to general health, mental health, motivation, memory and ability), spiritual (e.g. improved security, satisfaction and sense of purpose), cultural (e.g.

			associated familiarity and comfort), rights based factors (e.g. equality, dignity, respect, independence, enablement, empowerment and control) and others with reference to the recognition and fulfilment of individual preferences and needs.
	1.4	Explain the skills, attitudes and approaches needed by those providing support or brokering services, in order to implement person-centred care	The skills, attitudes and approaches needed by those providing support or brokering services, in order to implement person-centred care: E.g. Respect for the service-user, empathy, deviation from an institutional focus, dynamism of approach (e.g. no two service-users are alike nor will a service-user remain the same across time), a thorough appreciation of alternative viewpoints, ability to take alternative perspectives, recognition of and adherence to a service-users individual needs, effective multi-disciplinary partnership working (e.g. families/ alternative professionals to support the provision of person-centred holistic care) effective communication skills (e.g. to assist others to consistently provide person-centred care), confidence (e.g. to raise concerns or suggest changes/ improvements) and advocacy for the service-user. Approach must be constructed with empowerment and promotion of independence at its heart with a simultaneous appreciation of resource.
	1.5	Explain the relationship between rights, choice and person-centred care	The relationship between rights, choice and person-centred care: E.g. Person-centred care is an approach designed to enable and empower a service-users individual rights and choices; the concepts are integrally linked and include the right to make unwise choices. Where conflicts arise between person- centred care and duty of care; a balance must be struck between promoting choice, independence and rights against the fundamental duty to protect the health, safety and wellbeing of the service-user.
	1.6	Identify legislation and other national policy documents that promote person-centred care	Legislation and other national policy documents that promote person-centred care: E.g. The Equality and Human Rights Commission, Equality Act (2010), Putting People First: A shared vision and commitment to the transformation of Adult Social Care, Care Act (2014), Mental Capacity Act (2005), Human Rights Act (1998), Independent Living Strategy (2008), Children and Families Act (2014) and Health and Social Care Act (2012).
	1.7	Describe how person-centred care affects the balance of power between service-users and those providing support	How person-centred care affects the balance of power between service-users and those providing support: E.g. Person-centred care is an approach designed to enable and empower rights and choice; the balance

			of power is therefore shifted away from the service provider and towards the service-user (e.g. through increased control of decisions and directions relating to own care made in accordance with own unique preferences and needs).
	1.8	Explain how person-centred care may affect the way a person is supported from day-to-day	How person-centred care may affect the way a person is supported from day-to-day: E.g. Dynamic care strategy, variations in provided support dependent upon a service-users individual needs (e.g. both long term goals and short term needs), day-to-day affects include; provision of person-centred opportunities with the intention of enabling and empowering, increased opportunities for independence, increased opportunities to express and experience own preferences and reduced restrictions.
2. Understand the potential barriers to person-centred care	2.1	Describe the potential barriers to person-centred care	Potential barriers to person-centred care: E.g. Institutional focus/ culture, misunderstanding of the meaning behind/ implications of person-centred care, fixation with the condition as opposed to the person, agenda timetables and quotas, organisational expectations and targets, time constraints, staffing levels, training, cultural barriers (e.g. language and cultural awareness) resource availability and financial issues/ limitations.
	2.2	Explain ways to overcome potential barriers to person-centred care	Ways to overcome potential barriers to person-centred care: E.g. Person-centred care application and value demonstration, communication, training, collaborative practice, multidisciplinary engagement, use of advocacy services, appropriate staffing (e.g. levels and diversity), restriction of targets to quality as opposed to quantity and increasing availability of resources to support the delivery of person-centred care.
3. Understand the importance of a positive, person-centred approach to risk assessment	3.1	Explain the purpose of 'positive risk taking'	The purpose of 'positive risk taking': E.g. Taking risks and learning from the consequences of these is a part of everyday life, positive risk taking is an important component of empowerment, independence, choice and control and has positive impacts upon wellbeing. It helps to; build confidence, develop skills, learn about responsibility and consequence, act independently and develop resilience.
	3.2	Explain the process of developing a positive person-centred approach to risk assessment	The process of developing a positive person-centred approach to risk assessment: E.g. Manage risk in a way that maintains a service-users right to make choices; risk assessments must be centred around the service-user (e.g. needs, goals, preferences etc.), they must be proportionate, realistic and dynamic (e.g. regular review and re-assessment where

			required) and also include the right to make unwise decisions. The governing principle behind good approaches to risk and choice is that all service-users have the right to live their lives to the full providing this does not stop others from doing the same.
	3.3	Explain how informed consent factors into positive risk taking	How informed consent factors into positive risk taking: E.g. Positive risk taking requires informed the consent (e.g. awareness of risk and possible consequences), consent is uninformed if there are concerns regarding the capacity at that time (e.g. Mental Capacity Act 2005), capacity must be established prior to positive risk taking and relation to best interest decisions.
	3.4	Explain how a service-focused approach to risk assessment would differ from a person-centred approach	How a service-focused approach to risk assessment would differ from a person-centred approach: E.g. Service-focused risk assessments are conducted with the impact to service as the central criteria (e.g. what is best for the service; financial, logistical etc.) Person-centred risk assessments are conducted with the impact to the person as the central criteria (e.g. what is best for the person; needs, preferences, goals etc.).
	3.5	Identify the consequences for the service-user of a service-focused approach to risk-assessment	The consequences for the service-user of a service-focused approach to risk-assessment: E.g. Negative impacts to the service-user; increased dependence, increased vulnerability, non-adherence to a service-users individual needs, increased restriction and disadvantages with reference to assessment criteria 1.2.
4. Understand the role of learning and development activities in meeting individual needs	4.1	Describe the benefits to service-users of engaging in learning or development activities	The benefits to service-users of engaging in learning or development activities: E.g. Engagement with person-centred learning or development activities promotes; independence, reduced vulnerability, reduced restriction, health (e.g. memory, fitness, ability etc.), wellbeing (e.g. self-confidence, self-esteem, reduced agitation etc.), progression (e.g. life skill development), real world engagement and understanding, participation, resilience, social engagement and behavioural improvements.
	4.2	Explain the purpose of providing a range of learning or development activities for service-users to participate	The purpose of providing a range of learning or development activities for service-users to participate: E.g. Enables choice and person-centred activity provision and participation (e.g. based upon a service-users individual needs, ability, goals, preferences etc.) and specific activities are associated with specific benefits (e.g. physical vs mental); provision of a range therefore provides full coverage of these potential benefits.

	4.3	Explain how a service-users individual needs and preferences may influence how learning and development activities are accessed or delivered	How a service-users individual needs and preferences may influence how learning and development activities are accessed or delivered: E.g. Equality, diversity and inclusion must be demonstrated in all aspects of learning and development. Requires recognition of a service-users individual needs (e.g. ability, mobility, sensory deficits, need for support etc.) and preferences (e.g. activity type, activity provider, presence of others etc.) and provision of associated and individualised reasonable adjustments to access or delivery (e.g. font size, ramps, scribes, use of technology or learning aids, time provision, solo vs group activities, inclusion of friends, prompts/ reminders etc.); ensures inclusivity with regards to meeting a service-users individual preferences, learning styles and needs.
	4.4	Explain the importance of recognising progress achieved through a learning or development activity	The importance of recognising progress achieved through a learning or development activity: E.g. Positive reinforcement (e.g. encourages further learning or development), positive effects upon wellbeing (e.g. self-confidence, self-esteem, self-worth etc.), promotion of independence, benefits of outcome-focused reviews (e.g. monitoring individual goal achievement), supportive approach and promotion of effective working relationships.
5. Understand the role and value of active participation within person-centred care	5.1	Explain active participation in relation to person-centred care	Active participation in relation to person-centred care: E.g. Person-centred care requires the deployment of a dynamic and personalised care strategy; recognising a service-users individual preferences and needs with a view to empowering and promoting wellbeing and independence. Active participation is a way of working that supports a service-users right to participate in the activities and relationships of everyday life as independently as possible. The two concepts are therefore linked with regards to promotion of independence and are most effective when applied in tandem; supports the strengths, capabilities, needs, goals and adaptive skills of the service-user and affirms and develops independence, resilience, choice and control.
	5.2	Explain how active participation can address the holistic needs of a service-user	How active participation can address the holistic needs of a service-user: E.g. Individual fulfilment and positive impacts to wellbeing relating to increased; independence, resilience, learning and development, choice and control.

	5.3	Describe different ways of applying active participation to meet a service-users individual needs	Different ways of applying active participation to meet a service-users individual needs: E.g. Application dependent upon and tailored to the service-user (e.g. needs, goals, preferences, ability etc.), examples include; care plan development, medication administration, personal care, activity engagement, financial management, engagement with learning etc.
	5.4	Explain methods to promote the understanding and use of active participation	Methods to promote the understanding and use of active participation: E.g. Application and value demonstration, communication, training, collaborative practice, multidisciplinary engagement, reflective practice, case review and increasing availability of resources to support active participation.
6. Understand person-centred approaches with regards to the assessment and planning of care and/ or support	6.1	Explain the importance of a holistic approach to assessment and planning of care or support	The importance of a holistic approach to assessment and planning of care or support: E.g. Person-centred planning requires a holistic approach to recognise and respond to all aspects of importance to the service-user being assessed (e.g. social, environmental, physical, psychological and spiritual). Deviation from a holistic approach implies neglect of specific person-centred values.
	6.2	Describe ways of supporting a service-user to lead their own assessment and planning process	Ways of supporting a service-user to lead their own assessment and planning process: E.g. Adherence to principles of equality, diversity and inclusion, recognition of right to participate, involvement at earliest possible stage, provision of reasonable adjustments, partnership approach, engagement with the service-user regarding their own perception of; needs, goals, preferences, values, strengths, weaknesses (etc.), engagement with those known to the service-user (e.g. family) with regards to; history, needs, preferences, values, strengths, weaknesses (etc.), provision of own assessment of the service-user's needs, identification of associated options pathways and directions with a view to empowerment, shared decision making, shared goal setting and regular review conducted in collaboration with the service-user concerned.
	6.3	Explain why the assessment of capacity is situational	Why the assessment of capacity is situational: E.g. Lack of capacity cannot be assumed (e.g. there is a presumption of capacity) and capacity must be established for each decision with reference to the Mental Capacity Act (2005).

	6.4	Explain the importance of agreeing with the service-user and others the intended outcomes of the assessment process and care plan	The importance of agreeing with the service-user and others the intended outcomes of the assessment process and care plan: E.g. Promotion of; clarity, understanding, commitment, engagement, common goals, consistency/ continuity and opportunity for amendments.
	6.5	Explain factors that may influence the type and level of care or support to be provided	Factors that may influence the type and level of care or support to be provided: E.g. The service-users individual; needs, goals, ability (e.g. capacity), preferences and aspirations, condition based needs, family preferences, cultural requirements, spiritual requirements. Additional factors include; input from other professionals (e.g. history, potential etc.) and resource availability.
	6.6	Explain the importance of working with the service-user and others to explore options and resources for delivery of the care plan	The importance of working with the service-user and others to explore options and resources for delivery of the care plan: E.g. Clarification of roles and responsibilities, provision of information to support informed choice, identification of resource requirements, identification of potential barriers and solutions, identification and setting of common goals or objectives and the promotion of; clarity, understanding, commitment, engagement and consistency/ continuity of care.
	6.7	Explain the value of role allocation with regards to care plan delivery	The value of role allocation with regards to care plan delivery: E.g. Value to all those with involvement in the care plan (e.g. service-user, family, staff and other professionals); process transparency, accountability, responsibility, understanding, commitment, consistency/ continuity of care and assists effective delivery of agreed upon actions and objectives.
	6.8	Explain the reasons why an agreed care plan may be recorded in a variety of different formats	The reasons why an agreed care plan may be recorded in a variety of different formats: E.g. Enables person-centred information provision supporting equality, diversity, access and inclusion (e.g. importance of providing information in user friendly formats that meets the specific needs of the individual accessing the information), support for multidisciplinary collaboration and the varied documentation requirements of alternative professionals.
7. Understand how to support the implementation and review of person-centred care plans	7.1	Explain the importance of adhering to the agreed care plan	The importance of adhering to the agreed care plan: E.g. Legal and regulatory requirement, codes of conduct, agreed ways of working, enables provision of person-centred care and evidence based actions, adherence to strategy (e.g. agreed goals and objectives), safety and wellbeing of the

			service-user and others, maintenance and promotion of working relationships and consistency/ continuity of care.
	7.2	Explain how to support others to carry out aspects of the care plan for which they are responsible	How to support others to carry out aspects of the care plan for which they are responsible: E.g. Partnership working, communication, training, collaborative practice, feedback, performance review and access to support services.
	7.3	Describe methods for monitoring the delivery of a care plan	Methods for monitoring the delivery of a care plan: E.g. Record keeping and documentation (e.g. charts, diaries, notes, case files etc.), documentation audit/ review, mentoring, partnership working, shadowing, performance reviews and internal/ external communication (e.g. service-user, staff members, other involved professionals etc.).
	7.4	Describe methods for monitoring the effectiveness of a care plan	Methods for monitoring the effectiveness of a care plan: E.g. Record keeping and documentation (e.g. charts, diaries, notes, case files etc.), documentation audit/ review, review of adherence to initial objectives, internal/ external communication (e.g. service-user, staff members, other involved professionals etc.) and outcome monitoring.
	7.5	Explain how to adjust the plan in response to changing needs or circumstances	How to adjust the plan in response to changing needs or circumstances: E.g. Multi-disciplinary collaboration and with reference to assessment criteria 6.1-6.2; evidence based reassessment and care planning in accordance with new needs and circumstances.
	7.6	Explain the importance of documenting all proposed and agreed care plan changes	The importance of documenting all proposed and agreed care plan changes: E.g. Legal requirement, regulatory requirement, codes of conduct, agreed ways of working, vital for consistency/ continuity of care and enables future care plan audit and review.
	7.7	Evaluate the use of care plans in applying person-centred values	The use of care plans in applying person-centred values: E.g. Application of person-centred values dependent upon; the method used to initially develop the care plan (e.g. person-centred with active participation or more institution centred blanket approaches), adherence to the care plan (e.g. by staff) and the frequency of care plan review (e.g. the more frequent, the more effective the application of person-centred values).

Unit 2: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

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For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit is linked to: HSC21, HSC24, HSC31, HSC35, HSC41, HSC45, HSC269, HSC310, HSC328, HSC329, HSC331, HSC332, HSC344, HSC346, HSC350, HSC351, HSC364 (MH18), HSC370, HSC387, HSC388, HSC412, SCD HSC427, HSC3117, HSC3119 and Sensory Services 4-9 and 11.

Unit 3: Principles of Communication in Health and Social Care L/615/6717

Estimated TQT:	100
Estimated GLH:	75
Credit	10
Level	3

Unit Description:

This unit covers the underpinning knowledge of communication in health and social care. The unit develops the learner's knowledge and understanding of; the importance of effective communication, potential barriers to communication, communication needs, use of communication assistive technology/aids, promoting communication and the importance of reviewing communication needs and support.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand why effective communication is important in the work setting	1.1	Identify the different reasons people communicate	The different reasons people communicate: E.g. To express needs, to share ideas and information, to reassure, to express feelings and/ or concerns, to build relationships, socialise, to ask questions and to share experiences.
	1.2	Explain how communication affects relationships in the work setting	How communication affects relationships in the work setting: E.g. Effective communication enables positive working relationships; helps to build trust, aids understanding of individual servicer-user needs, used for negotiation, used to prevent or resolve conflict and prevent misunderstanding and relevant theories of communication (e.g. Tuckman's stages of group interaction; forming, storming, norming, performing and Goleman's Emotional Intelligence Competencies).
	1.3	Explain the features of two-way communication	The features of two-way communication: E.g. One person is the sender and another person the receiver, sender transmits message to receiver, receiver upon getting the message sends back a response to the original sender (e.g. acknowledging receipt of message). The model is; Sender-Message-Receiver-Response.
2. Understand barriers to communication	2.1	Explain how people from different backgrounds may use and/ or interpret communication methods in different ways	How people from different backgrounds may use and/ or interpret communication methods in different ways: E.g. Factors influencing communication include; age, gender, culture, socio-economic status, differences in verbal communication (e.g. language, vocabulary, dialect,

			intonations etc.) and differences in non-verbal communication (e.g. facial expressions, use of body language, eye contact, gestures etc.).
	2.2	Identify barriers to effective communication	Barriers to effective communication: E.g. Environmental barriers, 'clinical' barriers, emotional barriers, attitudinal barriers, bureaucratic barriers. Examples include; Language (e.g. dialect, use of jargon, sector-specific vocabulary etc.), environmental (e.g. noise, poor lighting etc.), emotional and behavioural (e.g. attitudes, anxiety, lack of confidence, aggression etc.), sensory impairment, health problems or medical conditions, learning disabilities and the impairment effects of alcohol or drugs.
	2.3	Explain ways to overcome barriers to communication	Ways to overcome barriers to communication: E.g. Use of; technological aids (e.g. hearing aids, induction loop, telephone relay services), assistive aids (e.g. visual cues), human aids (e.g. interpreters, signers, translators, advocates), use of age/ability appropriate vocabulary, staff training, environmental improvement and distraction reduction.
	2.4	Explain strategies that can be used to clarify misunderstandings	Strategies that can be used to clarify misunderstandings: E.g. Effective communication, checking/ monitoring understanding, repeating, rephrasing, use of visual cues, demonstration and support/ assistance.
	2.5	Explain ways to maintain confidentiality in day-to-day communications	Ways to maintain confidentiality in day-to-day communications: E.g. Restriction of personal information provision to the person/ authorised individuals concerned only, adherence to workplace policies and procedures (e.g. policies for sharing information), staff confidentiality training, document control (e.g. paper and electronic) and confidentiality relating to the collection, recording, storage and disposal of different types of information.
3. Understand specific communication needs and factors affecting them	3.1	Explain the importance of meeting a service-users individual communication needs	The importance of meeting a service-users individual communication needs: E.g. The underlying reasons behind the message and the potential effects of having unmet communication needs (e.g. frustration, anger, unable to communicate choice/ need, social exclusion/ isolation, behaviour that challenges), requirement for the delivery of person-centred care, requirement for legislative adherence (e.g. Human's Rights Act 1998 The Equality and Diversity Act 2010) and positive impacts upon quality of life and wellbeing.
	3.2	Explain how to establish the communication and language needs, wishes and preferences of service-users	How to establish the communication and language needs wishes and preferences of service-users: E.g. Communication and consultation (e.g.

			with service-user, their family and alternative professionals), consultation of previous care plans, recognition of and response to a service-users individual needs, ability and situation (e.g. age, stage of development, home language, preferred communication methods, communication goals, additional learning needs, physical disabilities, alternative methods of communication etc.) and regular review.
	3.3	Explain how to access information and support about identifying and addressing specific communication needs	How to access information and support about identifying and addressing specific communication needs: E.g. Interpreting service, translation service, speech and language services, advocacy services and third sector organisations (e.g. Stroke Association, Royal National Institute for Deaf People).
	3.4	Explain how own role and practice can impact on communication with a service-user who has specific communication needs	How own role and practice can impact on communication with a service-user who has specific communication needs: E.g. Experience related improvements to own competency understanding or using specific communication methods, styles and aids (e.g. enables more effective person-centred communication), familiarity/ trust related reductions in communication barriers, use of/ reliance upon alternative forms of communication (e.g. familiarity related changes to use of specific forms of verbal and non-verbal communication including behaviour), improved ability to recognise and respond to specific reactions (e.g. tone, pitch, silence, body language, facial expressions, eye contact, gestures, touch, emotional state), increased understanding of reactions indicating comprehension or confusion (e.g. enabling directed clarifications) and improved understanding of how and when to adjust the communication method.
	3.5	Analyse reasons why a service-user may use a form of communication that is not based on a formal language system	Reasons why a service-user may use a form of communication that is not based on a formal language system: E.g. Development and upbringing, adaptive response to; specific sensory impairments (e.g. visual, auditory, olfactory, kinaesthetic, gustatory), physical impairments and cognitive issues affecting communicative ability.
	3.6	Explain the factors to consider when promoting effective communication	The factors to consider when promoting effective communication: E.g. A service-users individual needs, use of assistive aids/ tools/ technology, Argyle's stages of the communication cycle (ideas occur, message coded, message sent, message received, message decoded, message understood), type of communication (e.g. complex, sensitive, formal, non-

			formal), context of communication (e.g. one-to-one, group, professional etc.), purpose of communication, confidentiality of communication, cultural factors, necessary adaptations, environmental factors (e.g. suitability), time and resource availability and methods to check/ monitor comprehension.
	3.7	Describe a range of non-verbal forms of communication	Non-verbal forms of communication: E.g. Position/ proximity, eye contact, behaviour, body language, touch, signs (e.g. Makaton), symbols and pictures (e.g. PECS), writing, objected of reference, now and next boards, human and technical aids.
	3.8	Explain a range of communication methods and styles to meet a service-users individual needs	Communication methods and styles to meet a service-users individual needs: E.g. Age, ability and needs appropriate; non-verbal communication (e.g. eye contact, touch, gestures, body language, behaviour), verbal communication (e.g. vocabulary, linguistic tone, pitch, pace), signing, symbols, objects of reference and use of assistive technology/ communication aids.
	3.9	Explain how to maximise the effectiveness of communication by making adaptations to own verbal and non-verbal communication style	How to maximise the effectiveness of communication by making adaptations to own verbal and non-verbal communication style: E.g. Checking/ monitoring understanding, avoiding misinterpretation of body language, use of active listening, repeating, rephrasing, use of visual cues, use of technological aids (e.g. hearing aids, induction loop, telephone relay services), use of human aids (e.g. interpreters, signers, translators, advocates), use of age-appropriate vocabulary, use of ability appropriate sentence structures, staff training, improving environment, reducing distractions and adapting method based upon effectiveness of comprehension.
	3.10	Explain how to monitor the effectiveness of chosen communication methods	How to monitor the effectiveness of chosen communication methods: E.g. Check comprehension/ understanding, monitor behavioural reaction and use Personal Communication Passports.
	3.11	Explain why meeting communication needs can be thought of as a 'dynamic process'	Why meeting communication needs can be thought of as a 'dynamic process': E.g. Multi-modal communication strategies, can include many different methods and tools of communication and situational dependence of communication needs.
4. Understand the use of communication-focused assistive technology and aids	4.1	Identify specialist services relating to communication technology and aids	Specialist services relating to communication technology and aids: E.g. Professionals such as; Speech and Language Therapists and Learning Disability Nurses, Organisations such as RNIB, Action on Hearing Loss

			(formerly RNID) Sense, Telecare, MND association, UK Connect - Strokes, Stroke association, Alzheimer's Society, Communication matters etc.
	4.2	Explain a range of communication methods and aids to support communication	Communication methods and aids to support communication: E.g. Methods and aids that support; writing (e.g. dictation/ voice recognition), reading (e.g. glasses, braille, large print), talking (e.g. symbols, signs, objects of recognition, interpreters, computers), language including sign language (e.g. interpreters), body language, hearing (e.g. hearing aids) and speech (e.g. voice amplifiers).
	4.3	Describe types of support that a service-user may need in order to use communication technology and aids	Types of support that a service-user may need in order to use communication technology and aids: E.g. Person-centred support; needs assessment, training (e.g. service-user, their close relatives, support workers etc.) prompts, reminders, psychological support and encouragement, recognition of achievement and maintenance of aid.
	4.4	Explain the importance of ensuring that communication equipment is correctly set up and working properly	The importance of ensuring that communication equipment is correctly set up and working properly: E.g. To ensure communication needs are met, prevention of reactions to unmet communication needs (e.g. behaviour that challenges), removal of communication barriers, promotion of confidence in use of communication equipment (e.g. affecting equipment usage and reliance going forward) and related impacts to development and wellbeing.
	4.5	Explain when and to whom referrals for maintenance or repair of assistive technology would be made	When and to whom referrals for maintenance or repair of assistive technology would be made: E.g. Planned proactive approach, regular scheduling (e.g. to prevent unplanned disruption to use of assistive technology), consultation with speech and language/ occupational therapists and maintenance normally provided from the supplier of the assistive technology.
	4.6	Explain how assistive technology can have a positive impact on the wellbeing and quality of life of service-users	How assistive technology can have a positive impact on the wellbeing and quality of life of service-users: E.g. Psychological, emotional, physical and social impacts of meeting communication needs.
5. Understand how to promote communication between individuals and others	5.1	Describe the importance of providing a service-user with opportunities for communication	The importance of providing a service-user with opportunities for communication: E.g. Fundamental right to communicate (Human Rights Act 1998), broad reaching benefits to biopsychosocial wellbeing and ensures a service-users individual needs are met.

	5.2	Explain how to support a service-user to develop communication methods to facilitate interaction with others	How to support a service-user to develop communication methods to facilitate interaction with others: E.g. Adherence to policy/ agreed ways of working, person-centred assessment (e.g. needs, goals, preferences etc.), multidisciplinary collaboration and consultation (e.g. speech and language therapists, carers specialist services and other support providers), trialling a range of methods/ approaches and enabling opportunities for interaction (e.g. communal activities etc.).
	5.3	Explain how to support others to understand and interpret a service-user's chosen method of communication	How to support others to understand and interpret a service-user's chosen method of communication: E.g. Training, mentoring, provision of necessary equipment and adaptations; interim measure to act as a go between or interpreter, long term goal would be education and training to develop the person's ability to understand and interpret the chosen method.
	5.4	Explain how to support others to be understood by a service-user	How to support others to be understood by a service-user: E.g. Training, mentoring, provision of necessary equipment and adaptations; interim measure to act as a go between or interpreter, long term goal would be education and training to develop the person's ability to understand and interpret the chosen method.
6. Understand the importance of reviewing an individual's communication needs and provided support	6.1	Explain the importance of documenting information regarding a service-users communication	The importance of documenting information regarding a service-users communication: E.g. Ensures consistency/ continuity of care, legal requirement to fully document, helps others to communicate effectively (e.g. assists delivery of person-centred care with reference to communication), works alongside a communication passport and enables evidence based changes/ adaptations to communication strategies.
	6.2	Explain how to evaluate the effectiveness of agreed methods of communication and support	How to evaluate the effectiveness of agreed methods of communication and support: E.g. Review the success of the agreed method of communication; monitor comprehension, consultation with the service-user and others, evaluative methods such as SWOT, reference and review of communication related documentation, monitor goal adherence, behavioural analysis and multidisciplinary collaboration.
	6.3	Explain the importance of reflecting upon own practice with regards to means of communication	The importance of reflecting upon own practice with regards to means of communication: E.g. Reflection enables continuous improvement; allows for identification of positives and successes (e.g. actions that should continue) and negatives (e.g. actions needing development, review or change).

	6.4	Explain how to support the continued development of a service-user's communication skills	How to support the continued development of a service-user's communication skills: E.g. Regular review of communication strategy and available resources, provision of opportunities for development and growth, person-centred approaches towards developing communication (e.g. provision of person-centred activities that require use and practice of the desired communication skill), multidisciplinary collaboration and recognition of and adherence to communication goals.

Unit 3: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

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Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit is linked to: CCLD301, GCU1, GEN22, HSC21, HSC24, HSC31, HSC35, HSC41, HSC45, HSC269, HSC370 and Sensory Services 4-9 and 11.

Unit 4: Principles of Safeguarding and Duty of Care in Health and Social Care F/615/6715

Estimated TQT:	100
Estimated GLH:	75
Credit	10
Level	3

Unit Description:

This unit covers the underpinning knowledge of safeguarding and duty of care in health and social care. The unit develops the learner's knowledge and understanding of; the national and local context of safeguarding and protection from abuse, recognising signs of abuse, supporting individuals to stay safe, reducing the likelihood of abuse, responding to suspected or alleged abuse, the contribution of duty of care to safe practice and addressing conflicts occurring between an individual's rights and duty of care.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the national and local context of safeguarding and protection from abuse	1.1	Explain what safeguarding means for adults and children	What safeguarding means for adults and children: E.g. Protecting health, wellbeing and human rights, enabling all individuals to live free from harm, abuse and neglect and ensuring that all individuals are supported to get good access to health care and stay well. Core principles include; empowerment, prevention, proportionality, protection, partnership and accountability.
	1.2	Identify legislation and national policies that relate to safeguarding	Legislation and national policies that relate to safeguarding: E.g. Children Act (1989), Children Act (2004), Safeguarding Vulnerable Groups Act (2006), Protection of Freedoms Act (2012), Children and Families Act (2014), Education Act (2002), Adoption and Children Act (2002), Female Genital Mutilation Act (2003), Children and Adoption Act (2006), Children and Young Persons Act (2008), Borders, Citizenship and Immigration Act (2009), Apprenticeships, Skills, Children and Learning Act (2009), Education Act (2011), Working together to safeguard children (2015). The Care Act (2014), Care Act Statutory Guidance (Department of Health, 2014), Mental Capacity Act (2005) and the Code of Practice (Department of Constitutional Affairs, 2007), Government Statement of Policy on Adult Safeguarding (HM Government, 2013), Safeguarding – roles and responsibilities in health and care services (Department of Health, Local Government Association, ADASS, NHS Confederation, Association of Chief Police Officers, 2013).

	1.3	Explain the relationship between local procedures and guidelines for safeguarding and legislative frameworks	The relationship between local procedures and guidelines for safeguarding and legislative frameworks: E.g. Procedures, protocols and practice guidance together provide a framework to guide actions and clarify roles and responsibilities in accordance with the latest legislation.
	1.4	Explain the roles of different agencies in safeguarding and protecting service-users from abuse	The roles of different agencies in safeguarding and protecting service-users from abuse: E.g. Importance of multi-agency and interagency working including; social services (e.g. social workers, care assistants, residential children's home workers), health services (e.g. GPs, nurses, occupational therapists, health visitors) and voluntary services (e.g. MIND, NSPCC, Age UK). Safeguarding Adults Boards: These bring together a number of different local agencies that work with vulnerable adults to share information and monitor their work (e.g. local agencies including the police, MIND, housing teams and advocacy groups). The Police: Their role is to safeguard vulnerable adults, investigate all reports of vulnerable adult abuse and protect and uphold the rights of vulnerable adults. CQC: To monitor and provide guidance on what all health and social care providers must do to safeguard vulnerable adults from abuse, the safeguarding policies, procedures and systems developed are in place to prevent vulnerable adults from being abused.' Ofsted: To inspect and regulate services that care for children and young people, includes regulation of services providing education and skills for learners of all ages. Health and Social Services: To raise concerns, report allegations and to aid in the investigation and subsequently action plan, responsibilities for overseeing the Safeguarding Assessment and its outcome, consulting the police regarding all safeguarding incidents, convening or chairing strategy meetings including the agreement of responsibilities, lead professional actions and timescales, coordinating and monitoring investigations, overseeing the convening of Safeguarding Case Conferences and providing information about activities and outcomes to the Safeguarding Coordinator.
	1.5	Explain own role in safeguarding and protecting service-users from abuse	Own role in safeguarding and protecting service-users from abuse: E.g. Role dependent but includes to; recognise, report, provide a written account of the cause of concern and liaise with other professionals.

2. Know how to recognise signs of abuse	2.1	Describe the following types of abuse: • Physical abuse • Sexual abuse • Emotional/ psychological abuse • Financial abuse • Material abuse • Institutional abuse • Self-abuse/ neglect • Neglect by others • Acts of omission	Physical abuse: E.g. Abuse involving contact intended to cause feelings of intimidation, pain, injury or other physical suffering/ bodily harm (e.g. hitting, shaking, biting, throwing, burning, scalding, suffocating, force-feeding etc.). Sexual abuse: E.g. Abuse involving the forcing of undesired sexual behaviour by one person upon another, a component but not determinant of sexual assault, includes encouraging or observing inappropriate sexual activities and any behaviour by any adult towards a child to stimulate either the adult or child sexually. Emotional/ psychological abuse: E.g. Abuse characterised by a person subjecting or exposing another to behaviour that is psychologically harmful and often associated with situations of power imbalance (e.g. bullying, invoking threats or fear, devaluing an individual's self-esteem or perceptions of worth, verbal abuse and swearing, imposing inappropriate expectations, exploitation etc.). Financial and Material abuse: E.g. Illegal or unauthorised use/ control of a person's property, money or other valuables; includes unauthorised alterations to a persons will and often involves fraudulently obtained power of attorney. Risk of abuse increases with vulnerability (e.g. age and/ or disability). Institutional abuse: Typically occurs in a care home, nursing home, acute hospital or in-patient setting (e.g. 'institutions') and can involve any of the following forms of abuse: discriminatory abuse, financial abuse, neglect, physical abuse, emotional/ psychological abuse, sexual abuse and/ or verbal abuse. Self-abuse/ neglect: E.g. Self-destructive behaviour, includes a broad range of extreme actions/ emotions (e.g. self-harm, self-deprivation, drug-abuse etc.) and can affect any age but most visible in young adults/ adolescents). Neglect by others and Acts of omission: E.g. Passive forms of abuse, involves a caregiver failing to provide adequate care for an individual's needs where this individual is unable to address these needs independently (e.g. omission to the detriment of the person being cared for), examples can include a failure to provide sufficient; supervision, nourishment and medical care.

	2.2	Identify the signs and/ or symptoms associated with each type of abuse	The signs and/ or symptoms associated with each type of abuse: E.g. Physical abuse: Person-dependent but can include; bruising, bite marks, burn marks, withdrawal, changes in behaviour and death in extreme cases. Sexual abuse: Person-dependent but can include; self-harm, inappropriate sexualised behaviours, repeated urinary infections, depression, loss of self-esteem, impaired ability to form relationships and other behavioural changes. Emotional abuse: Person-dependent but can include; self-harm, depression, loss of self-esteem, loss of self-confidence, withdrawal and other behavioural changes. Financial and material abuse: Person-dependent but can include; loss of trust, insecurity, fearfulness, withdrawal, conforming or submissive behaviour, disappearance of possessions and power of attorney obtained when individual unable to comprehend. Institutional abuse: Person-dependent but can include; loss of self-esteem and confidence, submissive behaviour, apathy, loss of control, withdrawal and other behavioural changes. Self-neglect, neglect by others and omissions: Person-dependent but can include; unkempt appearance, weight loss, dehydration, worsening of condition, self-harm, submissive behaviour, withdrawal and other behavioural changes.
	2.3	Describe factors that may contribute to an individual being more vulnerable to abuse	Factors that may contribute to an individual being more vulnerable to abuse: E.g. Age (e.g. elderly and young children), physical ability (e.g. frailty and development maturity), physical disability or sensory impairment, cognitive ability (e.g. maturity, level of education and intellectual understanding, learning difficulties), emotional resilience (e.g. mental health difficulties, depression), stress (e.g. impact of stressful life events including bereavement, divorce, drug abuse, illness or injury), culture or religion (e.g. as a result of prejudice or discrimination), socio-economic factors (e.g. financial situation) and particular settings or situations.
3. Understand how to support individuals to gain an understanding about how to stay safe	3.1	Explain how to support a service-user to gain an understanding about their right to stay safe	How to support a service-user to gain an understanding about their right to stay safe: E.g. Person-centred communication, multidisciplinary working across agencies, person-centred information provision, active participation and ensuring the service-user understands their right to; choice, independence, dignity, respect, equality and privacy.

	3.2	Explain how to support a service-user to gain an understanding about their responsibility to contribute to keeping themselves safe	How to support a service-user to gain an understanding about their responsibility to contribute to keeping themselves safe: E.g. Person-centred communication, multidisciplinary working across agencies, active participation (e.g. participation in maintaining own safety) and person-centred information provision to help increase understanding of; the different types of abuse, how to stay safe and how to raise concerns.
	3.3	Explain why a service-users rights, responsibilities and risks must be balanced	Why a service-users rights, responsibilities and risks must be balanced: E.g. A balance must be struck between promoting choice, independence and rights (e.g. the right to make choices and take risks) against the fundamental duty to protect the health, safety and wellbeing of the service-user (e.g. the need to safeguard from harm). Promotion of choice and rights decreases likelihood of abuse, increases resilience, decreases vulnerability and promotes empowerment and independence. This requires; own impartiality, a separation of personal views from the service-users decision making processes, awareness of legislation and agreed ways of working (e.g. that concern or influence rights) and knowledge of when the need to safeguard to prevent overrides the need to enable independently directed choice and risk taking.
	3.4	Explain how to challenge behaviours or actions that may lead to harm or abuse	How to challenge behaviours or actions that may lead to harm or abuse: E.g. Importance of following legislation, policies, procedures and agreed ways of working, referral to manager or supervisor for support and guidance, adherence to and promotion of the core principles of safeguarding; empowerment, prevention, proportionality, protection, partnership and accountability.
4. Understand ways to reduce the likelihood of abuse	4.1	Explain the purpose of Disclosure and Barring Service (DBS) checks	The purpose of DBS checks: E.g. Helps employers to make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups.
	4.2	Describe unsafe practices that may affect the wellbeing of a service-user	Unsafe practices that may affect the wellbeing of a service-user: E.g. Differs by role but includes; non-adherence to policies procedures and agreed ways of working and any practice that could threaten/ jeopardise the rights or safety of the service-user.
	4.3	Explain the actions to take if unsafe practices have been identified	The actions to take if unsafe practices have been identified: E.g. Share concerns with senior colleagues or managers, report concerns using local

			incident reporting systems, follow up concerns and if still concerns refer to whistleblowing policy.
	4.4	Explain how the likelihood of abuse may be reduced through acting in a person-centred manner	How the likelihood of abuse may be reduced through acting in a person-centred manner: E.g. Reductive impact across all forms of abuse, particularly psychological, emotional and institutional; encouraging active participation, promoting choice and rights, recognising individual triggers, the dignity challenge, policies, procedures and agreed ways of working.
	4.5	Explain how multidisciplinary working can reduce risk of abuse	How multidisciplinary working can reduce risk of abuse: E.g. Multi-agency approach to provision and services, shared; information, communication and decision-making processes and forums leading to improved results. Reduced opportunity to miss warning signs, dynamic approach to action planning, inclusive practice and person-centred planning, includes; joint policies, training etc.
	4.6	Explain the importance of an accessible complaints procedure for reducing the likelihood of abuse	The importance of an accessible complaints procedure for reducing the likelihood of abuse: E.g. Legal requirement to have a complaints procedure in place, accessibility permits timely response to issue(s) of complaint and timeliness essential for safeguarding. Includes; transparent policies, procedures and agreed ways of working, clear systems for reporting and recording complaints, importance of accountability, robust procedures for following up on any complaints and ways of ensuring the procedure is accessible (e.g. published policy, high visibility, widespread distribution etc.).
5. Know how to respond to suspected or alleged abuse	5.1	Explain the purpose of whistleblowing	The purpose of whistleblowing: E.g. Removal of unsafe or unethical behaviours from the workplace, legislative requirement, provides opportunity to raise concerns internally and externally and facilitates positive change. Intended to encourage individuals to make good faith reports of suspected; improper, unsafe and/ or inappropriate activity.
	5.2	Explain the actions to take if there are suspicions that a service-user is being abused	The actions to take if there are suspicions that a service-user is being abused: E.g. Importance of following legislation, policies, procedures and agreed ways of working, information collection and recording (e.g. who the alleged victim is, who the alleged abuser is, categories of abuse which could be happening, when abuse has happened, where abuse has happened, when and where abuse was first disclosed), importance of; treating all allegations or suspicions seriously, not asking leading questions

			with individuals concerned, respectful listening, avoiding hearsay and ensuring available evidence is preserved. Additional responsibilities include; lines of communication and reporting (e.g. reporting suspicions or allegations to appropriate/ named person), production of clear verbal and accurate written reports (e.g. signed and dated details of alleged/ suspected abuse, signed and dated witness statements, use of photographic evidence etc.), maintenance of confidentiality, agreed procedures for sharing and storing information and evidence (e.g. security) and the importance of timescales to ensure reliability and validity of all evidence collected.
	5.3	Explain the actions to take if a service-user alleges that they are being abused	Actions to take if a service-user alleges that they are being abused: E.g. Importance of following legislation, policies, procedures and agreed ways of working; remain calm, do not show shock or disbelief, listen respectfully, reassure (e.g. they did the right thing to tell you, you are treating the information seriously, it was not their fault, you are going to inform the appropriate person you /the service will take steps to protect and support them etc.), be sympathetic, do not ask leading questions, be aware of the possibility that medical evidence might be needed and report disclosure appropriately (e.g. to line manager, senior manager, social services or the police).
	5.4	Explain the requirements for recording and reporting suspected or disclosed abuse	The requirements for recording and reporting suspected or disclosed abuse: E.g. Importance of following legislation, policies, procedures and agreed ways of working; document the suspicion/ disclosure at the first opportunity, sign and date the record, separate factual information from opinion, include what was actually said (e.g. using their own words and phrases), the circumstances leading to the disclosure/ suspicion, the setting of the disclosure/ suspicion and any available witnesses or bystanders. Use a pen or biro with black ink (e.g. so that the report can be photocopied) and be aware that the report may be required later as part of a legal action or disciplinary procedure.
	5.5	Explain ways to ensure that evidence of abuse is preserved	Ways to ensure that evidence of abuse is preserved: E.g. Adherence to policy, procedure and agreed ways of working; use of signed and dated written reports (e.g. objective details of alleged/ suspected abuse, witness statements and photographic evidence where available), maintenance of confidentiality, secure information handling (e.g. storage) and importance of timescales to ensure reliability and validity of evidence.

	5.6	Explain the actions that should be taken if reported concerns are not acted upon	Actions that should be taken if reported concerns are not acted upon: E.g. Follow local and national policies and procedures for escalation and whistleblowing.
	5.7	Explain how to access safeguarding support services	How to access safeguarding support services: E.g. Contact; Social Care Institute for Excellence (SCIE), Social Services, Care Quality Commission (CQC), Carers Direct Helpline and/ or NSPCC.
6. Understand how duty of care contributes to safe practice	6.1	Explain what it means to have a duty of care in own work role	What it means to have a duty of care in own work role: E.g. Legal obligation requiring adherence to a standard of reasonable care, requires accountability and includes overarching requirement to safeguard the welfare and wellbeing of all service-users within own care.
	6.2	Explain the purpose of identity checks for anyone requesting access to premises or information	The purpose of identity checks for anyone requesting access to premises or information: E.g. To safeguard and protect the premises, the people within the premises and/ or the information requested, ensures those accessing have a legal right to do so, enables documentation of personnel and promotes compliance with a range of requirements (e.g. health and safety, confidentiality, duty of care etc.)
	6.3	Explain how duty of care contributes to the safeguarding or protection of service-users	How duty of care contributes to the safeguarding or protection of service-users: E.g. Protection of all service-users from harm/ abuse, preservation of respect and dignity, prevention from intimidation or humiliation and minimisation of unacceptable risk; ensures the upholding of rights, enables individualised empowerment and promotes safety and wellbeing.
7. Know how to address conflicts or dilemmas that may arise between an individual's rights and the duty of care	7.1	Describe potential conflicts or dilemmas that may arise between the duty of care and a service-users rights	Potential conflicts or dilemmas that may arise between the duty of care and a service-users rights: E.g. The balance between safeguarding a service-user from harm and the service-users right to make choices (e.g. both wise and unwise) and take risks. Examples of conflict are broad but can relate to; relationships, unsafe behaviour such as drug/ alcohol abuse, truanting, staying out without permission, aggression and violence, bullying and intimidation, vandalism, self-neglect etc.
	7.2	Explain how to manage risks associated with conflicts or dilemmas between a service-users rights and the duty of care	How to manage risks associated with conflicts or dilemmas between a service-users rights and the duty of care: E.g. Implementing and following policies and codes of practice, adherence to procedures and agreed ways of working, supporting choice whilst minimising risk (e.g. risk assessment), enabling positive risk taking (e.g. positive approach towards risk assessment), acting in best interests, fostering culture of openness and

			support, being consistent, maintaining professional boundaries and following systems/ agreed ways of working for raising concerns.
	7.3	Explain where to get additional support and advice about conflicts and dilemmas	Where to get additional support and advice about conflicts and dilemmas: E.g. Line management, training and professional development, health professionals, school/college services, counselling services, mediation and advocacy services.

Unit 4: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit is linked to: CCLD305, GCU2, HSC24, HSC34, HSC35, HSC240, HSC345 and SCDHSC0024 – Support the safeguarding of individuals, SCDHSC0034 – Promote the safeguarding of children and young people, SCDHSC0035 – Promote the safeguarding of individuals, SCDHSC00325 – Contribute to the support of children and young people who have experienced harm or abuse, SCDHSC0335 – Contribute to the support of individuals who have experienced harm or abuse, SCDHSC0044 – Lead practice that promotes the safeguarding of children and young people, SCDHSC0045 – Lead practice that promotes the safeguarding of individuals.

Unit 5: Principles of Equality, Diversity and Rights in Health and Social Care A/615/6714

Estimated TQT:	50
Estimated GLH:	25
Credit	5
Level	3

Unit Description:

This unit covers the underpinning knowledge and understanding of equality, diversity and rights in health and social care. The unit develops the learner's knowledge and understanding of; concepts of equality diversity and rights, rights with regards to accessing healthcare, discriminatory practices and national initiatives to promote anti-discriminatory practices.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand concepts of equality, diversity and rights in health and social care	1.1	Explain the meaning of the following terms in relation to health and social care: • Equality • Diversity • Rights	Equality: E.g. Promotion of rights respect and fairness, providing choice and opportunity, ensuring inclusivity and services in response to a service-user's individual needs. Diversity: E.g. Differences between individuals and groups (e.g. culture, nationality, ability, ethnic origin, gender, age, religion, beliefs, sexual orientation, social class etc.). Rights: E.g. Basic, legal and civil.
	1.2	Describe how staff members should apply values of equality in a health and social care service	How staff members should apply values of equality in a health and social care service: E.g. Policies and procedures in workplace setting, inclusive practices and procedures, challenging discrimination, promoting rights, empowering, removing barriers (e.g. to physical access, to effective communication), improving participation, promoting dignity and respect and placing service-users at the centre of service planning and delivery.
	1.3	Explain why it is important to recognise and respect a service-users heritage	Why it is important to recognise and respect a service-users heritage: E.g. Heritage refers to a service-users culture, history and personal experiences; it is unique to them. Importance of recognising and respecting to; acknowledge and address preferences (e.g. culture, dress, language, diet. religion, rituals etc.), promote dignity, empower and enable, improve perceptions of self-value/ worth, remove barriers, prevent isolation/ withdrawal and promote acceptance understanding and wellbeing.

	1.4	Explain how inclusive practice promotes equality and supports diversity	How inclusive practice promotes equality and supports diversity: E.g. Encourages choice, empowers service-users, encourages independence and promotes civil liberties.
	1.5	Describe methods to support others to promote equality and rights	Methods to support others to promote equality and rights: E.g. Observing the social model of disability, following procedures, promoting choice empowerment and independence, removing barriers (e.g. to access), promoting equality and rights, providing opportunities, group discussion with regards to own reflective practice, advocacy for the service-user, understanding and sharing information regarding a service-users individual needs, demonstrating ways to value differences, highlighting the benefits of diversity to others (e.g. cultural enrichment, the arts, food, social cohesion, value gained through diversity of opinions etc.), modelling the use of appropriate language to others, taking part in staff-training activities, demonstrating person-centred practice in interactions and providing accessible information on disciplinary and complaints procedures.
	1.6	Explain the benefits of understanding diversity in relation to health and social care	The benefits of understanding diversity in relation to health and social care: E.g. Allows you to identify and challenge discriminatory behaviour, recognising stereotypes in attitudes or written materials, understanding and adapting own beliefs and attitudes, knowing how to report concerns and knowing how to review and develop policy and procedures.
2. Understand the rights of all individuals with regards to accessing healthcare	2.1	Explain what is meant by a rights based approach to accessing healthcare	What is meant by a rights based approach to accessing healthcare: E.g. Human right to access healthcare, access may require support or adjustments and FREDA approach to rights (e.g. fairness, respect, equality, dignity and autonomy).
	2.2	Describe barriers to accessing healthcare services that a service-user with learning disabilities may experience	Barriers to accessing healthcare services that a service-user with learning disabilities may experience: E.g. Lack of accessible information, lack of reasonable adjustments, communication and comprehension of processes, organisational (e.g. availability of resources, knowledge, attitudes etc.) and accessibility/ availability of service providers.
	2.3	Explain ways to overcome barriers to accessing healthcare services	Ways to overcome barriers to accessing healthcare services: E.g. Education and training, effective person-centred assessments, effective communication, provision of reasonable adjustments (e.g. alternative format information, accessibility adjustments etc.), consultation and

			collaboration with specialist agencies, person-centred adaptations (e.g. preference driven adjustments) and increasing availability of resources.
	2.4	Explain the legislative requirements if a service-user is assessed to not have the capacity to consent to a specific treatment decision	The legislative requirements if a service-user is assessed to not have the capacity to consent to a specific treatment decision: E.g. MCA (2005) and DOLS; rights and choices, right to alter decisions, understanding and retaining information, lack of capacity to give consent, 'best interests', advance directives and written records.
	2.5	Explain ways to support a service-user to give informed consent in line with legislation, policies and guidance	Ways to support a service-user to give informed consent in line with legislation, policies and guidance: E.g. Agreed ways of working, consideration given to impact of environment and allocated member of staff (e.g. could/ will change have an effect), involvement of others known to the service-user (e.g. family and friends), additional multidisciplinary involvement (e.g. speech and language therapist, psychologist etc.), provision of reasonable adjustments (e.g. use of technology, changes to communication method; pictures, signs, photos etc.) and consideration given to the impact of time of day (e.g. is there a time dependency to capacity etc.).
	2.6	Explain ways in which healthcare services should make 'reasonable adjustments' to ensure that they provide equal access to all service-users	Ways in which healthcare services should make 'reasonable adjustments' to ensure that they provide equal access to all service-users: E.g. Staff training, information in alternative formats, reminders, use of technology, outreach services, accessibility adjustments and provider contracts.
3. Understand discriminatory practices within health and social care	3.1	Describe a range of discriminatory practices within health and social care	Discriminatory practices within health and social care: E.g. Infringement of rights, the various types of abuse, the covert or overt abuse of power, bullying, prejudice, stereotyping, labelling and provision of non-person-centred care.
	3.2	Describe the potential impact of discriminatory practices upon a service-user	The potential impact of discriminatory practices upon a service-user: E.g. Disempowerment, reduced independence, reduced progression, low self-esteem and self-confidence, withdrawal, negative effects upon wellbeing, marginalisation, restricted opportunities, unemployment, lack of social cohesion, negative behaviours (e.g. violence or criminality) and loss of rights.
	3.3	Describe how to challenge discrimination in a way that promotes change	How to challenge discrimination in a way that promotes change: E.g. Identifying and challenging discriminatory behaviour, recognising and correcting stereotypes in attitudes or written materials, reflecting upon and

			adapting own behaviour beliefs and attitudes, assisting others to adapt behaviour beliefs and attitudes (e.g. through demonstration, assistance and support), reporting concerns appropriately and regularly reviewing and developing policy and procedures.
4. Understand the role of national initiatives in promoting anti-discriminatory practice	4.1	Identify legislation that promotes anti-discriminatory practice	Legislation that promotes anti-discriminatory practice: E.g. Sex Discrimination Act (1975), Mental Health Act (1983), Mental Health (Northern Ireland) Order (1986), The Convention on the Rights of the Child (1989), The Children Act (2004), Race Relations (Amendment) Act (2000), Disability Discrimination Act (1995), Human Rights Act (1998), Data Protection Act (1998), Nursing and Residential Care Homes Regulations 1984 (amended 2002), Care Standards Act (2000), The Children Act (2004), Mental Capacity Act (2005), Age Discrimination Act (2006) and Equality Act (2010)- this replaced previous acts that reference discrimination.
	4.2	Describe a range of non-legislation based initiatives aimed at promoting anti-discriminatory practice	Non-legislation based initiatives aimed at promoting anti-discriminatory practice: E.g. Codes of practice, conduct and charters established by professional bodies; General Social Care Council/ Care Council for Wales/ Northern Ireland (e.g. entitlement to services), quality assurance processes (e.g. inspections including Ofsted and CQC), organisational policies and procedures (e.g. equal opportunities, bullying, harassment, confidentiality, health and safety, work practices, positive promotion of individual rights, advocacy, staff recruitment, development and training and complaints procedures etc.) and protected characteristics.
	4.3	Explain how national initiatives promote anti-discriminatory practice	How national initiatives promote anti-discriminatory practice: E.g. Person-centred approach to care and care provision, ensures a service-users individual needs are met and rights upheld (e.g. privacy, safety, access, empowerment, independence), provides a system of redress, provides clear set of guidelines for practitioners to follow, promotes understanding, raises standards of care and promotes consistency/ continuity of care.
	4.4	Explain the impact of the following Acts in promoting anti-discriminatory practice: • Equality Act (2010) • Mental Health Act (1983)	The impact of the Equality Act (2010) and Mental Health Act (1983) in promoting anti-discriminatory practice: E.g. Provides framework for anti-discriminatory practice and upholding of rights, statutory duty placed on public bodies to have due regard to the need to; promote equality of opportunity, eliminate discrimination, eliminate harassment relating to disabilities, promote positive attitudes towards disabilities, enable access

			and participation and provide reasonable adjustments based upon a service-users individual needs (e.g. to minimise disadvantage). Adherence to these Acts informs practice and reduces likelihood of discrimination towards those with a disability and/ or mental health issue.

Unit 5: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
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The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit is linked to: HSC21, HSC24, HSC31, HSC34, HSC35, HSC41, HSC45, HSC310, HSC311, HSC326, HSC329, HSC331, HSC332, HSC337, HSC344, HSC346, HSC356, HSC385, HSC398, HSC412, HSC3116, HSC3117, HSC3119, CCLD 305 and GCU 5.

Unit 6: Principles of Teamwork and Multidisciplinary Working in Health and Social Care M/615/6712

Estimated TQT:	50
Estimated GLH:	25
Credit	5
Level	3

Unit Description:

This unit covers the underpinning knowledge of teamwork and multidisciplinary working in health and social care. The unit develops the learner's knowledge and understanding of; principles underpinning effective team work, the contribution of other professionals and agencies and working in partnership with families.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand principles underpinning effective team work	1.1	Explain why all teams require: • Clear objectives • Defined roles and responsibilities • Trust and accountability • Confidentiality • Defined channels of communication • Conflict resolution processes	Why all teams require; clear objectives, defined roles and responsibilities, trust and accountability, confidentiality, defined channels of communication and conflict resolution processes: E.g. These are the principles underpinning effective teamwork, collectively they provide a framework for each role within a team with regards to; duties, responsibilities, focus, boundaries and channels to discuss and act upon suggestions, issues and concerns. Permits improvements to function and processes, impacts individual/ team understanding, satisfaction and performance.
	1.2	Describe the relationship between mutual respect and effective teamwork	The relationship between mutual respect and effective teamwork: E.g. Highly correlated concepts, guiding principle behind conflict resolution, permits co-ordinated efforts and planned task sharing in accordance with objectives, role and individual expertise. Leads to improvements to; individual/ team satisfaction and performance.
	1.3	Describe the benefits of effective teamwork	The benefits of effective teamwork: E.g. Improvements to; output, implementation, innovation, awareness of alternative perspectives, issue resolution, problem solving and creativity, team focus, working relationships, expertise sharing, task speed and efficacy, workloads and individual perceptions of value etc.
	1.4	Explain how organisational values can influence teamwork	How organisational values can influence teamwork: E.g. Values are unique to each organisation and are the standards that guide staff conduct, this includes interaction with internal and external members of staff or

			stakeholders, leads to a broad range of organisational value dependent impacts to teamwork effectiveness and subsequent output (e.g. organisational values that recognise openness, mutual respect and engagement can improve innovation, working relationships, expertise sharing and conflict resolution processes thereby impacting upon task performance and output etc.).
	1.5	Explain the importance of involving team members in decision making processes	The importance of involving team members in decision making processes: E.g. Increased perceptions of value, increased engagement (e.g. with the decision and team), improved day-to-day decision making abilities, stronger bonds of responsibility for making the decision, increased focus on future-oriented problem solving strategies and improvements to morale and motivation driven by involvement.
	1.6	Describe the systems and processes necessary for a team to manage change	The systems and processes necessary for a team to manage change: E.g. Communication policy, figurehead/ reference, training and consistently applied; agreed ways of working, culture and ethos.
	1.7	Describe when to seek advice or support from other team members	When to seek advice or support from other team members: E.g. Upon reaching limitations of own role or when uncertain with regards to the application of; agreed ways of working, policies or procedures.
	1.8	Explain when to offer your own advice or support to other team members	When to offer your own advice or support to other team members: E.g. When it is requested, if it is your area of expertise, if a colleague seems to have difficulty or as part of training.
	1.9	Describe how to contribute to the development of continuous improvement within the work of a team	How to contribute to the development of continuous improvement within the work of a team: E.g. Dependent upon role but could include; identifying improvements, planning, making changes, role in communication to the team, being proactive, encouraging participation, following agreed ways of working and promoting best practice.
	1.10	Explain the relationship between constructive feedback and effective teamwork	The relationship between constructive feedback and effective teamwork: E.g. Highly correlated concepts, helps establish positive working relationships, enables continuous improvement and skill sharing, can improve team output, demonstrates professionalism and respect and distinction between feedback and constructive feedback.

	1.11	Explain why self-reflection is an essential component of any work based review	Why self-reflection is an essential component of any work based review: E.g. Self-reflection a vital component of learning, enables individually tailored improvement, helps develop skills and review their effectiveness to enable future improvements.
2. Understand the contribution of other professionals and agencies within health and social care	2.1	Describe circumstances that would indicate the need to involve other professionals, outside of the immediate team	Circumstances that would indicate the need to involve other professionals, outside of the immediate team: E.g. Conflicts, serious incidents, identification of unmanaged hazards, safeguarding concerns, allegations of criminality, bullying and harassment and case dependent referral needs (e.g. occupational therapist, psychologist, doctor, advocate etc.)
	2.2	Explain a range of referral processes to gain the support of other professionals	A range of referral processes to gain the support of other professionals: E.g. Services that are offered internally such as counselling, mediation, HR support and also external services such as statutory services, NHS, Police, Social Services, ACAS, Helplines etc. Referral may be self, peer, or managerial.
	2.3	Explain benefits of working in partnership with other professionals or agencies	Benefits of working in partnership with other professionals or agencies: E.g. Improved outcomes, specialist assistance, shared expertise, improved awareness, promotion of both holistic care and consistency/ continuity of care.
	2.4	Explain methods for information provision when communicating with other professionals or agencies	Methods for information provision when communicating with other professionals or agencies: E.g. Confidentiality, consent, agreed ways of working and written or verbal mediums.
	2.5	Describe the impact specialist agencies can have upon the wellbeing of a service-user	The impact specialist agencies can have upon the wellbeing of a service-user: E.g. Positive impacts driven by provision of; person-centred care and support, alternative viewpoints, empowering resources, appropriate expertise and holistic care.
	2.6	Describe values and skills that underpin multidisciplinary collaboration	Values and skills that underpin multidisciplinary collaboration: E.g. Respect, recognition of skills, partnership, effective communication and additional factors with reference to assessment criteria 1.1.
	2.7	Identify factors that could hinder multidisciplinary collaboration	Factors that could hinder multidisciplinary collaboration: E.g. Lack of trust and respect, lack of clarity and understanding of different roles, organisational and personal ethos and non-adherence to the principles underpinning effective teamwork (e.g. with reference to assessment criteria 1.1).

	2.8	Describe methods to monitor and review the progress of multidisciplinary collaborative work	Methods to monitor and review the progress of multidisciplinary collaborative work: E.g. Audit, questionnaires, team meetings, interagency conferences, case review, reflective practice and key performance indicators (KPIs).
3. Understand working in partnership with families	3.1	Evaluate the contribution of families to the care and support of related service-users	The contribution of families to the care and support of related service-users: E.g. Dependent upon both the family and the service-users individual needs, where positive can include; advocacy, enablement/ promotion of person-centred care, best interest decisions, preference driven care plan modifications, provision of home comforts and involvement of other professionals etc.
	3.2	Describe factors affecting the involvement of family members in care and support	Factors affecting the involvement of family members in care and support: E.g. Multitude of factors driven by the service-user and/ or the individual members of the family, factors can have the following basis; social (e.g. relationships, trust, conflict etc.), financial (e.g. minimising costs, maximising care provision etc.), logistical (e.g. distance, time, availability, skillset etc.), psychological/ emotional (e.g. distress, discomfort, denial, empathy, acceptance etc.) or other (e.g. confidentiality, consent, access etc.).
	3.3	Explain how to support family members to understand person-centred approaches and agreed ways of working	How to support family members to understand person-centred approaches and agreed ways of working: E.g. Education, discussion, inclusion, involvement and promotion of active participation.
	3.4	Explain methods to identify the support family members need to carry out their role	Methods to identify the support family members need to carry out their role: E.g. Discussions with the service-user, family members and other professionals, liaison with advocacy services and carer support groups/ organisations and conducting a needs assessment.
	3.5	Explain the importance of involving family members in the related service-users review	The importance of involving family members in the related service-users review: E.g. Assists with the continued provision of person-centred care, provides a personal and family perspective, promotes involvement and understanding, promotes process transparency, supports the development of professional relationships and collaborative working, assists with best interest decisions and promotes consistency/ continuity of care.
	3.6	Explain how the attitudes of a worker can affect partnership working with families	How the attitudes of a worker can affect partnership working with families: E.g. Positive and negative aspects of attitude impacting working

			relationships (e.g. trust, openness, supportiveness, understanding, engagement etc.)

Unit 6: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

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Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
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The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit is linked to: Skills for Justice National Occupational Standard: F403 Develop and sustain effective working relationships with staff in other agencies.

Unit 7: Principles of Record Keeping within Health and Social Care K/615/6711

Estimated TQT:	50
Estimated GLH:	25
Credit	5
Level	2

Unit Description:

This unit covers the underpinning knowledge of record keeping within health and social care. The unit develops the learner's knowledge and understanding of; the role of secure information handling, accessing support relating to information handling and recording information in accordance with agreed ways of working.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the role of secure handling of information in health and social care settings	1.1	Identify the legislation that relates to recording, storing and sharing of information in health and social care	Legislation that relates to recording, storing and sharing of information in health and social care: E.g. General Data Protection Requirements (GDPR) (EU) 2016/679, Freedom of Information Act (2000) and Health and Social Care Act (2008).
	1.2	Explain why secure systems for recording and storing information are essential within a health and social care setting	Why secure systems for recording and storing information are essential within a health and social care setting: E.g. Legislative adherence, maintenance of confidentiality, mitigation of risk (e.g. identity theft, unauthorised access etc.), maintenance of service-user rights and to promote information provision to those requiring access.
	1.3	Describe features of manual and electronic information storage systems that help ensure security	Features of manual and electronic information storage systems that help ensure security: E.g. Encryption, secure passwords, electronic audit trails, secured IT networks, identity checks, security passes, locked files, shredding paper-based information and logging out of electronic data systems.
	1.4	Explain how to share information whilst preserving the confidentiality of the service-user	How to share information whilst preserving the confidentiality of the service-user: E.g. Adherence to policy, procedure and agreed ways of working (e.g. information governance procedures), ensuring confidential information (e.g. names) is not disclosed without consent, ensuring information is only shared with those legitimately requiring access, preventing accidental disclosures of information and practicing strict security measures.

	1.5	Explain the potential impact(s) of secure information sharing upon consistency/ continuity of care	Potential impact(s) of secure information sharing upon consistency/ continuity of care: E.g. Promotes consistency/ continuity of care; assists multidisciplinary collaboration, raises awareness of previous actions and current directions, reduces risk of action duplication, reduces risk of care plan deviation and supports all individuals to continue the provision of care and support from accurate and current records.
2. Understand how to access support for handling information in health and social care settings	2.1	Explain how to access guidance, information and advice regarding information handling	How to access guidance, information and advice regarding information handling: E.g. Legislation, policies and procedures, information commissioner's office, advocacy groups, charities, colleagues, senior members of staff and consultation with the service-user whose information is being handled.
	2.2	Explain the actions to take when there are concerns over the recording, storing or sharing of information	Actions to take when there are concerns over the recording, storing or sharing of information: E.g. Report to a colleague, report to a senior member of staff, document concerns and whistleblowing.
	2.3	Explain the possible consequences of poor information handling practices	Possible consequences of poor information handling practices: E.g. Loss of consistency/ continuity of care, damage to reputation, disciplinary action, organisational consequences and legal implications.
3. Understand how to record information in accordance with agreed ways of working	3.1	Describe a range of kept record formats	Kept record formats: E.g. Hand written records, electronic records, hand held records, emails, text messages, letters, reports, photographs, videos, tape recordings, print outs and scanned documents.
	3.2	Describe the key principles of good record keeping	Principles of good record keeping: E.g. Factual (e.g. objective), consistent, accurate, dated, sequenced logically, contemporaneous and containing accepted terminology.
	3.3	Explain the colour of ink to be used for writing records	Colour of ink to be used for writing records: E.g. Employer directed requirement, usually black but no legal stipulation, assists with photocopying and transcription.
	3.4	Explain the importance of legibility within kept records	The importance of legibility within kept records: E.g. Legal requirement; needs to be legible to enable information to be acted upon.
	3.5	Explain the basis for record writing responsibility allocation	The basis for record writing responsibility allocation: E.g. The individual who provided the care, support or treatment should be the person who documents and records; ensures accountability and consistency/ continuity within kept records.

	3.6	Describe how multidisciplinary working affects the process of record keeping	How multidisciplinary working affects the process of record keeping: E.g. Organisations have agreed ways of working in relation to record keeping, this ensures all individuals are working to the same system and abiding by same rules of recording, promotes consistency/ continuity of records across teams and professions.
	3.7	Explain how to correct errors and mistakes within records	How to correct errors and mistakes within records: E.g. Single line, initials, date and avoidance of correction fluid.
	3.8	Explain why an open record is generally considered to be good practice	Why an open record is generally considered to be good practice: E.g. Shared with person referred to; promotes openness and transparency, improves commitment and contributes towards the removal of barriers and the upholding of individual rights.
	3.9	Explain why records must not be written off site/away from the workplace	Why records must not be written off site/away from the workplace: E.g. Security/ confidentiality of records at risk; could be lost, stolen or viewed by those not authorised.
	3.10	Explain the rights of a service-user to access and view their own records	The rights of a service-user to access and view their own records: E.g. Under national legislation (General Data Protection Requirements (GDPR) (EU) 2016/679) all service-users have a right of access.

Unit 7: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Unit 8: Principles of Medication Handling and Awareness H/615/6710

Estimated TQT:	100
Estimated GLH:	75
Credit	10
Level	3

Unit Description:

This unit covers the underpinning knowledge of medication handling and awareness. The unit develops the learner's knowledge and understanding of; legislation, policies and procedures relevant to medication administration, use of medications common within a health and social care setting, safe handling of medication, techniques for administering medication and monitoring responses to medication administration.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the legislation, policies and procedures that are relevant to the administration of medication	1.1	Identify legislation and guidelines relevant to the administration of medication	Legislation and guidelines relevant to the administration of medication: E.g. Medicines Act (1968) and amendments, the Human Medicine Regulations (2012), Misuse of Drugs Act (1971) and amendments, Health and Safety at Work Act (1974), COSHH Regulations (1999), Care Standards Act (2000) (receipt, storage and administration of medicines), Domiciliary Care Agencies Regulations (2002), Access to Health Records Act (1990), General Data Protection Requirements (GDPR) (EU) 2016/679, Hazardous Waste Regulations (2005), guidance: Administration and Control of Medicines in Care Homes and Children's Services June (2003), The Handling of Medicines in Social Care (Royal Pharmaceutical Society 2007), Standards for Medicines Management (Nursing and Midwifery Council 2004), NICE Guideline Managing medicines in care homes (2014), organisational code of conduct, procedures and guidelines.
	1.2	Explain how and why policies, procedures and agreed ways of working must reflect and incorporate legislative requirements	How and why policies, procedures and agreed ways of working must reflect and incorporate legislative requirements: E.g. Policies and procedures are put in place to ensure legislative adherence, promotes safety of all individuals within the setting, policies and procedures must reflect legislation to ensure that they are correct (e.g. fit-for-purpose and reflect latest guidance) and that the organisation is operating legally.

	1.3	Explain the necessity of medication training for all personnel administering medication	The necessity of medication training for all personnel administering medication: E.g. Medication administration is defined as a skill that requires additional and specific training. This is a legal requirement to ensure the safety of all concerned.
	1.4	Explain the following principles with regards to medication administration: • Consent • Self administration • Active participation • Dignity and privacy • Confidentiality	Consent: E.g. Legislative requirement, requires adherence to agreed ways of working, relates to the rights of a service-user to consent to a particular treatment, separation between informed and uninformed consent, the role of Mental Capacity Act (2005) and situations that require 'best interest' decisions. Positive impacts upon a service-user's wellbeing and perceptions of control. Self-administration: E.g. Adherence to agreed ways of working, medication specific, relates to the rights of a service-user to control own medication administration (e.g. service-user an active partner in own care and support), preference/ need driven and requires regular risk assessment. Positive impacts upon the empowerment of a service-user and levels of independence. Active participation: E.g. Adherence to agreed ways of working, medication specific, relates to the rights of a service-user to participate in own medication administration (e.g. service-user an active partner in own care and support), preference/ need driven and requires regular risk assessment. Positive impacts upon the empowerment of a service-user and levels of independence. Dignity and Privacy: E.g. Agreed ways of working, relates to both confidentiality and a service-user's rights, requires reference to care/ support plans and sensitivity to personal, religious and cultural preferences. Positive impacts upon a service-user's wellbeing. Confidentiality: E.g. Legislative requirement, requires adherence to agreed ways of working, relates to the rights of a service-user with regards to confidential medication administration which includes the creation, storage and sharing of medication records. Positive impacts upon a service-user's wellbeing.
2. Understand the use of medications that are common within a health and social care setting	2.1	Explain how to access information about a service-users medication requirements	How to access information about a service-users medication requirements: E.g. Patient information leaflets, medication administration records (MARs), care plans, consultation with family or other involved professionals, support from manager/ supervisor and reference to organisational policies, procedures and agreed ways of working.

	2.2	Describe common types of medication including their effects and potential side effects	Common types of medication including therapeutic effects and side effects: E.g. ADHD Medication (Stimulants/ Non-Stimulants): Effects: Decrease symptoms of ADHD including problems concentrating, forgetfulness, hyperactivity, inability to finish tasks. Side Effects: Medication and dose dependent but can include; Sleep problems, reduced appetite, delayed growth, head/stomach ache, rebound effects, tics, moodiness and irritability. Examples: (Dextro)amphetamine (e.g. Adderall, Dexedrine), Methylphenidate (e.g. Concerta, Metadate CD, Ritalin) and Atomoxetine (e.g. Strattera). Analgesics: Effects: Pain relief. Side Effects: Medication and dose dependent but can include; addiction, stomach irritation, liver damage, sleep disturbances, nausea, vomiting and constipation. Examples: Paracetamol, NSAIDs (e.g. Aspirin, Ibuprofen), Opioids (e.g. Morphine, Codeine) and Combinations (e.g. Co-Codamol). Antibiotics: Effects: Treating infection caused by bacteria. Side Effects: Medication and dose dependent but can include; Hypersensitivity reactions, allergic reactions, fever, nausea, vomiting and diarrhoea. Examples: Penicillin and Ampicillin. Anticoagulants: Effects: Reduce risk of blood clots/ prolong clotting time. Side Effects: Medication and dose dependent but can include; bleeding complications. Examples: Warfarin, Rivaroxaban (e.g. Xarelto), Dabigatran (e.g. Pradaxa), Apixaban (e.g. Eliquis) and Edoxaban (e.g. Lixiana). Antidepressants: Effects: Used to treat clinical depression or prevent it recurring. Side Effects: Medication and dose dependent but can include; agitation, nausea, stomach aches, diarrhoea, constipation, loss of appetite, dizziness, insomnia, headache, sexual dysfunction, heart arrhythmia, dry mouth, drowsiness, weight gain, sweating and shivering. Examples: Fluoxetine (e.g. Prozac), Citalopram (e.g. Cipramil), Aroxetine (e.g. Seroxat), Venlafaxine (e.g. Efexor), Irtazapine (e.g. Zispin), Amitriptyline (e.g. Tryptizol), Clomipramine (e.g. Anafranil) and Imipramine (e.g. Tofranil). Antihistamines: Effects: Symptomatic relief for a number of allergic conditions (e.g. hay fever and insect stings). Side Effects: Medication and dose dependent but can include; drowsiness and sedation. Examples: Diphenhydramine, Chlorphenamine, Loratadine and Cetirizine.

			Antipsychotics: Effects: Primarily used to manage psychosis (including delusions, hallucinations, paranoia or disordered thought), principally in schizophrenia and bipolar disorder. Side Effects: Medication and dose dependent but common symptoms can include; Sedation, headaches, dizziness, diarrhoea, constipation, anxiety, sexual dysfunction, tremor (and other movement disorders), blurred vision, dry mouth. Examples: Clozapine, Risperidone, Aripiprazole and Olanzapine. Benzodiazepines: Effects: Broad range of uses, actions include; sedation, anti-anxiety, anticonvulsant (anti-epileptic), muscle relaxation, alcohol withdrawal. Side Effects: Medication and dose/duration dependent but can include; sedation, muscle relaxation, drowsiness, dizziness, reduced alertness/ concentration, decreased coordination, sexual dysfunction, depression, hypoventilation, nausea, appetite, blurred vision, confusion, nightmares, affective and behavioural problems. Examples: Clorazepate, Diazepam, Flurazepam, Lorazepam, Temazepam, Clonazepam, Dinazolam, Alprazolam and Midazolam. Blood pressure medication: Effects: Reduction of high blood pressure. Side Effects: Medication and dose/duration dependent but can include; persistent cough, rash, dizziness, constipation, headache, palpitations, sexual dysfunction, fatigue, insomnia. Examples: Angiotensin Converting Enzyme/ ACE Inhibitors (e.g. Captopril, Cilazapril, Imidapril, Ramipril), Angiotensin II Receptor Blockers/ ARBs (e.g. Losartan, Valsartan, Candesartan), Calcium Channel Blockers/ CCBs, Thiazide Diuretics (e.g. Chlortalidone, Bendroflumethiazide, Furosemide, Amiloride, Spironolactone) and Beta-Blockers (e.g. Propranolol, Timolol, Atenolol, Metoprolol). Dementia medication: Effects: Contribution towards maintenance of cognitive functionality. Side Effects: Medication and dose/duration dependent but can include; Diarrhoea, muscle cramps, fatigue, nausea, insomnia, headache, incontinence, chest pain, confusion, hallucinations, coordination problems, easy bruising or bleeding, weight loss, redness or swelling around eyes, anxiety, aggression. Examples: Cholinesterase inhibitors (e.g. Donepezil, Galantamine, Rivastigmine) and Novel/ NMDA targeting (Memantine). Additional information on side effects: Obtainable from eMC.

	2.3	Explain the distinction between controlled and non-controlled forms of medication	The distinction between controlled and non-controlled forms of medication: E.g. Controlled medication is under the Misuse of Drugs (Safe Custody) Regulations (1973) meaning stricter legal controls (e.g. production, prescription, supply and storage). Controlled classification driven by therapeutic benefit weighed against potential harm if misused and divided into five categories (schedules) with regards to required levels of control.
	2.4	Explain the use of 'as required' PRN medications within a health and social care setting	The use of 'as required' PRN medications within a health and social care setting: E.g. Person-dependent medication and medication administration, requires; legislative and procedural adherence, meeting agreed ways of working, care plan adherence, clear indications for use, procedures for renewal of prescription, audit trail and control of stock. PRN medications can range from analgesics to antipsychotics.
	2.5	Explain the use of anti-psychotic medications within a health a social care setting	The use of anti-psychotic medications within a health a social care setting: E.g. Person-dependent medication and medication administration, requires; legislative and procedural adherence, meeting agreed ways of working, care plan adherence, clear indications for use, 'best interest' decisions, procedures for renewal of prescription, audit trail and control of stock. Issues with regards to over-prescribing and administering to incorrectly manage behaviours.
	2.6	Explain best practice with regards to the provision of 'over the counter' remedies and supplements within a health and social care setting	Best practice with regards to the provision of 'over the counter' remedies and supplements within a health and social care setting: E.g. Person-dependent medication and medication administration, requires; legislative and procedural adherence, meeting agreed ways of working, care plan adherence, audit trail and control of stock. Must be provided under recommendation of appropriate professional.
	2.7	Explain why the administration of medication must occur at specific and documented time intervals	Why the administration of medication must occur at specific and documented time intervals: E.g. Person-dependent medication administration includes time of administration due to; time dependency of therapeutic effects, time related permissibility of medication side effects (e.g. arousal vs sedation), medication duration of action, repeat dosage requirements and minimising toxicity, specific metabolic state/ stomach content requirements and specific physiological state requirements (e.g. blood pressure, heart rate, blood glucose etc.). Documentation a legislative requirement to; minimise risk, promote consistency/ continuity, provide

			audit trail and ensure/ demonstrate medication provision in accordance with agreed care plan.
	2.8	Describe how to address ethical issues that may arise over the use of medication	How to address ethical issues that may arise over the use of medication: E.g. Ensure compliance with; legislation (e.g. Mental Capacity Act 2005), agreed ways of working and policies and procedures, multidisciplinary collaboration (e.g. service-user, their family, medical professionals), shared decision making, best interest meetings/ decisions and documentation of all agreed decisions.
3. Understand the principles of safe handling of medication	3.1	Describe how to receive supplies of medication in accordance with agreed ways of working	How to receive supplies of medication in accordance with agreed ways of working: E.g. Visual checks/ comparison of dispensed medication and the medication and dosage on the prescription; name of person to whom the prescription has been issued, date of prescription, expiry date, dosage, frequency, timing (e.g. night, morning, before/ after food), route of administration, storage requirements (e.g. light, temperature etc.). Recording receipts using appropriate documentation and adherence to storage and confidentiality requirements.
	3.2	Explain the procedure for safe storage of medication in a health and social care setting	The procedure for safe storage of medication in a health and social care setting: E.g. Clinical settings: Medicines stored centrally in locked cabinet/cupboard, controlled access, security system, medicines in original containers as supplied/ labelled by the pharmacist or dispensing GP practice and stored at correct temperature as stated on patient information leaflet. Residential care settings: Risk assessment required, personal lockable cupboards for service-users to self-medicate and/ or central storage of medicines in locked cupboard accessible only to staff trained to administer medicines; key security systems etc. Day services: Service-users retain own medicines; day care staff may accept responsibility for giving medicines, provide storage facilities, arrange for a specially dispensed supply etc. Domiciliary care: Service-user makes decision about how they will store own medication.
	3.3	Explain infection control techniques used when handling medication	Infection control techniques used when handling medication: E.g. Following agreed ways of working, hygiene procedures, using standard precautions to minimise/ prevent infection and cross infection (e.g. hand washing, use

			of personal protective equipment, non-touch technique), correct storage (e.g. temperatures), correct disposal (e.g. colour coded bags, sharps bins).
	3.4	Explain the relationship between the non-touch technique and the health and safety of the individuals involved in the handling of medication	The relationship between the non-touch technique and the health and safety of the individuals involved in the handling of medication: E.g. Non-touch technique restricts the exposure and effect of the medication to intended recipient of treatment and minimises the risk of cross-contamination from practitioner to service-user.
	3.5	Explain the purpose of medication administration records (MARs sheets)	The purpose of medication administration records (MARs sheets): E.g. Provides a record of all medication to be administered as well as what is currently within the setting. Includes additional information about the service-user (e.g. allergies, warnings or special instructions to be followed). Allows for the audit, information sharing and documentation throughout the medication cycle.
	3.6	Describe how to use medication administration records (MARs sheets)	How to use medication administration records (MARs sheets): E.g. Select, check, prepare medication and record administration
	3.7	Explain the procedure(s) for the safe disposal of medication in a health and social care setting	The procedure(s) for the safe disposal of medication in a health and social care setting: E.g. Current local and national organisational procedures, recording of disposal including equipment (e.g. syringes, needles etc.), pharmacy returns, supplier returns, use of licensed waste disposal companies, record keeping, disposal documentation and routine audit.
4. Understand techniques for administering medication	4.1	Identify the different routes of medication administration	The different routes of medication administration: E.g. Instillation (e.g. nose, eyes and ears), Inhalation, Oral, Buccal, Sublingual, Topical, Transdermal, Rectal, Vaginal, Intravenous, Intramuscular, Subcutaneous and Patient Specific (e.g. Gastrostomy and Nasogastric Tube).
	4.2	Describe materials and equipment that can assist with the administration of specific forms of medication	Materials and equipment that can assist with the administration of specific forms of medication: E.g. Medicine pots, measuring spoons, oral syringes, nebulisers, inhalers, ear droppers, eye droppers and Monitored Dosage Systems (MDS).
	4.3	Identify medication that requires the measurement of specific physiological attributes	Medication that requires the measurement of specific physiological attributes: E.g. Insulin (Blood Glucose), Warfarin (INR), Digoxin (Heart Rate), Antipsychotic medication (ECG's), Diuretics (Urea and Electrolytes), Orlistat (Weight), Inhalers (Peak Flows) and Paracetamol for Fever (Temperature).

	4.4	Describe different procedures for the administration of medication	Different procedures for the administration of medication: E.g. Person-dependent administration procedures; Select, check, prepare, record, person and medication specific; route(s) of administration, degrees of participation and use of assistive equipment.
	4.5	Explain how medication administration can be person-centred whilst retaining adherence to the administration instructions	How medication administration can be person-centred whilst retaining adherence to the administration instructions: E.g. Choice and rights, dignity and privacy and administration preferences enabled where possible.
	4.6	Explain the circumstances dictating the permissibility of medication administration through self-administration	Circumstances dictating the permissibility of medication administration through self-administration: E.g. Requirements for risk assessment and regular re-assessment, informed consent of service-user and an understanding of how to store and administer medication, family involvement (if appropriate), provision of medication information to self-administrator (e.g. therapeutic effects, storage requirements, side effects, addressing side effects, special instructions, obtaining further supplies etc.) and necessary equipment (e.g. administrative aids, reminders, enlarged labels etc.).
	4.7	Explain the circumstances which would dictate the need for medication administration through 'covert dosing'	Circumstances which would dictate the need for medication administration through 'covert dosing': E.g. Best interest decision made with adherence to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards; must be discussed and agreed within a best interest setting, must be a multidisciplinary decision (e.g. family, health and social care staff, social workers, medical practitioners etc.), requires written authorisation and requires close monitoring and regular review.
	4.8	Describe how to prevent the re-distribution of medication between service-users in a health and social care setting	How to prevent the re-distribution of medication between service-users in a health and social care setting: E.g. Ensure service-users are monitored whilst taking medication, do not leave medication unsecure or unattended and ensure administration records are maintained (e.g. MARS).
5. Understand how to monitor responses to medication administration	5.1	Explain how to record the use of medication and any associated changes to a service-user	How to record the use of medication and any associated changes to a service-user: E.g. Adherence to policy, procedure and agreed ways of working, recording requests for medication; received, administered or destroyed, accurate and factual documentation (e.g. MARs completed legibly in ink, written correctly and clearly to prevent misunderstanding and with the inclusion of relevant signatures and dates), inclusion of second signature for controlled drugs and recording of all changes to the service-

			user as part of case related record keeping procedures (e.g. service-users daily care plan/ diary etc.).
	5.2	Describe how to recognise common adverse reactions to medication	How to recognise common adverse reactions to medication: E.g. Medication specific, will evoke non-desired effects (often visible) including; anaphylaxis (e.g. swelling, rash and apnea), Steven Johnsons Syndrome (e.g. flu-like symptoms, a rash and large blisters) and/ or other symptoms (e.g. excessive bleeding, pigmentary changes, changes to physical/mental health and behavioural changes etc.).
	5.3	Explain the actions to take upon identifying a possible adverse reaction to medication	The actions to take upon identifying a possible adverse reaction to medication: E.g. Agreed ways of working, immediately; report, seek appropriate medical advice and record the incident.

Unit 8: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

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Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
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Links

This unit is linked to: HSC21, HSC24, HSC31, HSC35, HSC41, HSC45, HSC213, HSC214, HSC221, HSC236, HSC375, HSC387, HSC388, HSC3121, SCD CCLD0338 – Develop productive working relationships with others and SCD and Skills for Health/DANOS national occupational standard: AH2 Prepare for, and administer medication to individuals, and monitor the effects.

Unit 9: Principles of Behaviour that Challenges and Positive Behavioural Support M/615/6709

Estimated TQT:	100
Estimated GLH:	75
Credit	10
Level	3

Unit Description:

This unit covers the underpinning knowledge of behaviour that challenges and positive behavioural support (PBS). The unit develops the learner's knowledge and understanding of concepts relating to behaviour that challenges, including; implications, warning signs, PBS, primary prevention strategies, secondary prevention strategies, non-aversive reactive strategies and the role of restrictive interventions within health and social care settings.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the concept and implications of 'behaviour that challenges'	1.1	Define the term 'behaviour that challenges'	Behaviour that challenges: E.g. Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.
	1.2	Identify the legislation that relates to behaviour that challenges	Legislation that relates to behaviour that challenges: E.g. Dependent upon setting and age group. Examples include; Children Act (1989), Children Act (2004), Inspection of Children's Homes: framework for inspection from April (2014), Autism Act (2009), Health and Social Care Act (2008), Equality Act (2010), Health and Safety at Work etc. Act (1974), Human Rights Act (1998), Mental Capacity Act (2005), Mental Health Act (2007), Protection of Freedoms Act (2012), Safeguarding Vulnerable Groups Act (2006), Valuing People Now: a new three-year strategy for people with learning disabilities (2009), standards and guidance from statutory and third sector organisations.
	1.3	Describe factors that can lead to a behaviour being classified as challenging	Factors that can lead to a behaviour being classified as challenging: E.g. Behaviour that places the physical safety of the service-user or others in serious jeopardy and/ or would limit community integration. Non-verbal examples include; wandering, pacing, cornering, intimidating facial expressions. Verbal examples include; shouting, swearing, racism, sexism

			or other offensive language. Physical examples include; scratching, biting, slapping, inappropriate touching, self-harm, spitting, punching, hitting, throwing of objects and other forms of assault.
	1.4	Describe environmental factors that can trigger behaviour that challenges	Environmental factors that can trigger behaviour that challenges: E.g. Wide range of person-dependent environmental factors including; sensory challenges (e.g. noise, light, colour, smell, temperature, touch), changes to routines (e.g. sleep, activity availability etc.) overcrowding, restrictions and factors relating to insufficient or over stimulation.
	1.5	Describe human factors that can trigger behaviour that challenges	Human factors that can trigger behaviour that challenges: E.g. Wide range of person-dependent human factors of internal and/ or external nature. Internal: E.g. Processing limitations (e.g. inability to process new information or instructions), emotional state (e.g. anger, anxiety, distress, mania, depression, delusions, personality disorders and other emotion related extremes), physiological state (can be medication induced), loss of inhibitions, poor judgment and planning, difficulty communicating needs, memory loss, disorientation, reduced spatial awareness, loss of insight, perceptions of threat, powerlessness and social isolation, inactivity, boredom, pain and specific history/background related associations. External: E.g. Largely driven by insufficient/ ineffective person-centred care (e.g. inappropriate communication, non-adherence to a service-users individual needs and routines, insufficient activity provision and under /over stimulation etc.), specific external behaviours and staff member's history/ background (e.g. relationship) with the service-user.
	1.6	Explain how a urinary tract infection (UTI) can impact upon a service-users behaviour	How a urinary tract infection (UTI) can impact upon a service-users behaviour: E.g. Increase in pain/ discomfort leading to behavioural symptoms, UTI related changes to; emotional state, levels of confusion, fatigue, perception and awareness (includes delusions and hallucinations) and inhibition control. Effects magnified when combined with additional difficulties (e.g. communication).
	1.7	Explain the difference between fast and slow triggers for behaviour that challenges	The difference between fast and slow triggers for behaviour that challenges: E.g. Triggers are factors that make behaviour that challenges more likely to occur. Slow triggers: Aspects of a person's environment or daily routine that affect the occurrence of behaviour that challenges but do not immediately precipitate the behavioural event.

			Fast triggers: Specific events that occur immediately prior to the occurrence of behaviour that challenges. Their impact upon behaviour is rapid or immediate.
	1.8	Identify factors that might contribute to the reinforcement of a service-users behaviour that challenges	Factors that might contribute to the reinforcement of a service-user's behaviour that challenges: E.g. Behaviour of others (staff, friends, family etc.), over-reliance/ inappropriate usage of positive/negative reinforcement strategies (e.g. inappropriate reward or punishment, inconsistent application of reinforcement strategies etc.).
	1.9	Describe the time intensity model and it's relation to behaviour that challenges	The time intensity model and it's relation to behaviour that challenges: E.g. The stages of increasing agitation to crisis point and back again over time, behaviour that challenges can occur at crisis point, model assists others to understand, interpret and respond to the emotional and physiological changes that occur during an episode of behaviour that challenges
	1.10	Describe the potential impacts of an incident of behaviour that challenges to: • The person who exhibited the behaviour • The individuals who witnessed the incident	The potential impacts of an incident of behaviour that challenges: E.g. To the person who exhibited the behaviour: Impacts are person and situation dependent and can include; physical, emotional and physiological (e.g. injury, agitation, arousal etc.), those relating to social engagement (including exclusion), ability to access services, criminal record and financial consequences. To individuals witnessing the incident: Impacts are person and situation dependent and can include; physical, emotional and physiological (e.g. injury, fear, arousal etc.), those relating to social engagement (e.g. withdrawal) and behavioural impacts (e.g. mimicry/ imitation and other altered patterns of behaviour).
	1.11	Describe the purpose of post-incident support including a post-incident staff debriefing	The purpose of post-incident support including a post-incident staff debriefing: E.g. Post-incident support can include; emotional support, time away from the setting, first aid, quiet-time, space, temporary redeployment, additional training, personal reflection, counselling, opportunity to express feelings and post-incident discussion including an ABC (Antecedent, Behaviour, and Consequence) analysis. Support strategies are in place to ensure the wellbeing of those with involvement in the incident and to reduce the likelihood of repeat incident occurrence; post incident conclusions should be documented within care plans, shared with relevant members of staff and may lead to procedural review.

2. Understand warning signs that might suggest the onset of behaviour that challenges	2.1	Explain the person dependency of warning signs that might suggest the onset of behaviour that challenges	The person dependency of warning signs that might suggest the onset of behaviour that challenges: E.g. Person and situation dependent output of underlying physiological, psychological or emotional changes. Often depends upon internal biological factors but can also relate to specific forms of learned behaviour.
	2.2	Describe methods to obtain information relating to a service-users behaviour	Methods to obtain information relating to a service-users behaviour: E.g. Observation, functional analysis, use of agreed documentation (care plans etc.) and consultation with; service-user, their family/ friends and other professionals with involvement in the service-users life.
	2.3	Identify examples of warning signs that might suggest the onset of behaviour that challenges	Examples of warning signs that might suggest the onset of behaviour that challenges: E.g. Person-dependent warning signs, out of character for the service-user, including; Physiological (e.g. face reddening, tremor, pupil dilation/constriction, hyper-secretory issues (sweating/drooling) sexual arousal and altered rates of respiration), Cognitive (e.g. confusion, loss of insight and memory problems) and Behavioural (e.g. teeth grinding, specific vocalisations, repetitive behaviours, self-injurious behaviours, withdrawal, alterations to eye contact, absence seizure type symptoms, non-compliance, inappropriate non-verbal behaviour (including sexual) and recognition of/ respect for personal space).
3. Understand the concept of positive behavioural support	3.1	Identify the legislation and guidance that relates to positive behavioural support	Legislation and guidance that relates to positive behavioural support (PBS): E.g. Children Act (1989), Children Act (2004), Inspection of Children's Homes: framework for inspection from April (2014), Autism Act (2009), Health and Social Care Act (2008), Equality Act (2010), Health and Safety at Work etc. Act (1974), Human Rights Act (1998), Mental Capacity Act (2005), Mental Health Act (2007), Protection of Freedoms Act (2012), Safeguarding Vulnerable Groups Act (2006), The Children Act (1989) Guidance and Regulations- Volume 4: Residential Care, Working Together to Safeguard Children- A guide to inter-agency working to safeguard and promote the welfare of children (2013), Positive and Proactive Care: Reducing the need for restrictive interventions (2014); Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs, Valuing People Now: a new three-year strategy for people with learning disabilities (2009), standards and guidance from statutory and third sector organisations.

	3.2	Describe how the positive behavioural support model can be used to understand behaviour that challenges	How the positive behavioural support (PBS) model can be used to understand behaviour that challenges: E.g. PBS is based on a number of core values including; recognition of each person's individuality and human rights, a rejection of aversive and restrictive practices and an acceptance that behaviours that challenge serve an important person specific function. Recognition of these values contributes towards; understanding behaviours that challenge, understanding the issues underlying the behaviour that challenges and addressing the issues triggering the behaviour. PBS incorporates the principles of Applied Behaviour Analysis (ABA) (e.g. a scientific process of examining what causes and maintains behaviour, in order to bring about positive change) with Social Role Valorisation (SRV) (e.g. promotes valued social roles for those who are socially disadvantaged) and person-centred care.
	3.3	Explain the key characteristics of positive behavioural support	The key characteristics of positive behavioural support (PBS): E.g. PBS is a way of; understanding behaviours that challenge (e.g. why, when and how they occur), assessing the broader social and physical context in which the behaviour occurs (e.g. purpose of behaviour for the service-user), planning and implementing ways of supporting the person which enhance quality of life for both the service-user and their support network and other factors with reference to assessment criteria 3.2.
	3.4	Explain the role of the following strategies within positive behavioural support: • Primary prevention • Secondary prevention • Non-aversive reactive	The role of the following strategies within positive behavioural support (PBS): E.g. These strategies are integral components of PBS. They contribute towards the realisation of the core values and application of PBS. Primary Prevention Strategies: Proactive strategies that involve changing aspects of a person's living, working and recreational environments to reduce the likelihood of behaviour that challenges occurring. Secondary Prevention Strategies: Strategies deployed when a service-users behaviour that challenges begins to escalate in order to reduce the impact of this incident (e.g. de-escalation strategies). Non-Aversive Reactive Strategies: Methods of responding to un-prevented behaviour that challenges safely and efficiently; non-restrictive physical interventions (e.g. physical presence, non-verbal prompts, touch, guiding, proxemics/ distancing, disengagement).

	3.5	Explain the differences between proactive and reactive strategies	The differences between proactive and reactive strategies: E.g. Proactive strategies focus on eliminating problems before they have a chance to appear/ escalate (e.g. into behaviour that challenges). Reactive strategies focus on responding to events (e.g. behaviour that challenges) safely and effectively after they have occurred. Proactive Strategies: Serve to reduce the occurrence of behaviour that challenges. Prevention and early de-escalation will allow changes in behaviour patterns to develop (e.g. effective communication, maintenance of good interpersonal relationships and recognising early triggers). Reactive Strategies: Serve to achieve safe and effective management of behaviour that challenges (e.g. interventions that are brought into play when behaviour that challenges occurs and provides clear strategy for the required response).
	3.6	Explain the importance of social validity within positive behavioural support	The importance of social validity within positive behavioural support (PBS): E.g. Social validity is an integral component of PBS and refers to interventions that are ethical; address socially significant problems, have clear benefits for the service-user, are acceptable to the service-user (and others) and use the least restrictive or intrusive approach.
	3.7	Identify barriers to positive behavioural support	Barriers to positive behavioural support (PBS): E.g. Non adherence to core values of PBS (e.g. insufficient person-centred care, lack of understanding of the function of behaviours, under-reliance upon proactive/ preventative strategies and over-reliance upon aversive/ restrictive reactive strategies). Barriers can be organisational, individual, cultural, historical, financial etc.
	3.8	Describe the process for reviewing a service-users positive behavioural support plan	The process for reviewing a service-users positive behavioural support (PBS) plan: E.g. Review should take place regularly and involve the service-user and their support network as much as possible (e.g. their family, support staff and advocates). Past incidents must be considered (e.g. incident, deployed strategies and strategy effectiveness) to guide future PBS actions. Review must be agreed and documented in accordance with agreed ways of working.
	3.9	Explain the relationship between least restrictive practice and positive behavioural support strategies	The relationship between least restrictive practice and positive behavioural support (PBS) strategies: E.g. Core value of PBS; links to social validity and person-centred care.

4. Understand primary prevention strategies	4.1	Identify primary prevention strategies	Primary prevention strategies: E.g. Person-centred daily planning, active participation, active support, identifying and removing triggers, communication, involvement, empowerment, provision of choice and changing features of the environment (e.g. environmental enrichment, modification of environment driven sensory load, accessibility adjustments etc.).
	4.2	Explain how 'active support' can help to reduce the likelihood of a service-user displaying behaviour that challenges	How 'active support' can help to reduce the likelihood of a service-user displaying behaviour that challenges: E.g. Person-centred proactive preventative strategy, links to core values of PBS and reduces likelihood of behaviour that challenges through improvements to; participation, empowerment, control, choice, independence, perceived value within community, wellbeing, skills, adaptive behaviour and quality of life.
	4.3	Explain the importance of effective communication within primary prevention strategies	The importance of effective communication within primary prevention strategies: E.g. Person-centred proactive preventative strategy, links to core values of PBS and communication issues common contributing factor to behaviour that challenges (e.g. increased agitation/ frustration due to unmet needs or misunderstanding and contributor to crisis point of time intensity model).
	4.4	Explain the role of structure and daily planning within primary prevention strategies	The role of structure and daily planning within primary prevention strategies: E.g. Person-centred proactive preventative strategy, links to core values of PBS, reduces likelihood of behaviour that challenges through improvements to; living, working and recreational environment(s) (e.g. routine and enrichment promotes understanding and participation, improves outcomes and contributes towards quality of life).
5. Understand secondary prevention strategies	5.1	Identify secondary prevention strategies	Secondary prevention strategies: E.g. Stimulus change, stimulus removal, prompting to coping skills, strategic capitulation (e.g. concessions), diversion, redirection and distraction.
	5.2	Explain when to use secondary intervention strategies	When to use secondary intervention strategies: E.g. Applied when behaviour that challenges begins to escalate and used to prevent behaviour escalation to the point of incident.
6. Understand non-aversive reactive strategies	6.1	Identify non-aversive reactive strategies	Non-aversive reactive strategies: E.g. Physical presence, non-verbal prompts, touch, guiding, proxemics/ distancing and disengagement.

	6.2	Explain when to use reactive strategies	When to use reactive strategies: E.g. Applied when secondary intervention strategies are proving ineffective to manage behaviour that challenges and used to prevent harm or injury to the service-user and/ or others.
	6.3	Explain the risks associated with reactive strategies	The risks associated with reactive strategies: E.g. Non-preventative approach, can act as a trigger for further/ future behaviour that challenges, harm to those involved if strategy ineffective and behaviour that challenges continues to escalate (e.g. psychological and/ or physical).
7. Understand the role of restrictive interventions within a health and social care setting	7.1	Define the term 'restrictive intervention'	Restrictive intervention: E.g. Any intervention that is used to restrict the rights or freedom of movement of a person (e.g. escorting, manoeuvring, temporary physical containment or holding, seclusion, full restraint, mechanical restraint and chemical restraint including certain PRN medications).
	7.2	Explain the circumstances that dictate the need for a restrictive intervention	The circumstances that dictate the need for a restrictive intervention: E.g. Last resort to manage behaviour that challenges to prevent harm occurring to the service-user or others. Requires; individualised risk assessments (e.g. with multidisciplinary involvement of relevant agencies and key people), staff training and initial and ineffective deployment of proactive and non-aversive reactive measures.
	7.3	Explain why when using a restrictive intervention you must always use the least restrictive method available	Why when using a restrictive intervention you must always use the least restrictive method available: E.g. Restriction must be necessary and proportionate, if not necessary or proportionate the restrictive intervention is unlawful and with increased restriction comes an increased risk of causing negative impacts to the service-user (e.g. both physical and psychological).
	7.4	Describe safeguards relating to restrictive interventions	Safeguards relating to restrictive interventions: E.g. Policies, procedures, agreed ways of working, training, risk assessments, multidisciplinary input/collaboration, incident reporting, post intervention documentation and regular reviews.
	7.5	Describe methods for reporting the occurrence of a restrictive intervention	Methods for reporting the occurrence of a restrictive intervention: Personnel informed, ABC form, incident form, MARs sheet and care plan.

Unit 9: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Unit 10: Principles of Dementia Care K/615/6708

Estimated TQT:	100
Estimated GLH:	75
Credit	10
Level	3

Unit Description:

This unit covers the underpinning knowledge of dementia care. The unit develops the learner's knowledge and understanding of dementia related; neurology, impacts of recognition and diagnosis, diversity, person-centred care, communicational needs, positive interactions, nutritional needs and legislation and agreed ways of working with regards to rights and choices.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the neurology of dementia	1.1	Identify different types of dementia	Different types of dementia: E.g. Alzheimer's disease, vascular dementia, dementia with Lewy bodies, frontotemporal dementia (e.g. Picks disease), prions related dementia (e.g. CJD), young onset dementia, Korsakoff-Syndrome, HIV associated and rarer types.
	1.2	Describe a range of causes of dementia	Causes of dementia: Alzheimer's disease: E.g. The loss of brain cells thought to be caused by clumps of protein, known as 'plaques' and 'tangles' that gradually form in the brain. Vascular dementia: E.g. When the brain's blood supply is interrupted (e.g. from atherosclerosis or stroke). Lewy bodies: E.g. Small, circular lumps of protein that develop inside brain cells. It is not known what causes them but it is thought they interfere with the chemical messages of the brain. Frontotemporal dementia: E.g. Caused by damage and shrinking in two areas of the brain. Others: E.g. Infections, such as encephalitis and HIV-related infections, some brain tumours; a lack of vitamin B in the diet, head injury and long-term alcohol misuse.
	1.3	Describe types of impairment often experienced by those with dementia	Types of impairment often experienced by those with dementia: E.g. Decline in memory, reasoning and communication, changes in behaviour,

			loss of skills, sensory impairment(s), fluctuating ability and movement difficulties.
	1.4	Explain the impacts of dementia upon information processing abilities	The impacts of dementia upon information processing abilities: E.g. Type specific impact(s) upon; sensory information processing (e.g. sight, sound, olfaction, touch and taste), cognition (e.g. short term, working and long term memory) and capacity.
	1.5	Explain how factors other than dementia may influence the condition of a service-user with dementia	How factors other than dementia may influence the condition of a service-user with dementia: E.g. Physical state (e.g. additional conditions), psychological state, the differences between dementia, depression and confusional states, sensory changes due to age-related degeneration (e.g. macular degeneration and cataracts affecting vision, loss of hearing and increase of tinnitus affecting balance etc.), reduced metabolism causing poor appetite and muscle wastage, age related osteoporosis and fear of falling and specific impacts of a fall.
	1.6	Explain why the abilities and needs of a service-user with dementia might fluctuate	Why the abilities and needs of a service-user with dementia might fluctuate: E.g. Changes to the physical environment (e.g. moving home, starting at a day centre), changes to the social environment (e.g. changes in carers, loss of family or friends and social isolation), bereavement, changes to the emotional environment (e.g. carers become stressed, experience of abuse, personal changes), changes in treatment, changes in medication, changes in physical condition (e.g. bacteria or viral infections), vascular changes, rapidity of onset of dementia, availability of intact neuronal networks and situational capacity.
2. Understand the impacts of the recognition and diagnosis of dementia	2.1	Explain the importance of recording any indications that a service-user might be exhibiting symptoms of dementia, in accordance with agreed ways of working	The importance of recording any indications that a service-user might be exhibiting symptoms of dementia, in accordance with agreed ways of working: E.g. Written or electronic recording that is; factual, legible, dated, signed or authenticated and confidential. Importance of recording to highlight risk and establish; if there is a pattern, an improvement or a worsening of symptoms. Aids accurate diagnosis, directs actions and facilitates advanced care planning.
	2.2	Explain the process of reporting possible indications of dementia within agreed ways of working	The process of reporting possible indications of dementia within agreed ways of working: E.g. Agreed ways of reporting in own organisation (e.g. verbal, written, electronic etc.) and requires; accurate, timely, and confidential reporting.

	2.3	Describe the impacts of an early diagnosis of dementia	Impacts of an early diagnosis of dementia: E.g. Person-dependent impacts but include; Quality of life (e.g. fear, wellbeing, feeling of lack of control, loss of dignity, loss of identity, loss of independence, invasion of privacy, fear of losing own home, inability to communicate needs and preferences, difficulty in dealing with own finances etc.), social (e.g. loss of friends, loss of community involvement, attitudes/plans of others including family and employer etc.), health (e.g. increased likelihood of injury or harm, increased risk of falls, nutritional changes, changes to personal hygiene, reduced exercise etc.) and increased vulnerability to abuse (e.g. emotional, neglect, physical, sexual, financial).
	2.4	Describe the possible impacts of receiving a diagnosis of dementia upon: • The service-user with dementia • The service-users friends and family	Possible impacts of receiving a diagnosis of dementia upon the service-user with dementia: E.g. Person-dependent; emotional response (e.g. fear, denial, impulsiveness, recklessness, sadness, anger etc.), need for information and need for sources of support (e.g. emotional and financial). Possible impacts of receiving a diagnosis of dementia upon the service-users friends and family: E.g. Person/ relationship dependent; emotional response (e.g. fear, denial, impulsiveness, recklessness, sadness, anger etc.), need for information and need for sources of support (e.g. emotional and financial).
3. Understand the concept of diversity and its relevance to working with individuals who have dementia	3.1	Explain why it is important to identify the specific and unique needs of a service-user with dementia	Why it is important to identify the specific and unique needs of a service-user with dementia: E.g. Recognition of personhood, provision of person-centred care and support which meets the service-users individual needs, empowerment of the service-user, promotion of positive self-esteem, promotion of independence, promotion of identity and factors relating to the upholding of rights.
	3.2	Describe why a service-user with dementia may be subjected to discrimination and/ or oppression	Why a service-user with dementia may be subjected to discrimination and/ or oppression: E.g. Cognitive effects increasing vulnerability (e.g. affecting likelihood of abuse), misunderstanding of symptoms and characteristics of dementia, poor working practice due to lack of training, working practice conducted with institutional focus (e.g. as opposed to person-centred), stigma traditionally attached to mental health and/ or individual sources of prejudice with regards to; age, gender, ethnicity, religion, sexual orientation and/ or perceived intellect.

	3.3	Compare the experience of dementia for an individual who acquired the condition as an older person with one who acquired it as a younger person	The experience of dementia for an individual who acquired the condition as an older person and one who acquired it as a younger person: E.g. Experience of younger individuals with dementia: Person-dependent but can include; disruption of career, reduction of working hours, reduction of ability to earn income, loss of income, lack of preparation, negative effects on social circles/ relationships, broad challenges to wellbeing, perceived loss of future and independence, lack of appropriate health and social care provision for younger adults and symptoms at referral may be more subtle than those of older individuals (e.g. improved ability but increased difficulty obtaining a diagnosis and support). Experience of older individuals with dementia: Person-dependent but can include; disruption of career, reduction of working hours, reduction of ability to earn income, loss of income, negative effects on social circles/ relationships, loss of social circles/ relationships (e.g. loss of partners), broad challenges to wellbeing, confusion of symptoms with other conditions, assumption that symptoms are associated with older age, combined effects of co-existing conditions associated with older age (e.g. reduction of hearing and sight), increased likelihood of discrimination/ oppression (e.g. due to age related vulnerability), reduced ability (e.g. mobility, cognitive ability, communicative ability etc.), increased frailty, reduced independence and isolation/ loneliness due to age related reduction in social circles.
	3.4	Describe how the experience of dementia might be different for service-users: • Who have a learning disability • Who are from different ethnic backgrounds • Who are at end of life care	How the experience of dementia might be different for service-users who have a learning disability: E.g. Person-dependent but can include; potential amplification of effects of dementia (e.g. cognitive difficulties, communicative difficulties and mobility difficulties), increased need for support, development of symptoms at an earlier age (e.g. particularly with Down's syndrome), late diagnosis due to existing learning disability, increased likelihood of discrimination/ oppression (e.g. due to increased vulnerability), reduced independence and increased need for advocacy. How the experience of dementia might be different for service-users who are from different ethnic backgrounds: E.g. Person-dependent but can include; common symptoms, observation of cultural/ religious requirements, loss of second language, fear and anxiety due to loss of language, increased likelihood of communication barriers (e.g. can

			increase sense of frustration/ isolation/ loneliness), increased likelihood of discrimination/ oppression (e.g. due to ethnicity related prejudices), additional challenges to wellbeing where cultural recognition is inadequate and specific sensitivities with regards to personal care. How the experience of dementia might be different for service-users who are at the end of life: Person-dependent but can include; recognition of the onset of death, religious fixation, need for palliative treatment including pain relief, increased bodily discomfort/ soreness, reduced appetite, combined effects of co-existing conditions including those associated with older age (e.g. reduction of hearing and sight), increased need for validation, reduced behavioural control, increased difficulties (e.g. cognitive, communicative and mobility related) and implementation of advance directives.
4. Understand how a person-centred approach must underpin dementia care	4.1	Compare person-centred and non-person-centred approaches to dementia care	Person-centred and non-person-centred approaches to dementia care: Person-centred approach: E.g. A care strategy that recognises and respects the uniqueness of the service-user (e.g. strengths, abilities, preferences, goals, needs, history, relationships etc.), places the service-user being cared for at the heart of their own care (e.g. places the person first and the dementia second) and reflects a broad range of person-centred values (e.g. dignity, respect, choice, independence, privacy, rights, empowerment and equality). Care related decisions/ actions are made based upon and around the service-user as opposed to the service/ institution. Non-person-centred approaches: E.g. Care strategies that do not recognise nor respect the uniqueness of the service-user; institutional perspective, bio-medical perspective, service-users individual preferences/ needs unmet (e.g. physical and psychological) and strategy arguably abusive.
	4.2	Describe how dementia stereotypes may affect the service-user with dementia	How dementia stereotypes may affect the service-user with dementia: E.g. Person-dependent impacts but can include; stigmatisation/ prejudice and related negative impacts to wellbeing (e.g. psychological), social exclusion, social withdrawal, disabling/ disempowering assumption of automatic loss of independence (e.g. unable to drive, unable to care for self, unable to make decisions about own care) and dissatisfying interactions with the medical community (e.g. difficulty in obtaining early diagnosis, uncertainty about availability of support services and treatments).

	4.3	Explain why it is important not to assume that a service-user with dementia cannot make their own decisions	Why it is important not to assume that a service-user with dementia cannot make their own decisions: E.g. Legal assumption of mental capacity unless proven otherwise, right of all individuals to make decisions, avoidance of disempowerment, promotion of independence and importance of taking time to assess a service-users individual ability.
	4.4	Describe how carers and others can be involved in the planning of support that promotes the rights and choices of a service-user with dementia but also minimises the risk of harm	How carers and others can be involved in the planning of support that promotes the rights and choices of a service-user with dementia but also minimises the risk of harm: E.g. Use of person-centred planning tools (e.g. relationship circles, one page profiles etc.), involvement in assessing acceptable risks, involvement in support planning/ strategy meetings, multidisciplinary engagement and communication, involvement in review meetings (e.g. based upon own practice), advocacy and use of advocacy services.
	4.5	Explain why service-users with dementia need to be supported to make advanced care plans as early as possible	Why service-users with dementia need to be supported to make advanced care plans as early as possible: E.g. Reduces risk of loss of capacity impacting ability to express preferences and make decisions/ choices (e.g. about future care/ treatment), likelihood of capacity greater the earlier the advance care plan is made and an important component of empowerment.
	4.6	Explain how the best interests of a service-user with dementia are considered when planning and delivering care and support	How the best interests of a service-user with dementia are considered when planning and delivering care and support: E.g. Shared decision making (e.g. with the service-user), use of personal histories to take account of preferences and goals, multidisciplinary collaboration, involvement of families in planning and implementing person-centred care and support, adherence to the National Dementia Strategy guidelines, adherence to organisational policies, procedures and strategies for dementia care, positive approaches towards risk assessment, adaptation of environments and resources to enable active participation, recognition of a service-users right to non-participation and adherence to the agreed care plan.
	4.7	Explain the relationship between the enablement of rights and choices for a service-user with dementia and the service-user making non-best interest decisions	The relationship between the enablement of rights and choices for a service-user with dementia and the service-user making non-best interest decisions: E.g. Component of person-centred care; balance must be struck between promoting choice, independence and rights against the fundamental duty to protect the health, safety and wellbeing of the service-user with dementia (e.g. the right of a service-user to make choices and take risks vs own duty of care and safeguarding requirements), can lead to

			non-best interest decisions being made by the service-user in accordance with own preferences and values, process requires risk assessment and may also require advocacy.
	4.8	Describe a range of techniques that can be used to meet the dynamic needs of a service-user with dementia	Techniques that can be used to meet the dynamic needs of a service-user with dementia: E.g. Increasing the level of support to address unmet needs, changing the type of support, changing the method of delivering support, reality orientation approaches, validation approaches, use of assistive technologies (e.g. pressure mats, door alarms linked to staff pagers, personal pendant alarms etc.), provision of an enabling and safe environment (e.g. hand rails, safe flooring, use of colour/ textures, practical aids etc.), use of social environment to enable positive interactions, use of reminiscence techniques to facilitate positive interactions, involving family and friends, recognising and respecting the service-users preferences strengths and abilities (e.g. person-centred techniques), effective communication and provision of; activities specific to the needs of the service-user (e.g. music sensory), alternative therapies (e.g. aromatherapy, massage, sensory etc.) and ample opportunities for exercise.
	4.9	Explain methods to support a service-user with dementia to overcome their fears	Methods to support a service-user with dementia to overcome their fears: E.g. Person-centred care and communication, involvement in decision making processes and reviews (e.g. shared decision making), involvement of family and friends, emotional support, information provision (e.g. about accessible and appropriate support services), engagement with support services (e.g. Alzheimer's Society) and other forms of multidisciplinary collaboration (e.g. engagement with psychological services, chaplain etc.).
	4.10	Describe methods to assist a service-user with dementia to maintain their identity	Methods to assist a service-user with dementia to maintain their identity: E.g. Use of preferred name, use of preferred method of communication, use of reality orientation techniques, involvement of family and friends, matching activities to current abilities, validation of the service-user (e.g. through reciprocal conversation which acknowledges the legitimacy of that person's opinions as their own), promotion of exercise and conduct of reminiscence therapy.
	4.11	Explain the steps that can be taken to support the family of a service-user with dementia	Steps that can be taken to support the family of a service-user with dementia: E.g. Communication, involvement and participation in decisions, reminiscence therapy and referral to support agencies.

	4.12	Describe methods to maintain privacy and dignity when caring for a service-user with dementia	Methods to maintain privacy and dignity when caring for a service-user with dementia: E.g. Person-centred care; covering of service-users during procedures, avoidance of unnecessary exposure (e.g. use of screens, curtains, closing doors, use of privacy notices to prevent intrusion etc.), observation of cultural and religious requirements, use of preferred names and titles, use of a polite and respectful tone when speaking, provision of action explanation prior to conduct, obtaining informed consent, observation of confidentiality requirements, providing additional and timely assistance where required and recognising a service-users right to refuse care (e.g. personal care).
5. Understand the communicational needs of an individual with dementia	5.1	Explain the importance of effective communication to a service-user with dementia	The importance of effective communication to a service-user with dementia: E.g. Essential for meeting a service-user's individual needs, enables more effective delivery of person-centred care; positive impacts to wellbeing, major component of empowerment, enables/ promotes independence, improves sense of understanding and control, improves perceptions of self-worth and value, reduces levels of isolation (e.g. through increased social inclusion), reduces agitation, reduces need to communicate through behaviour and improves working relationships and engagement for both parties.
	5.2	Describe the potential impacts of different forms of dementia upon a service-users ability to communicate	The potential impacts of different forms of dementia upon a service-users ability to communicate: E.g. Alzheimer's disease (e.g. apraxia of speech, confusion of verbalisation, out of context verbalisation and dysarthria – most commonly hypokinetic dysarthria), Multi-infarct dementia (MID) (e.g. aphasia and dysarthria), Pick's disease (e.g. hypokinetic dysarthria) and Lewy body disease (e.g. hypokinetic dysarthria).
	5.3	Explain how service-users with dementia may communicate through behaviour	How service-users with dementia may communicate through behaviour: E.g. Behaviour is a form of communication, reliance upon behaviour to communicate increases when communication needs are unmet (e.g. verbal abilities decrease or method of communication used by others inappropriate for the service-user), behaviour can be positive or negative and is often intended to convey emotion or need (e.g. use of gestures, non-verbal language, tactile approaches, inappropriate verbal responses, social engagement, social withdrawal, inappropriate physical responses etc.).

	5.4	Identify the physical and mental health needs that must be considered when communicating with a service-user with dementia	The physical and mental health needs that must be considered when communicating with a service-user with dementia: E.g. Physical health needs: Person-dependent but can include; pain and discomfort, hearing loss, sight loss, effects of dementia on mobility, discomfort due to constipation, fragile skin, co-existing conditions (e.g. arthritis, hypo/hyper-tension, osteoporosis etc.) and seasonal illnesses such as influenza. Mental health needs: Person-dependent but can include; confusion, loss of memory, depression, anxiety, effects of dementia on speech patterns, diminishing cognitive skills (e.g. problem solving skills and ability to learn new information), fears, effects of co-existing mental ill health and learning disabilities.
	5.5	Explain why pain in service-users with dementia is often poorly recognised	Why pain in service-users with dementia is often poorly recognised: E.g. Often confused with behaviour, the service-user is often not able to communicate the issue of being in pain and difficulty separating condition based emotional responses from specific pain responses.
	5.6	Explain how environmental factors might affect the ability of a service-user with dementia to communicate	How environmental factors might affect the ability of a service-user with dementia to communicate: E.g. Person-dependent, environmental factors impacting communication can include; sensory inputs/ stimulation (e.g. visual, auditory, olfactory; under/ over stimulation or competition), temperature, activity provision and appropriateness, degrees of active participation, environmental accessibility, resource availability (e.g. both personnel and communication aids), organisational culture/ ethos, presence/ persistence of language barriers, cultural sensitivity and the impacts of others.
	5.7	Contrast the use of reality orientated approaches to communication with validation orientated approaches	The use of reality and validation orientated approaches to communication: E.g. Person-dependent approach usage, approach dependent method and outcome. Reality orientated approaches to communication: E.g. Surrounding a service-user with familiar artefacts and conversations, reminding them of familiar realities and placing conversations in the present. Aims to preserve cognitive status for as long as possible. Validation orientated approaches to communication: E.g. Reciprocated communication of respect, recognition of the opinions of another as legitimate expressions of feelings, reassurance and acceptance of a

			service-users disorientation. Aims to facilitate communication and reduce distress.
	5.8	Explain how the communicational style, abilities and needs of a service-user with dementia can be used to develop and maintain their care plan	How the communicational style, abilities and needs of a service-user with dementia can be used to develop and maintain their care plan: E.g. Ascertain preferences and needs; use of life histories, use of person-centred tools (e.g. One Page Profiles), use of communication charts, reference to daily documentation, consultation with the service-user, consultation with their family and friends, additional multidisciplinary consultation (e.g. speech and language therapists, carers etc.) and decision making agreements. Develop and maintain care plan; documentation of agreed communication strategy (e.g. based upon previously identified preferences and needs), use of service-users preferred method of communication (e.g. adherence to agreed strategy), training of others in relation to the service-users preferred form of communication, use of preferred names and titles, active monitoring, documenting and reporting all communicational changes and undertaking regular collaborative review.
6. Understand positive interactions when communicating with individuals with dementia	6.1	Identify examples of positive interactions with service-users with dementia	Examples of positive interactions with service-users with dementia: E.g. Person-dependent and list not exhaustive but includes; use of preferred communication method/s, engagement of the service-user, two-way communication, self-instigated reminiscence therapy, activity participation, involvement in decision making, maintenance of eye contact, use of positive body language, use of appropriate tone and pitch, respect for personal space and any interaction that empowers and/ or promotes independence or wellbeing).
	6.2	Describe how the physical environment can be used to enable positive interactions with service-users with dementia	How the physical environment can be used to enable positive interactions with service-users with dementia: E.g. Person-dependent and list not exhaustive but includes; environmental enrichment, adaptation of aspects of environment to meet the needs of the service-users, resource provision/ availability (e.g. presence of communication aids), use of life histories to provide appropriate activities and environments (e.g. themed settings, game nights etc.), recognition and involvement of service-user interests, involvement of service-users in group activities and utilisation of friendship groups/ family in interactions.

	6.3	Explain how reminiscence techniques can be used to facilitate positive interactions	How reminiscence techniques can be used to facilitate positive interactions: E.g. Person-dependent and person-centred approach; draws upon and reflects a service-users unique life history, service-users are supported to focus on and engage with topics of personal relevance, provides a focus for conversations, promotes familiarity of environment, enables and empowers, has positive effects upon wellbeing (e.g. self-worth, self-esteem etc.) and helps to develop rapport/ trust between service-user and service provider thereby promoting further positive interactions.
	6.4	Explain how positive interactions with service-users with dementia can affect the service-users wellbeing	How positive interactions with service-users with dementia can affect the service-users wellbeing: E.g. Positive interactions an essential component of wellbeing; promotion of personhood, promotion of inclusion, reduction of agitation, promotion of respect/ dignity, reduction of depressive symptoms, social engagement, connection with others in the setting, avoidance of exclusion or perceptions of isolation, improvements to sense of self-worth and self-esteem and benefits gained through identity maintenance.
	6.5	Explain how the use of verbal language can hinder positive interactions when communicating with a service-user with dementia	How the use of verbal language can hinder positive interactions when communicating with a service-user with dementia: E.g. Person-dependent communication strategies and language dependence, verbal communication not always preferred method (e.g. individual needs, preferences, sensory needs, presence of language barriers etc.), additional preferences with regards to style of verbal communication (e.g. tone and pitch) and use of inappropriate communication strategy can lead to misunderstandings and/ or hinder present and future positive interactions (e.g. as a result of unmet communicative needs).
	6.6	Describe how the behaviour of others might affect a service-user with dementia	How the behaviour of others might affect a service-user with dementia: E.g. Person and behaviour-dependent positive or negative impacts to; wellbeing, understanding, acceptance, own behaviour, working relationships, compliance, condition, motivation, progression, social engagement, empowerment, independence, dignity, self-esteem and the presence of barriers.
7. Understand the nutritional needs of individuals with dementia	7.1	Explain how the cognitive and functional changes associated with dementia can affect eating, drinking and nutrition	How the cognitive and functional changes associated with dementia can affect eating, drinking and nutrition: E.g. Age related appetite reduction (e.g. linked to reduced activity and metabolism), sensory changes affecting recognition of/ appetite for food and drink (e.g. loss of sight, smell, taste,

			hearing etc.), cognitive changes impacting recollection of last meal time and subsequent hunger/ thirst (e.g. forget eating/ not eating), variations in meal-time association (e.g. driven by environment, memory and changes to sleep-wake cycle etc.) changes in tolerance for food/ drink textures and consistency affecting types consumed (whole food, fork 'mash-able' liquid thickeners etc.) and where left unchecked/ unassisted these changes can lead to nutritional issues.
	7.2	Explain how poor nutrition can affect a service-users experience of dementia	How poor nutrition can affect a service-users experience of dementia: E.g. Person-dependent negative impacts upon; wellbeing, comfort, agitation, understanding, cognition, communicative abilities, mobility, independence and behaviour. Additional factors can include an increased risk of; pain, falling, condition worsening, development of additional conditions (e.g. muscle wastage, organ failure etc.), dehydration and infection.
	7.3	Explain the importance of including a variety of food and drink in the diet of a service-user with dementia	The importance of including a variety of food and drink in the diet of a service-user with dementia: E.g. Food and drink preferences change over time, providing a variety ensures the availability of person-centred choice (impacting empowerment and independence) and balanced diet provision essential component of physical and psychological health.
	7.4	Explain the importance of respecting a service-users personal and cultural preferences for food and drink	The importance of respecting a service-users personal and cultural preferences for food and drink: E.g. Respecting preferences is an essential component of person-centred care; promotes food and drink intake, good nutrition and positive impacts with reference to the problems identified within assessment criteria 7.2.
	7.5	Describe how mealtime cultures can create a barrier to meeting the nutritional needs of service-users with dementia	How mealtime cultures can create a barrier to meeting the nutritional needs of service-users with dementia: E.g. Rigidity of meal timings and location, environment related increases to sensory input affecting nutritional intake (e.g. sight, smell, sound; sensory overload), staffing related limitations to availability of person-centred nutritional support, logistics driven limitations to meal choice and proximity related barriers (e.g. the actions of others impacting upon the meal of another and related space constraints).
	7.6	Describe how meal time environments can be designed to assist service-users to eat and drink	How meal time environments can be designed to assist service-users to eat and drink: E.g. Minimising distractions, providing reminiscence, ensuring the food is available at all times (e.g. removal of time/ location dependency), ensuring the provision of choice, providing group and single

			eating experiences, ensuring provision of individualised levels of support, promoting independence and ensuring adequate space and resource availability.
8. Understand key legislation and agreed ways of working that support the fulfilment of rights and choices for individuals with dementia	8.1	Identify the legislation that relates to fulfilment of rights and choices, whilst minimising risk of harm, for service-users with dementia	Legislation that relates to fulfilment of rights and choices, whilst minimising risk of harm, for service-users with dementia: E.g. Equalities Act (2010), Mental Capacity Act (2005), Codes of Practice, Deprivation of Liberty Safeguards Amendment, (2009) and Mental Health Act (2007).
	8.2	Describe agreed ways of working that relate to the rights and choices of a service-user with dementia	Agreed ways of working that relate to the rights and choices of a service-user with dementia: E.g. Person-centred care; adhering to individualised care plans, involving the service-user in decisions (e.g. shared decision making), recognition and respect for the service-users individual preferences and goals, involvement of families and friends, multidisciplinary collaboration with a view to empowerment (e.g. speech and language therapists, occupational therapists, psychologists, carers, advocates etc.), provision of choice and opportunities, enablement of positive risk taking, preservation of privacy and dignity (e.g. during procedures), adaptation of environments and resources to promote and enable active participation, regular review of the agreed upon care plan (e.g. with the service-user and the multidisciplinary team), recognition of the service-users right to non-participation, adherence to the National Dementia Strategy guidelines and adherence to organisational policies, procedures and strategies for dementia care.
	8.3	Summarise an individual's duty of care when assisting a service-user with dementia	An individual's duty of care when assisting a service-user with dementia: E.g. The balance between promoting choice independence and rights against the fundamental duty to protect the health, safety and wellbeing of the service-user.
	8.4	Describe how legislation, policy and agreed ways of working support inclusive practice and equality for dementia care	How legislation, policy and agreed ways of working support inclusive practice and equality for dementia care: E.g. Protection against direct and indirect discrimination, protection against unequal and unfair treatment, shared decision making, provision of independent advocacy to support

			decision making, provision of adapted environments and resources to enable full and active participation and use of person-centred approaches to empower and enable all service-users receiving dementia care.

Unit 10: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Unit 11: Principles of End of Life Care H/615/6707

Estimated TQT:	100
Estimated GLH:	75
Credit	10
Level	3

Unit Description:

This unit covers the underpinning knowledge of end of life care. The unit develops the learner's knowledge and understanding of key characteristics of end of life care, including; legislation and agreed ways of working, advance care planning, factors affecting care, responses to anticipated death, addressing sensitive issues and available support services and organisations.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the key characteristics of end of life care	1.1	Define the term 'end of life care'	End of life care: E.g. Health care provided to those with a terminal illness or terminal condition that has become advanced, progressive and incurable. This includes care for those who are in the final hours or days of their lives and encompasses palliative care (e.g. managing pain and other distressing symptoms).
	1.2	Identify conditions for which end of life care might be provided	Conditions for which end of life care might be provided: E.g. Advanced incurable conditions including; cancer, dementia, motor neurone disease, organ failure, systems failure, those at risk of acute crisis (e.g. heart failure and chronic respiratory disease), those with life threatening acute conditions caused by sudden catastrophic events (e.g. head injury or stroke induced brain damage) and those in permanent vegetative states (PVS).
	1.3	Describe the factors that indicate the need for end of life care	The factors that indicate the need for end of life care: E.g. Diagnosis of a terminal illness or terminal condition that has become advanced, progressive and incurable; often preceded by a sudden worsening/ deterioration of condition.
	1.4	Explain the stages of the local end of life care pathway	The stages of the local end of life care pathway: E.g. End of Life Care Strategy (DH 2008); Step 1: Discussions as the end of life approaches, Step 2: Assessment, care planning and review, Step 3: Co-ordination of care, Step 4: Delivery of high quality services in different settings, Step 5: Care in the last days of life and Step 6: Care after death.

	1.5	Identify symptoms that could suggest a service-users last few days of life might be approaching	Symptoms that could suggest a service-users last few days of life might be approaching: E.g. Person-dependent; profound weakness, complete dependency, reduced consciousness, inability to take/ retain diet and fluids, inability to swallow (including medication), reduced cooperation, increased confusion/ disorientation, delusions, hallucinations, increased/ decreased vocalisations, respiratory secretions, shallow breathing, apnea, pale skin, cool skin and thread pulse.
2. Understand the legislation and agreed ways of working that support the rights of individuals at end of life	2.1	Identify legislation and agreed ways of working designed to protect the rights of service-users in end of life care	Legislation and agreed ways of working designed to protect the rights of service-users in end of life care: E.g. National End of Life Care Programme, End of Life Care Quality Standard, When a Patient Dies (2005), Standards for bereavement care in the UK (revised by Cruse Bereavement Care and the Bereavement Services Association), NICE: End of life care for people with life-limiting conditions (2017), Community Care Act (1990), Dignity Challenge and regulations relating to the death certification process.
	2.2	Explain how legislation and agreed ways of working can influence a service-users end of life experience	How legislation and agreed ways of working can influence a service-users end of life experience: E.g. Provides a standardised framework for best practice based on the latest evidence, influences the service-users; understanding, wellbeing, empowerment, control, dignity, comfort, distress, acceptance (etc.) and can improve end of life experience.
3. Understand advance care planning in relation to end of life	3.1	Contrast a care or support plan with an advance care plan	Care plan: E.g. Person-centred plan directing individualised day-to-day care strategy, stems from and reflects a service-users individual diagnosis and needs (e.g. strengths, weaknesses, goals, preferences etc.), creation/ review requires multidisciplinary input and care plan promotes consistency/ continuity of care across professionals. Advance Care plan: E.g. Person-centred plan directing individualised care strategy when approaching end of life, written by the service-user and based upon; personal values, preferences and discussions with loved ones.
	3.2	Explain the purpose(s) of advance care planning in relation to end of life care	The purpose(s) of advance care planning in relation to end of life care: E.g. Ensures end of life care delivered in accordance with a service-users individual needs wishes and preferences and directs care strategy in advance for when a service-user can no longer communicate their preferences.
	3.3	Explain the benefits of increasing a service-users control over their end of life care	The benefits of increasing a service-users control over their end of life care: E.g. Positive, person-centred impacts to the service-users wellbeing (e.g.

			empowerment, control, reduced distress, reduced anxiety, increased understanding and acceptance, security, increased compliance etc.) Additional positive impacts to the service-users support networks (e.g. reduced decisional demands, increased understanding of the service-users preferences, increased acceptance, reduced anxiety, increased knowledge of required actions etc.).
	3.4	Describe own role in supporting and recording advance care planning decisions	Own role in supporting and recording advance care planning decisions: E.g. Actions in accordance with advance care plan and documentation of agreed changes.
	3.5	Explain how symptom management is an integral part of the care planning process	How symptom management is an integral part of the care planning process: E.g. Symptoms can cause the service-user (or others) distress or discomfort, symptom management (e.g. palliative care) is required to maximise comfort and wellbeing during end of life care, it is the responsibility of healthcare professionals to eliminate or minimise a service-users negative symptoms during end of life; requires early planning and continual review.
	3.6	Explain why it is important to pass on information about a service-users wishes, needs and preferences for end of life care	Why it is important to pass on information about a service-users wishes, needs and preferences for end of life care: E.g. Agreed ways of working, contribution to person-centred care and advance care planning; impacts upon wellbeing (e.g. with reference to assessment criteria 3.3).
	3.7	Explain why a service-user might chose to experience end of life care: • In their own home • In a care home	Why a service-user might chose to experience end of life care in their own home: E.g. Personal preference/ choice, familiarity, comfort, proximity to friends/ family, desire to avoid clinical setting and perceived improvements to dignity and peace. Why a service-user might chose to experience end of life care in a care home: E.g. Personal preference/ choice, loss of partner, fears over being alone, family issues, concerns about being a burden to the family, dependency concerns- particularly for intimate needs (e.g. toileting and bathing), concerns regarding the availability of pain relief, desire to keep home from becoming a hospital, desire for less medicalised environment than hospital and desire for 24hr care.
	3.8	Summarise relevant ethical and legal issues that might arise in relation to advance care planning	Relevant ethical and legal issues that might arise in relation to advance care planning: E.g. Consent, choice, capacity, wishes, needs, preferences,

			disagreements, challenges between wishes and medical needs, family issues, financial issues etc.
4. Understand factors that affect end of life care	4.1	Explain how culture and religion/ beliefs can impact end of life care	How culture and religion/ beliefs can impact end of life care: E.g. Person-dependent effects upon; symptom management, environment, diet, dignity, privacy, interaction amongst others, exposure to others, beliefs around dying and religious requirements.
	4.2	Identify key people in a service-users end of life care	Key people in a service-users end of life care: E.g. The service-user, their family and networks, GP and medical staff, nursing staff, pharmacists, specialists, hospice staff, carers, social workers, agency staff/ advisers, housing workers, chaplain/ religious figures and funeral directors.
	4.3	Explain how key people can have a distinctive role in a service-users end of life care	How key people can have a distinctive role in a service-users end of life care: E.g. Person/ relationship dependent knowledge of the service-user and role dependent areas of expertise and competency (e.g. physical needs, psychological needs, emotional needs, spiritual needs, social needs, financial needs, logistical needs etc.).
	4.4	Describe methods to help a service-user to feel respected and valued throughout their end of life experience	Methods to help a service-user to feel respected and valued throughout their end of life experience: E.g. Consistent application of person-centred values (e.g. choice, empowerment, enablement etc.), person-centred communication and adherence to preferences, promotion of reminiscence techniques, assumption of capacity, engagement with family, honouring the religious or cultural wishes/ requirements of the service-user whilst ensuring legal obligations are met and providing opportunities for advance decisions/ advance care plans to be made and followed.
	4.5	Identify examples of how a service-users end of life wellbeing can be enhanced by: • Environmental factors • Non-medical interventions • Use of equipment and aids	Examples of how a service-users end of life wellbeing can be enhanced by: Environmental factors: E.g. Provision of person-centred; environmental enrichment (e.g. familiar/ personal items, paintings, music, plants etc.), lighting, heating, ventilation and opportunities for social engagement. Non-medical interventions: E.g. Provision of person-centred; support, advocacy, balanced diet, alternative therapies (e.g. massage, aromatherapy etc.), spiritual mediation, activities that enable active participation and communication therapies (e.g. reminiscence therapy). Use of equipment and aids: E.g. Provision of person-centred; equipment to assist movement (e.g. lifts, ramps, wheel chairs, frames, hoists, slings, collapsible bedrails etc.), equipment to assist comfort (e.g. slide sheets,

			hoists, pads etc.) and equipment to assist safety (e.g. bedrails, alarm mats etc.).
	4.6	Explain the necessity of monitoring service-users on end of life care for changes in symptoms or condition	The necessity of monitoring service-users on end of life care for changes in symptoms or condition: E.g. To provide safe, appropriate and compassionate person-centred care, maintenance of symptom managements and palliative care, to inform the next stages of the local end of life care pathway and to permit timely intervention where required.
	4.7	Explain why support for a service-users health and wellbeing may not always relate to the underlying condition	Why support for a service-users health and wellbeing may not always relate to the underlying condition: E.g. Holistic care requires both condition management and care for a service-users individual needs, individual needs are an essential component of health and wellbeing (e.g. a service-user may have; financial, housing and or family concerns/ issues, a need for spiritualism, a need for assistance planning post life events such as a funeral, a desire to fulfil pre-death goals/ ambitions and/ or a need for support maintaining a regular activities/ hobbies etc.) and meeting individual needs has positive impacts upon the health and wellbeing of the service-user (e.g. reduced stressors, increased satisfaction, increased understanding/ acceptance etc.).
5. Understand an individual's response to their anticipated death	5.1	Identify models of loss and grief	Models of loss and grief: E.g. Kübler-Ross: 5 Stages of Grief Model (1969), Worden (1989) 4 tasks of Mourning, (Stroebe & Schute, 1999), Dual Process Model of Grief, Klass, D., Silverman. S, Nickman, S (Eds) (1996) Continuing Bonds and The Range of Response to Loss model (RRL).
	5.2	Explain how to support a service-user who is experiencing grief	How to support a service-user who is experiencing grief: E.g. Grief as a reaction to loss includes a range of person-dependent feelings, thoughts, and behaviours; varies according to culture, background, gender, beliefs, personality, history and relationship to the deceased. Support/ coping strategies must be tailored to the needs of the service-user but can include; acknowledgement of what has happened, expressing concern, offer of support, listening with compassion, offering practical assistance and monitoring for warning signs indicating the need for professional help.
	5.3	Explain how to support a service-user to respond to their unique concerns and fears during the last stages of life	How to support a service-user to respond to their unique concerns and fears during the last stages of life: E.g. Person-centred strategies (e.g. communication, active participation, family engagement and spiritual/

			religious engagement), use of support groups, counselling services and hospice networks etc.
	5.4	Describe how a service-users awareness of spirituality might change as they approach end of life	How a service-users awareness of spirituality might change as they approach end of life: E.g. Re-examining and rekindling beliefs and observances and often driven by need for reassurance.
	5.5	Evaluate the impact of awareness and capacity on a service-users experience during end of life care	The impact of awareness and capacity on a service-users experience during end of life care: E.g. Person-dependent impacts of increased or decreased capacity and/ or awareness affecting; understanding, acceptance, rejection, comfort, distress, satisfaction, need, ability, independence, beliefs, relationships, quality of life etc.)
6. Understand how to address sensitive issues that relate to end if life care	6.1	Explain the importance of documenting significant conversations during end of life care	The importance of documenting significant conversations during end of life care: E.g. To ensure wishes, feelings, preferences and beliefs are communicated and listened to as far as legally possible, maintains best interests, promotes communication, may contribute to review of advance care plan, informs decisions and ensures validity of decision making process.
	6.2	Describe factors influencing responsibility for relaying significant news to an individual or key people	Factors influencing responsibility for relaying significant news to an individual or key people: E.g. Individual preferences, agreed ways of working, type of news and relationship with key people.
	6.3	Describe conflicts that may arise in relation to death, dying or end of life care	Conflicts that may arise in relation to death, dying or end of life care: E.g. Preferences, wishes and best interests, withdrawing treatment, the balance between symptom control and quality of life (e.g. invasiveness, impacts to daily routine, impacts to social engagement etc.) and disputes with or between key people.
7. Understand organisations and support services available to individuals and key people in relation to end of life care	7.1	Describe the possible emotional effects of end of life upon: • The service-user experiencing end of life • The service-users family • Those working in end of life care situations	The possible emotional effects of end of life upon; the service-user, the service-users family and those working in end of life care situations: E.g. Broad and person and relationship-dependent, includes; fear of the unknown, loss and grief, stress, anxiety, tension, responsibility, guilt, upset, apathy, avoidance, denial, acceptance etc.
	7.2	Describe the role of support organisations and specialist services relating to end of life care	The role of support organisations and specialist services relating to end of life care: E.g. Broad networks of support available, can be service-user,

			family and/ or staff facing, support includes; financial, emotional, logistical, spiritual, advocacy based etc.
	7.3	Explain the role and value of an advocate in relation to end of life care	The role and value of an advocate in relation to end of life care: E.g. Will raise issues and concerns for and in place of the service-user, provides independency, ensures equality and upholding of rights, contribution towards best interest decisions, provision of best practice guidance, provides voice for service-user on end of life care and prevents against discriminatory practices.

Unit 11: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

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Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
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The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

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Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit is linked to: HSC385

Unit 12: Principles of Caring for Autistic Spectrum Conditions D/615/6706

Estimated TQT:	100
Estimated GLH:	75
Credit	10
Level	3

Unit Description:

This unit covers the underpinning knowledge of caring for autistic spectrum conditions. The unit develops the learner's knowledge and understanding of autistic spectrum related; legislative frameworks, main characteristics, behaviours including repetitive behaviours and obsessions and impacts upon verbal and non-verbal communication. Learners will also develop an understanding of how to support individuals with an autistic spectrum condition; to communicate, generally and to cope with situations of transition and/ or change.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand legislative frameworks that relate to individuals with autistic spectrum conditions	1.1	Identify legislation that relates to autistic spectrum conditions	Legislation that relates to autistic spectrum conditions: E.g. The Autism Act (2009), Autism Strategy (2010), NICE Guidelines for Children with Autism (2012), The NICE Guidelines for Adults with Autism (2012), Children and Families Act (2014), Care Act (2014), Statutory Guidance to Local Authorities (2015), NICE Support and Management of Children with Autism under 19 – (2013), Equalities Act (2010) and Mental Capacity Act (2005).
	1.2	Explain the purpose of the Autism Act (2009)	The purpose of the Autism Act (2009): E.g. Autism only legislation, promotes adherence to government vision for adults with autism to have/ lead; fulfilling lives, rewarding lives, acceptance within society, access to diagnosis, access to support, support from public services, fair treatment and recognition as an individual.
	1.3	Describe the key difference(s) between the Autism Act (2009) and the Children and Families Act (2014) with reference to demographic coverage	The key difference(s) between the Autism Act (2009) and the Children and Families Act (2014) with reference to demographic coverage: E.g. Autism Act (2009): Adult only legislation. Children and Families Act (2014): Legislation for children up to age 25, crossover for 19-25 year olds.
	1.4	Explain the contributions of autism rights groups for the support of service-users with an autistic spectrum condition	The contributions of autism rights groups for the support of service-users with an autistic spectrum condition: E.g. Powerful lobbying groups, maintenance of focus on rights and equality, advocacy, coordination/

			provision of autism facing research (and related actions) and a platform for autistic voices to be heard.
	1.5	Explain how legislative frameworks underpin the development of services for service-users with an autistic spectrum condition	How legislative frameworks underpin the development of services for service-users with an autistic spectrum condition: E.g. Legislation has led to several guidelines that directly impact upon the development and scope of services (e.g. Autism Act (2009); led to Statutory Guidelines from DoH in (2015) and NICE Guidelines on diagnosis and pathways, Care Act (2014); led to a refocus on assessments, inclusion of risk of neglect and the need to look at carers' needs, Children & Families Act (2014); led to a focus on individual needs and holistic service provision etc.).
	1.6	Explain how legislative application can be dependent upon the needs of the service-user	How legislative application can be dependent upon the needs of the service-user: E.g. Legislation guides support provision, different forms of legislation address different types of need, support provision must be dynamic and dependent upon the needs and circumstances of the service-user, legislative application therefore depends upon the need(s) being addressed at any particular time (e.g. age group, capacity, behaviour etc.).
2. Understand the main characteristics of autistic spectrum conditions	2.1	Define 'Autistic Spectrum Disorders' according to the most recent Diagnostic and Statistical Manual (DSM)	Autistic Spectrum Disorders: E.g. Dyad of impairments; social communication difficulties and restricted and repetitive behaviours (including sensory).
	2.2	Summarise theories of autistic spectrum conditions	Theories of autistic spectrum conditions: E.g. Theory of Mind (ToM), sensory differences, mirror neurones and social response, genetics and genetic mutations, brain function, mind-blindness and extreme male brain theory.
	2.3	Explain why autism is classed as a neurodevelopment disorder as opposed to a mental illness	Why autism is classed as a neurodevelopment disorder as opposed to a mental illness: E.g. Lifelong condition driven by impairments of the growth and development of the brain and/ or central nervous system, detectable in infancy, will not improve with time and affects brain function.
	2.4	Explain the purpose(s) of routine behaviours	The purpose(s) of routine behaviours: E.g. World comprehension, familiarity and predictability; routines can enable and assist with the understanding and ordering of daily life.
	2.5	Describe the potential impact(s) of restricted/ rigid routines upon coping with situations of transition/ change	The potential impact(s) of restricted/ rigid routines upon coping with situations of transition/ change: E.g. Change and transition requires

			alteration to routine, can lead to wide variety of person-dependent and inflexibility driven effects (e.g. anxieties, behavioural reactions, social reactions etc.) and preparation is key to mitigating effects of change.
	2.6	Explain why autism is regarded as a spectrum condition	Why autism is regarded as a spectrum condition: E.g. Functional impacts of autism extend across a spectrum, for every autistic individual there will be similarities (e.g. social comprehension difficulties) and differences (e.g. verbal abilities) in terms of condition specific impacts, diversity of impacts theorised to be linked to the unique characteristics of the underlying neurodevelopmental disorder and impacts with similar appearance are thought to be caused by the same underlying mechanisms.
	2.7	Explain why there are alternative choices of terminology used to describe the autistic spectrum	Why there are alternative choices of terminology used to describe the autistic spectrum: E.g. Historical terminology, DSM revisions, individual perceptions and terminology changes/ refinements driven by improvements to general and functional awareness.
	2.8	Describe how language and intellectual abilities vary across the autistic spectrum	How language and intellectual abilities vary across the autistic spectrum: E.g. Language can be on a scale from entirely non-verbal to fluently verbal; this is largely driven by nature (e.g. neurological impacts of underlying autism related neurodevelopmental disorder) but also nurture (e.g. educational environment) and does not indicate level of intellectual ability. Intelligence can also be on a scale from low functioning to high functioning; this can be driven by neurological impacts outside of those of autism (e.g. presence of co-concurrent learning disabilities) and the specifics of the individual themselves (e.g. trait driven individual differences in engagement with educational material, often a factor of unique interests).
	2.9	Describe the sensory and perceptual differences commonly experienced by those with an autistic spectrum condition	The sensory and perceptual differences commonly experienced by those with an autistic spectrum condition: E.g. Hyposensitivity and/ or hypersensitivity; auditory, visual, olfactory, taste, touch, vestibular, proprioceptive. Can lead to sensory overload if sensory input in excess; modality and sensitivity dependent threshold. Sensory inputs (alongside biochemical) drive perception; perceptual alterations can therefore be partially attributed to autism related sensory differences.
	2.10	Describe behaviours that can be attributed to sensory differences	Behaviours that can be attributed to sensory differences: E.g. Wide range of person-dependent behaviours including; covering eyes/ ears, ear movement, rigid preferences, stimming, touching, smelling etc.

	2.11	Identify other conditions that may be associated with autistic spectrum conditions	Other conditions that may be associated with autistic spectrum conditions: E.g. Impaired hearing/ vision, ADHD, Down's Syndrome, Dyslexia, Dyspraxia, Epilepsy, Fragile X, Learning Disabilities, Hyperlexia, OCD, Childhood onset Schizophrenia, Bipolar Disorder etc.
	2.12	Explain why it is important to recognise that each service-user on the autistic spectrum has their own unique abilities, needs, strengths, gifts and interests	Why it is important to recognise that each service-user on the autistic spectrum has their own unique abilities, needs, strengths, gifts and interests: Provision of person-centred care and empowerment, promotion of individualised learning and development, positive effects upon wellbeing, identification of individualised anxiety triggers and coping strategies.
3. Understand obsessions and repetitive behaviours within autistic spectrum conditions	3.1	Explain what is meant by the term 'obsessions'	Obsessions: A specialist interest or preoccupation that brings comfort to the individual, extremely broad range of potential focuses (e.g. vehicles, music, computer coding etc.) and exposure the only limitation to obsessional focus.
	3.2	Evaluate the potential impacts of obsessions upon service-users with autistic spectrum conditions	The potential impacts of obsessions upon service-users with autistic spectrum conditions: E.g. Impacts are dependent upon the person, the obsession and the environment within which it is displayed (e.g. social appropriateness, social response etc.). Obsessions can bring comfort to the service-user, can provide a route to learning academic and social skills and/ or can used as motivators. Unfulfilled/ unfulfillable obsessions can cause negative effects to the service-user including distress and anxiety.
	3.3	Explain what is meant by the term 'stimming'	Stimming: E.g. Self-stimulatory behaviour; repetitive physical movement sound and/ or movement of objects.
	3.4	Evaluate the potential impacts of stimming upon service-users with autistic spectrum conditions	The potential impacts of stimming upon service-users with autistic spectrum conditions: E.g. Person-dependent but can include; sensory input, societal perceptions, world comprehension, comfort and positive impacts to wellbeing.
4. Understand how autistic spectrum conditions can impact upon verbal and non-verbal communication	4.1	Describe a range of communication based unwritten social rules	Communication based unwritten social rules: E.g. Reciprocation of greetings, familiarity based greetings, use of body language consistent with verbal communication, personal space, eye contact and tone/ volume of voice etc.
	4.2	Explain why comprehension of unwritten social rules may be challenging for a service-user with an autistic spectrum condition	Why comprehension of unwritten social rules may be challenging for a service-user with an autistic spectrum condition: E.g. With reference to assessment criteria 2.2, difficulty due to; reliance upon understanding

			context, rules unwritten and vary situationally, misunderstanding of body language and issues with regards to recognising and understanding alternative view-points and the impact of own actions upon these.
	4.3	Explain why idioms and slang are inappropriate if communicating with a service-user with an autistic spectrum condition	Why idioms and slang are inappropriate if communicating with a service-user with an autistic spectrum condition: E.g. Idioms and slang are non-literal phrases; meaning is not driven by individual words. Those with an autistic spectrum condition often have a literal understanding, idioms and slang can therefore cause confusion, decrease world understanding and can raise anxieties leading to a behavioural response.
	4.4	Evaluate the role of 'tone of voice' when communicating with a service-user with an autistic spectrum condition	The role of 'tone of voice' when communicating with a service-user with an autistic spectrum condition: E.g. Tone of voice is a factor of communication meaning, those with an autistic spectrum condition may struggle to interpret tone of voice (e.g. an unwritten social rule); use of tone therefore low impact with regards to promoting comprehension of communication message (e.g. role minimal) but consistent use important with regards to assisting future comprehension of unwritten social rules (e.g. educational value).
	4.5	Explain how autistic spectrum conditions can impact upon information 'processing times'	How autistic spectrum conditions can impact upon information processing times: E.g. Processing time refers to the time taken to comprehend a particular message or instruction; it is person-dependent and can be variably impacted (e.g. delayed) by autistic spectrum conditions.
	4.6	Explain how language should be structured to promote comprehension when communicating with a service-user with an autistic spectrum condition	How language should be structured to promote comprehension when communicating with a service-user with an autistic spectrum condition: E.g. Person-centred, simple, clear, free of slang/ idioms, inclusion of service-users name, inclusion of scheduling words (e.g. then, next, soon, first, finished) and provision of sufficient processing time.
	4.7	Explain the importance of instating task parameters when working with a service-user with an autistic spectrum condition	The importance of instating task parameters when working with a service-user with an autistic spectrum condition: E.g. Promotion of task and boundary comprehension and value with regards to scheduling (e.g. both for the service-user and others).
	4.8	Describe the concept of personal space	Personal space: E.g. Unwritten social rule, the physical space surrounding an individual, encroachment (e.g. by others) can evoke feelings of threat or discomfort.

	4.9	Explain why the concept of personal space may be challenging for a service-user with an autistic spectrum condition	Why the concept of personal space may be challenging for a service-user with an autistic spectrum condition: E.g. Unwritten social rule, challenging with reference to assessment criteria 4.2.
	4.10	Explain the difficulties a service-user with an autistic spectrum condition may face in determining appropriateness of behaviour	The difficulties a service-user with an autistic spectrum condition may face in determining appropriateness of behaviour: E.g. Behaviour changes according to people, situation and circumstance and requires an appreciation of context, those with an autistic spectrum condition struggle to understand context as is a situationally dependent unwritten social rule (e.g. with reference to assessment criteria 4.2); service-users may therefore require an explanation of behaviour for each and every context in order to understand appropriateness.
5. Understand how to support individuals with an autistic spectrum condition with verbal and non-verbal communication	5.1	Explain how to maximise the effectiveness of communication by making adaptations to own verbal and non-verbal communication style	How to maximise the effectiveness of communication by making adaptations to own verbal and non-verbal communication style: E.g. Self-reflection, monitoring comprehension, person-dependent adaptations, recognition of context, own training, use of assistive resources, use of multi and/ or single channel methods, adherence to care plan/ progression goal and verbal/ non-verbal consistency.
	5.2	Evaluate the relationship between behaviour and communication for a service-user with an autistic spectrum condition	The relationship between behaviour and communication for a service-user with an autistic spectrum condition: E.g. Behaviour is a form of communication and reliance upon behaviour to communicate increases with increasing communication difficulties.
	5.3	Describe how 'behaviour that challenges' can be a way of expressing emotions where there are communication differences	How 'behaviour that challenges' can be a way of expressing emotions where there are communication differences: E.g. Behaviour used to communicate communication issue related emotions, due to presence of communication barrier these emotions are largely negative (e.g. frustration, confusion, distress etc.), behavioural response aligns with underlying emotion (e.g. lashing out, self-harming, inappropriate sexual comfort etc.) and can be driven by a lack of understanding of the impact and response to emotions.
	5.4	Describe methods and systems used to develop and support the communication of a service-user with an autistic spectrum condition	Methods and systems used to develop and support the communication of a service-user with an autistic spectrum condition: E.g. Social stories, videos, simulated situations, apps and actions with reference to assessment criteria 5.1.

	5.5	Describe ways of helping a service-user to understand their autistic spectrum condition	Ways of helping a service-user to understand their autistic spectrum condition: E.g. Social stories and effective person-centred communication.
6. Understand how to support individuals with an autistic spectrum condition	6.1	Explain why it is important to establish a person-centred plan catering to a service-users individual preferences and needs	Why it is important to establish a person-centred plan catering to a service-users individual preferences and needs E.g. Recognition of uniqueness of the service-user, identification of and response to a service-users individual needs (e.g. communication, sensory, assistive, personal etc.), promotion of routine adherence and recognition, provision of person-centred opportunities for development and progression, positive impacts upon wellbeing and identification and avoidance of anxiety triggers.
	6.2	Explain why consultation with families/ parents/ carers and other professionals is important in person-centred planning and support	Why consultation with families/ parents/ carers and other professionals is important in person-centred planning and support: E.g. A service-user can display different behaviours in different situations; collaboration provides a more thorough analysis of the service-users individual needs preferences and aspirations and how best to respond to these, this in turn enables more effective person-centred care plan development and application with reference to meeting these individual needs.
	6.3	Describe different techniques and approaches to support service-users with an autistic spectrum condition to learn and develop new skills	Different techniques and approaches to support service-users with an autistic spectrum condition to learn and develop new skills: E.g. Person-centred; communication methods, recognition of/ adherence to strengths, visual instructions, videos, simulations, stories (e.g. social), use of obsessions as motivators or introduction to new skills, use of reward, action repetition, use of applied behaviour analysis (ABA), intensive interaction, Makaton and TEACCH.
	6.4	Explain the purpose of producing a hard copy/ copies of a service-users routine in visual, auditory and/ or sensory format	The purpose of producing a hard copy/ copies of a service-users routine in visual, auditory and/ or sensory format: E.g. Assists; routine comprehension (e.g. service-user, staff and others), event sequencing and action planning. Aims to reduce communication barriers, to promote consistency/ continuity and to minimise uncertainty or potential sources of anxiety for the service-user.
	6.5	Explain how to support a service-user with an autistic spectrum condition to develop their personal skills	How to support a service-user with an autistic spectrum condition to develop their personal skills: E.g. Person-centred; communication methods, recognition of/ adherence to strengths, visual instructions, videos, simulations, stories (e.g. social), use of obsessions as motivators

			or introduction to new skills, use of reward, action repetition, use of applied behaviour analysis (ABA), intensive interaction, Makaton and TEACCH.
	6.6	Explain the concept and contributing factors behind a 'meltdown'	The concept and contributing factors behind a 'meltdown': E.g. An intense response to overwhelming situations, results in temporary loss of behavioural control, loss of control can be; verbal (e.g. shouting, screaming, crying etc.), physical (e.g. kicking, lashing out, biting etc.) or a combination of both. Meltdowns are driven by person-dependent factors, common antecedents include; specific sensory inputs (e.g. temperature, smell, noise, light etc.), communication barriers, routine non-adherence and other condition specific factors (e.g. co-existing conditions).
	6.7	Explain the concept and contributing factors behind a 'closedown'	The concept and contributing factors behind a 'closedown': E.g. A withdrawal response to overwhelming situations (e.g. social isolation, hiding, apathy, increased gaze avoidance, self-harm, increased risk taking). Closedowns are driven by person-dependent factors, often those causing frustration (e.g. communication barriers, routine non-adherence, preference non-adherence and co-existing conditions etc.).
	6.8	Explain how to alter sensory load by making adaptations to the physical and sensory environment	How to alter sensory load by making adaptations to the physical and sensory environment: E.g. Reduction of sensory load/ increased sensory stimulation; person-dependent application. Methods to support sensory needs include; adjustable lighting, adjustable volume controls, increased/ decreased visual stimuli (e.g. paintings), textured surfaces, headphones (e.g. traditional or noise cancelling), swings, trampolines, sensory gardens, use of aromas, differential spaces, use of colour and provision of physical activities/ sources of interaction etc.
	6.9	Explain ways of helping a service-user with an autistic spectrum condition to protect themselves from harm	Ways of helping a service-user with an autistic spectrum condition to protect themselves from harm: E.g. Risk assessment and mitigation strategies, identification and avoidance of anxiety triggers, de-escalation strategies (e.g. proactive and reactive strategies), effective person-centred communication and use of communication aids (e.g. social stories).
	6.10	Describe the role that advocacy can play in the support of a service-user with an autistic spectrum condition	The role that advocacy can play in the support of a service-user with an autistic spectrum condition: E.g. Promotion of person-centred planning, best interest decisions, maintenance of focus on the person as opposed to the condition, provision of independent viewpoint, communication on behalf of the service-user and promotion of rights and equality.

7. Understand how to support individuals with an autistic spectrum condition to cope with situations of transition and/ or change	7.1	Explain how to support a service-user with an autistic spectrum condition to make transitions	How to support a service-user with an autistic spectrum condition to make transitions: E.g. Preparation/ planning, effective person-centred communication, use of social stories, identification and preservation of routines of most importance to the service-user, use of obsessions as motivators, use of strengths to support the transition, removal of obstacles and consistency of approach throughout.
	7.2	Explain how to support a service-user with an autistic spectrum condition to make changes to their routines	How to support a service-user with an autistic spectrum condition to make changes to their routines: E.g. Preparation/ planning, effective person-centred communication, use of social stories, use of obsessions as motivators, use of strengths to support the change, gradual alteration to routine (e.g. as opposed to instant and major), removal of obstacles and consistency of approach throughout.
	7.3	Explain the circumstances in which changes to routines would be encouraged	Circumstances in which changes to routines would be encouraged: E.g. Routine socially unacceptable, service-user unsafe, flexibility training, coping training and preparation for transition/ change.

Unit 12: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit has been developed in partnership with Living Autism:

Unit 13: Principles of Learning Disability Care Y/615/6705

Estimated TQT:	50
Estimated GLH:	25
Credit	5
Level	3

Unit Description:

This unit covers the underpinning knowledge of learning disability care. The unit develops the learner's knowledge and understanding of key characteristics of learning disabilities, including; legislation and policies, the historical context of learning disabilities and the principles of advocacy, empowerment and active participation within learning disability care.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the key characteristics of learning disabilities	1.1	Define the term 'learning disability'	Learning disability: E.g. Reduced intellectual ability and difficulty with everyday activities (e.g. household tasks, socialising, managing money etc.) and persists throughout life.
	1.2	Identify the approximate proportion of people within the UK who are classified as having a learning disability	The approximate proportion of people within the UK who are classified as having a learning disability: E.g. Statistic fluctuates and dependent upon source; estimated to be approximately 1.5million people in the UK (2% population).
	1.3	Contrast the medical and social models of disability	The medical model of disability: E.g. This model views disability as a 'problem' belonging to the disabled individual only and therefore is not an issue to concern anyone other than this person (e.g. if a wheelchair user is unable to access a building due to steps, the medical model suggests that this is due to the wheelchair rather than the steps). The social model of disability: E.g. This model draws on the idea that it is society that disables people (e.g. through designing everything to meet the needs of the majority of people who are not disabled). There is a recognition that society can play an active role in reducing and removing disabling barriers and that this task is the responsibility of society, rather than the disabled individual alone (e.g. counter to the medical model)
	1.4	Identify examples of causes of learning disabilities	Examples of causes of learning disabilities: E.g. Broad range of causes which can include; genetic (e.g. chromosomal abnormalities; Downs syndrome, Mosaic Turner syndrome etc.), inherited (e.g. Fragile X), birth

			related (e.g. birthing complications; brain damage due to oxygen starvation/ asphyxiation, premature birth induced developmental issues etc.), pregnancy related (e.g. Issues affecting mother; illness, drug or alcohol dependency i.e. Foetal Alcohol Syndrome etc.), acquired (e.g. early childhood illness or injury; acquired brain injury, abuse etc.), toxicity/ radiation induced or unknown.
	1.5	Identify the approximate proportion of people with a learning disability for whom the cause is unknown	The approximate proportion of people with a learning disability for whom the cause is unknown: E.g. Statistic fluctuates and dependent upon source; estimated to be approximately 50% for those with mild learning disabilities and 25% for those with severe learning disabilities.
	1.6	Describe possible impacts of having a learning disability upon day-to-day life	Possible impacts of having a learning disability upon day-to-day life: Broad and person-dependent impacts across all aspects of life (e.g. skill acquisition, learning and development, communication, social comprehension and inclusion, access to services, independence, care needs, vulnerability etc.).
	1.7	Describe the possible impacts on a family of having a family member who has a learning disability	The possible impacts on a family of having a family member who has a learning disability: E.g. Broad and person-dependent impacts including but not limited to; those relating to meeting the family members increased need for support (e.g. time off work, career change, involvement of other professionals/ specialist services, hired assistance, adjustments to living environment etc.), emotional impacts (e.g. blame, guilt, depression, avoidance, dispute etc.), financial impacts (e.g. often driven by the logistics of meeting the family members increased need for support) and social/ interpersonal impacts (e.g. reduced time for social engagement, perceptions of isolation, reduced care for self and relationship challenges driven by response to additional needs).
	1.8	Evaluate the potential effect(s) of being labelled as having a learning disability	The potential effect(s) of being labelled as having a learning disability: E.g. Effects are person-dependent and can be both positive and negative; Positive: Access to services (e.g. specialist support), provision of reasonable adjustments (e.g. tools, aids, equipment or allowances to promote equality), understanding/ justification of self (e.g. psychological reassurance) etc. Negative: Barriers to services (e.g. healthcare), stigma, challenges to wellbeing (e.g. self-worth doubts), depression, perceived isolation etc.

2. Understand the legislation and policies that support the rights of individuals with learning disabilities	2.1	Identify legislation and policies that are designed to promote the rights of service-users with learning disabilities	Legislation and policies that are designed to promote the rights of service-users with learning disabilities: E.g. Human Rights Act (1998), Mental Capacity Act (2005), Equality Act (2010) and Transforming Care and the – next steps UK Government.
	2.2	Describe how legislation and policies can influence the day-to-day experiences of service-users with learning disabilities	How legislation and policies can influence the day-to-day experiences of service-users with learning disabilities: E.g. Improved accessibility (e.g. healthcare), access to specialist support, access to reasonable adjustments, reduced inequalities, increased understanding, reduced stigma etc.
3. Understand the historical context of learning disabilities	3.1	Describe the types of services that have been provided for service-users with learning disabilities over time	The types of services that have been provided for service-users with learning disabilities over time: E.g. Pre 1990's; large institutions and asylums, 1990-2000: Specialist hospitals and care homes, Post 2010; supported living, smaller care homes and person-centred ways of working.
	3.2	Explain how present services may reflect old ways of working	How present services may reflect old ways of working: E.g. Two strands; resistance to change (e.g. staff and/ or service reflect older, institution-focused, ways of working) or recognition and adherence to change (e.g. services transformed on basis of past successes and failures; reducing social inequalities, providing person-centred care and support, reducing institutional focus, providing care and support in small specialist services within our communities etc.).
	3.3	Explain ways in which modern ways of working have impacted the following areas of life for a service-user with learning disabilities: • Living arrangements • Activity availability • Employment • Relationships • Healthcare availability	Ways in which modern ways of working have impacted the following areas of life for a service-user with learning disabilities: E.g. Living arrangements: Supported living becoming more common, smaller 3-4 person houses preferred, reduced restrictions, increased equality, increased independence etc. Activity availability: Increased availability, person-centred provision, reasonable adjustments, reduced restrictions, increased equality (e.g. of opportunities), increased independence etc. Employment: Increased availability, reasonable adjustments, reduced restrictions, increased equality (e.g. of opportunities), reduced stigma, inclusive practice, increased independence etc. Relationships: Recognition of rights, support provided regarding sexuality and sexual health, reduced stigma, increased equality, view to minimising vulnerability etc.

			Healthcare availability: Rights based approach to accessing healthcare, reduced barriers, reduced stigma, increased availability of specialised support services etc.
	3.4	Explain how attitudes are changing in relation to learning disabilities	How attitudes are changing in relation to learning disabilities: E.g. Reduced stigma, increased awareness and understanding, focus on inclusive approaches/ practices and increased equality of thought etc.
4. Understand the principles of advocacy, empowerment and active participation in relation to supporting individuals with learning disabilities	4.1	Define the term 'social inclusion'	The meaning of the term 'social inclusion': E.g. Social inclusion is the act of making all groups of people within a society feel valued and important.
	4.2	Explain the meaning of the term 'advocacy'	The meaning of the term 'advocacy': E.g. Advocacy can be defined as the act of arguing or pleading for something, most commonly a cause, idea or movement. In terms of learning disabilities, the term relates more specifically to voicing an independent opinion or expressing a view relating to; the services, choices, rights, opportunities and problems faced by service-users with learning disabilities (e.g. with the aim of improvement).
	4.3	Identify different types of advocacy	Different types of advocacy: E.g. Case advocacy, self-advocacy, peer-advocacy, paid independent advocacy, citizen advocacy and statutory advocacy.
	4.4	Explain how the concepts of empowerment and active participation can be built into everyday care and support	How the concepts of empowerment and active participation can be built into everyday care and support: E.g. Person-centred approaches and activity provision, use of assistive tools (e.g. communication tools, MAPS, PATHS, relationship circles etc.), positive risk taking, involvement in decisions (e.g. shared decision making), promotion of choice, promotion of independence and minimising inequality.
	4.5	Explain the relationship between empowerment and age/ability appropriate communication strategies	The relationship between empowerment and age/ability appropriate communication strategies: E.g. Person-centred empowerment requires person-centred individualised communication strategies (e.g. Makaton, British sign language, braille, alphabet/ communication boards, PECS/ other pictorial communication books/ folders/ flash cards, social stories, widget communication system, feelings cards, now and next / choice boards, assistive technology and communication aids, intensive interaction, accessible information including easy read etc.). Strategy must be dynamic and recognise both current ability of the service-user and the intended ability; often a factor of age.

	4.6	Explain the importance of future planning with regards to the empowerment of service-users with learning disabilities	The importance of future planning with regards to the empowerment of service-users with learning disabilities: E.g. Future planning with the involvement of the service-user is essential for individualised empowerment; it enables the service-user to control their direction through making choices and decisions relating to their own aims goals and intentions, it has person-centred value regardless of capacity and is an essential component of both development and independence.

Unit 13: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

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Assessment

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Unit 14: Principles of Epilepsy Care: R/615/6704

Estimated TQT:	50
Estimated GLH:	25
Credit	5
Level	3

Unit Description:

This unit covers the underpinning knowledge of epilepsy care. The unit develops the learner's knowledge and understanding of the term epilepsy and factors affecting the condition. Learners will also develop an understanding of seizure variations, including; classification, onset, awareness, symptoms associated with focal seizures, description of generalised onset seizures and responses to individuals experiencing a seizure.

Unit Grid: Learning Outcomes/Assessment Criteria/Content

Learning Outcome - The learner will:	Assessment Criteria - The learner can:		Indicative Contents:
1. Understand the term 'epilepsy' and the factors affecting the condition	1.1	Define the term 'epilepsy'	Epilepsy: E.g. Neurological disorder, symptoms can be triggered or spontaneous, involves sudden recurrent episodes of; sensory disturbance, loss of consciousness and/ or convulsions associated with abnormal electrical activity in the brain.
	1.2	Describe causes of epilepsy	Causes of epilepsy: E.g. Neuronal malformation during brain development, birth or perinatal injuries, genetic conditions (e.g. Tuberous Sclerosis), vascular insults (e.g. stroke), head injury/trauma, severe metabolic disturbances, drug/alcohol abuse, brain tumours/ cancer and infections (e.g. meningitis).
	1.3	Define the term 'seizure'	Seizure: E.g. Transient occurrence of signs and or symptoms, due to abnormal, excessive or synchronous neuronal activity in the brain, can manifest as changes to; movement, awareness, emotion, sensation, mood, behaviour and/ or communication.
	1.4	Explain the relationship between epilepsy and seizures	The relationship between epilepsy and seizures: E.g. Seizure integral to the diagnosis of epilepsy and seizure symptoms can be can be motor or non-motor.
	1.5	Identify factors affecting the nature of a seizure	Factors affecting seizure nature: E.g. Location of seizure onset, genetics, age, sleep-wake cycle/ circadian rhythms, prior injuries, medications, environmental stimuli etc.

2. Understand seizure classification	2.1	Identify the three features that dictate the classification of a seizure	The three features that dictate the classification of a seizure: E.g. Onset, level of awareness and other factors including motor and behavioural symptoms.
	2.2	Identify the four types of seizure onset	The four types of seizure onset: E.g. Focal seizure, generalised seizure, focal to bilateral seizure and unknown onset.
	2.3	Identify the four types of awareness during a seizure	The four types of awareness during a seizure: E.g. Focal aware, focal impaired awareness, awareness unknown and generalised seizures.
	2.4	Identify the three categories for motor and other symptoms associated with focal seizures	The three categories for motor and other symptoms associated with focal seizures: E.g. Focal motor seizure, focal non-motor seizure and auras.
	2.5	Identify the two types of generalised onset seizure	The two types of generalised onset seizure: E.g. Generalised motor seizure and generalised non-motor seizure.
3. Understand variations in seizure onset	3.1	Describe 'focal seizures'	Focal seizures: E.g. Abnormal brain activity, involves cells/ neuronal networks localised to one side of the brain and previously termed 'partial seizures'.
	3.2	Describe 'generalised seizures'	Generalised seizures: E.g. Abnormal brain activity, involves cells/ neuronal networks on both sides of the brain and previously termed 'primary generalised seizures'.
	3.3	Describe 'focal to bilateral seizures'	Focal to bilateral seizures: E.g. Abnormal brain activity, involves cells/ neuronal networks localised to one side of the brain, spreads to both sides of the brain and previously termed 'secondary generalised seizures'.
	3.4	Describe 'unknown onset' seizures	Unknown onset seizures: E.g. Onset of seizure unknown, further information required to classify onset, additional terminology enables description of those factors known (e.g. motor and non-motor symptoms).
	3.5	Explain the importance of knowing seizure onset	The importance of knowing seizure onset: E.g. Impacts upon; medication choices, surgery options, outlook and identification of cause.
4. Understand variations in awareness during a seizure	4.1	Describe 'focal aware' seizures	Focal aware seizures: E.g. Awareness intact, variable effects upon response levels and communicative ability and previously termed 'simple partial seizures'.
	4.2	Describe 'focal impaired awareness'	Focal impaired awareness: E.g. Awareness impaired, can occur at any time during a seizure, recollection independent of impaired awareness and previously termed 'complex partial seizures'.

	4.3	Describe 'awareness unknown' seizures	Awareness unknown seizures: E.g. Levels of awareness unknown, often relates to a person's situation and can also be indicated through omission of awareness term in seizure classification.
	4.4	Explain why classification as a generalised seizure subsumes the need to describe awareness	Why classification as a generalised seizure subsumes the need to describe awareness: E.g. Generalised seizures synonymous with impacted awareness or consciousness.
	4.5	Explain the importance of knowing a service-users level of awareness during a seizure	The importance of knowing a service-users level of awareness during a seizure: E.g. Impacts upon the safety of the service-user and related deployment of safeguarding measures.
	4.6	Explain why awareness is described as opposed to consciousness within seizure classifications	Why awareness is described as opposed to consciousness within seizure classifications: E.g. Ease of definition, ease of evaluation and consistency of application.
5. Understand the motor and other symptoms associated with focal seizures	5.1	Describe 'focal motor seizures'	Focal motor seizures: E.g. Movement occurs during seizure and can include; automatisms, loss of muscle tone (atonic), jerking (clonic), stiffening (tonic), epileptic spasms, hyperkinetic movements and myoclonic movements (sudden muscle contractions).
	5.2	Describe 'focal non-motor seizures'	Focal non-motor seizures: E.g. Seizure preceded by non-motor symptom(s) which can include; sensory, emotional cognitive, behavioural and autonomic effects.
	5.3	Describe 'Auras'	Auras: E.g. Term used to describe symptoms at the start of a seizure; terminology dated but prevalent.
6. Understand how to describe generalised onset seizures	6.1	Describe 'generalised motor seizures'	Generalised motor seizures: E.g. Movement occurs during seizure and can include; loss of muscle tone (atonic), jerking (clonic), stiffening (tonic), tonic-clonic, epileptic spasms and myoclonic movements (sudden muscle contractions). Loosely corresponds to previous terminology 'grand mal'.
	6.2	Describe 'generalised non-motor seizures'	Generalised non-motor seizures: E.g. Primarily absence seizures, includes typical and atypical and can involve; brief changes in awareness, staring and repeated movements (e.g. myoclonic movements and eyelid myoclonia). Previously termed 'petit mal'.
7. Understand how to respond to an individual with epilepsy experiencing a seizure	7.1	Identify common anti-epileptic medications (AEDs)	Common anti-epileptic medications (AEDs): E.g. Tablet, liquid, nasal spray buccal, injection or rectal; carbamazepine, sodium valproate, topiramate and midazolam.

	7.2	Identify the factors that dictate the level of assistance to provide a service-user during a seizure	The factors that dictate the level of assistance to provide a service-user during a seizure: E.g. Seizure; type, pattern, length, severity and impact upon consciousness.
	7.3	Explain the assistance to provide a service-user experiencing an absence seizure	The assistance to provide a service-user experiencing an absence seizure: E.g. Remove from danger, reassure the service-user and check/ recap comprehension of information provided at time of seizure.
	7.4	Explain the assistance to provide a service-user experiencing a tonic, atonic or myoclonic seizure	The assistance to provide a service-user experiencing a tonic, atonic or myoclonic seizure: E.g. Check the service-user for injury, provide first aid if necessary, reassure the service-user and observe until recovery.
	7.5	Explain the assistance to provide a service-user experiencing a tonic-clonic seizure	The assistance to provide a service-user experiencing a tonic-clonic seizure: E.g. Document time of onset, clear space around the service-user, protect the service-user's head (cushion, folded coat etc.), remove spectacles, reassure the service-user and document time of cessation. Call emergency services if; seizure duration longer than 2 minutes (child) or 5 minutes (adult) or a second seizure occurs prior to recovery.
	7.6	Explain the assistance to provide a service-user experiencing a focal aware seizure	The assistance to provide a service-user experiencing a focal aware seizure: E.g. Remove from danger, reassure the service-user and seek medical attention if the seizure develops into tonic-clonic.
	7.7	Explain the assistance to provide a service-user experiencing a focal impaired awareness seizure	The assistance to provide a service-user experiencing a focal impaired awareness seizure: E.g. Remove from danger, reassure the service-user, do not restrain or distract the service-user and observe until recovery.
	7.8	Explain when to place a service-user experiencing a seizure into the recovery position	When to place a service-user experiencing a seizure into the recovery position: E.g. At the end of the seizure and only if the unconscious service-user is free of injury (e.g. neck, back or spinal).
	7.9	Explain when to call the emergency services in response to a seizure	When to call emergency services in response to a seizure: E.g. Seizure lasts more than 2 minutes (child) or 5 minutes (adult), the service-user doesn't regain consciousness, further seizures follow, suspected status epilepticus, the service-user sustains an injury or inhales water, breathing difficulties persist or emergency medication administered in overdose.

Unit 14: Guidance on Delivery and Assessment

Delivery

This knowledge only unit may be delivered using a variety of methods such as classroom sessions, distance learning or a blended method. The course will require self-directed study alongside tutor support.

Definition

The term 'service-user' refers to anyone who is a current or potential patient or other user of health and / or social services.

Assessment

This unit will be assessed via an externally set, internally marked and verified and quality assured by SFJ AWARDS workbook. Workbooks are available to download via the SFJ AWARDS website.
All assessment criteria must be met in order to achieve the unit and assessment evidence must be the learners own work.

For each learner, an audio/ video recorded interview and identification check must be conducted following the assessment of their workbook. The learner interview must be conducted by an approved trainer, assessor or internal verifier (IV) and SFJ AWARDS reserves the right to attend and/ or lead selected learner interviews.

The interview must be carried out face-face or using video conference, which allows the interviewer to see the interviewee and check their identification, and recorded using audio/ video recording facilities. The interviewer must have the learner's workbook available during this interview and have **prepared at least two questions for each unit**. These questions must adhere to the content/ answers provided within the workbook and are intended to confirm learner understanding and authorship.

To ensure the person being interviewed is the named learner, the learner must show a valid form of photo ID to the interviewer for every non-consecutive interview. Both the learner and interviewer must also confirm their full names within the audio/ video recording. Evidence of each interview must be maintained securely, in line with the relevant data protection legislation, for a minimum of three years for quality assurance purposes.

Centres are required to confirm the satisfaction of the above interview/ identification check requirements within the workbook as part of the unit declarations.

Links

This unit has been developed using the guidance produced by the epilepsy foundation:

Link to Charity: http://www.epilepsy.com/
Link to Guidance: http://www.epilepsy.com/learn/types-seizures/new-terms-seizure-classification

Resources

Training Resources

Centres may use their own, or published learner support materials in delivering the qualification. Whatever support materials centres choose to use, they should ensure that their delivery methodology adequately prepares the learner for assessment.

SFJ AWARDS endorses published training resources and learner support materials by submitting the materials to a rigorous and robust quality assurance process, thus ensuring such materials are relevant, valid and appropriately support the qualification.

Resources and Useful websites

Health and Safety Executive	www.hse.gov.uk
Equalities and Human Rights Commissions	http://www.equalityhumanrights.com
The National Archives (For all UK legislation)	http://www.legislation.gov.uk
Living Autism	https://livingautism.com/
Epilepsy Foundation	http://www.epilepsy.com/