End of Life Care

Course Sample

Certificate in the Principles of End of Life Care Level 3

Programme

Student Name: ....

Company: ....

Tutor/mentor: ....

Start Date: ....

Contents

Unit 1   Understanding care at the end of life

About this unit

This unit provides learners with an overview of the emotive issues surrounding death and dying. It also helps learners to understand palliative care and its place within end of life care, along with the support services available to the individual and others.

Learning outcome 1

The learner will:

Understand different attitudes to death and dying.

The learner can:

1.1   Explain the factors that can affect an individual's views on death and dying, to include the following perspectives:

- Social
- Cultural
- Religious
- Spiritual.

1.1   Factors that can affect an individual's views on death and dying

Social

Whether we feel socially included, excluded or live in social isolation, will influence our attitudes and opinions. Experiences such as bereavement, divorce, loneliness, bullying and discrimination will affect the way we interact with others and our ability to understand and empathise.

All of the factors discussed will help to make us the people we are. This will include any obstacles we encounter, or privileges we experience. There is little doubt that deprivation and poverty disadvantages countless people, whilst privilege and wealth greatly benefit others. However, being brought up in an affluent area with great financial privilege may not guarantee a positive life experience, in the same way that deprivation and poverty may not necessarily lead to a negative life experience. People do succeed – or fail, despite their background.

Therefore values, beliefs and environment could have influenced the lives of the adults you support. Getting to know people and their history often gives guidance as to why they behave the way they do or think the way they think. The adults you support may have family members who are involved in their care and their lives. Again, events and circumstances in their lives will have affected their current situation, and both positive and negative experiences and their consequences can touch all members of a family.

Culture

A 'death denying' society

There is a belief that our modern society is 'death denying'. Death is becoming invisible, a taboo subject, which nobody discusses or even likes to think about. A number of reasons may explain this, including:

- The changes in family structures

- Living arrangements may mean that there is a fracturing of the extended family.

People can live a long distance from older members of the family and have limited contact with the process of ageing, dying and death, therefore encountering the process only at the very end of life or even after death, for example, the funeral.

Three generations of the same family tend not to live under the same roof as they once did. In previous generations children may experience the death of a grandparent living in the same house, and be exposed to the person dying at home. This is far more unusual now.

- Improved health care, disease prevention, the improvement of living conditions and immunisation programmes have dramatically increased life expectancy in the last 50 years. People rarely encounter death at a young age. Many years ago it was not unusual for children to die in infancy or from epidemics of infectious diseases, such as polio, diphtheria and measles or for mothers to die in childbirth. Medical care and knowledge were far more limited. Many, now treatable, diseases and conditions were incurable (e.g. diabetes, serious infections, congenital conditions) and most people have experienced death and dying within their family, friends and community by the time they reached adulthood. Nowadays people may encounter their first experience of death and dying when they are older adults – may be in their forties or fifties and even then may have no direct contact.

- In our society there is a tendency to 'professionalise' death. There used to be great community involvement in death and dying. People died at home and were 'laid out' at home in order for people to view the body and pay their last respects. This is done far less often now with nurses, care workers and undertakers performing the care tasks and rituals associated with caring for the deceased. The community and the extended family would provide support for the bereaved.

- In hospitals and care homes there may be a tendency to secrecy or hiding things when someone is close to death. A dying person may be transferred to a single room or staff may be reluctant to admit that someone has died or discuss death itself in order not to upset other elderly residents in a care home or patients in a hospital.

It may be easy to understand the reasons why society is death denying. Unfortunately death becomes 'hidden' and treated as a subject not to be discussed or even acknowledged.

Religious, cultural, and personal beliefs

Different cultures and religious groups hold different beliefs about life and death. These may be evident before and at the time of death. It is important that these beliefs, faiths and practices are always respected.

Within each faith there may be many different schools of thought. For example, within Buddhism there are several different schools to the teaching of their religion. Within Christianity there are several different churches, for example, Catholic, Church of England, Pentecostal and Anglican.

It must be remembered that faith is an individual matter. Showing respect for beliefs is about recognising individual preferences. Having knowledge of the beliefs and needs of different religious groups can help you to meet the needs of individuals as they approach death and after they have died.

Spiritual factors

Spirituality can be described as anything that gives a person purpose and meaning to life, such as family, friends, hobbies and interests. A person may gain comfort and support from that which is spiritually significant to them or, alternatively, may find the prospect of losing this unbearable. These factors will influence the individual's views on death and dying.

Learning outcome 2

The learner will:

Understand what the aims of end of life care are.

The learner can:

2.1   Explain what the aims of end of life care are

2.2   Highlight the differences between a 'good death' and a 'bad death'

2.3   Summarise the World Health Organisation's definition of palliative care

2.4   Explain the function of palliative care as part of end of life care

2.1 The aims of end of life care

End of life care aims to:

- Support individuals not only with their physical needs but also pain and other distressing symptoms

- Support the individual's psychological, emotional and social and spiritual needs

- Care and support relatives, friends and health care staff, both during the person's illness and after their death, in the form of bereavement care

- Improve and enhance the quality of life of individuals with a life limiting illness.

2.2 The differences between a 'good death' and a 'bad death'

A good death

This, at first, must seem a strange statement. How can death be good? It is important that you understand this concept as it is at the centre of the palliative care approach.
A good death can be looked upon as when a person is able to die where they wish and with whom they wish.

Wherever possible, individuals should be able to choose where they want to die. Support should be provided in order to facilitate this.

A bad death

Unfortunately where there are good deaths there are also bad deaths. A person may experience a bad death where the following occur:

- Lack of compassion and sensitivity on the part of staff

- Decisions made without consulting the person and their family by health care staff

- Persistent or unmanaged pain

- Unrelieved discomfort

- Fear and loneliness

- Staff unwilling to listen to needs and concerns

- Spiritual wishes disrespected or ignored

- Making decisions without involving and consulting the individual; making the assumption that the staff know better what the individual needs

- Withholding information from the individual and their family and friends. The staff deliberately colluding

- Inadequate or non-existent information.

There may be many reasons for this, although there can never be any excuses or justifications for a bad death. It is always unacceptable.

Certificate in the Principles of End of Life Care

Level 3

Student Assessment Workbook

Learner name: _____

Company/Agency: _____

Tutor: _____

Start date: _____

ACTIVITY EXERCISES

The purpose of the following exercises is to enable you to identify what you have learned from reading your programme.

Try to answer each activity thoroughly and only include relevant information in the answers. You may find it helpful to jot down your answers first in draft on a separate sheet. You can then summarise your information to contain only the main points, before writing your answers neatly in the workbook. If you have any difficulty finding answers to any of the questions, you must always ask for support.

If you require additional space to write down your answers, first look for extra space in the workbook nearby that you can use and refer to the correct pages. Additionally, you can also use extra sheets of paper, number these and refer in the workbook to these. Make sure that they are securely kept with your other work and cannot get lost.

When you have completed each Unit, submit the relevant documents to your tutor/assessor/mentor by the method agreed. Please remember to insert your name on each sheet of paper.

Unit	1	2	3	4	5
Sent to Tutor					
Received Back					

UNIT 1 UNDERSTANDING END OF LIFE CARE

Activity 1

List the factors that can affect an individual's views on death and dying.

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Unit 1 - 1.1

Activity 2

Explain how two of the factors listed in Activity 1 affect an individual's views on death and dying.

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Unit 1 - 1.1

Activity 3

Describe the aims of 'End of Life Care'.

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Unit 1 - 2.1

Activity 4

Explain in your own words how the term a 'good death' relates to the individuals in a care setting.

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Unit 1 - 2.2