

## Relational Competency Mapping

The relational mapping resource has been designed to support additional learning and understanding of the key components of person-centred care. The Common Core Principles and Competencies is the benchmark on which the other three resources have been derived from and how "best practice" can be delivered.

Title	End of Life Care Core Skills Education and Training Framework (2016)	Macmillan Values Based Standard	Every moment counts	National Voices narrative for person-centred care
Reference	Skills for Health and Skills for Care (2016) End of Life Care Core Skills Education and Training Framework (2016). London: Health Education England	Macmillan Cancer Support (2013) Macmillan Values Based Standard Overview. London: Macmillan Cancer Support.	National Voices & National Council of Palliative Care (2015) <i>Every moment counts</i> . London: National Voices	National Voices & Think local, Act Personal (2013) <i>A narrative for person-centred care</i> . London: NHS England/National Voices & Think local, Act Personal
	Subject 1: Person-centred end of life care	Naming - I am the expert on me - Outcome Patient can disclose information which will help staff to understand them and act on their needs.	I am respected as a whole person not treated as an illness.	All my needs as a person are assessed.
	Subject 2: Communication in end of life care	Private communication - my business is my business my business is business - Outcome patient has the space to listen and hear information and can secure in their reaction to information received. Patient decides they wish information be shared and with.	My care plan records information about who I am my life and past, what people value about me my strengths and abilities and my values.	My carer/family have their needs recognised and are given support to care for me.
	Subject 3: Equality, diversity and inclusion in end of life care	Communicating with more sensitivity - I am more than a condition - Outcome patients are empowered to share any concerns about what they have been told. Patients receive better support based on their reaction to information.	People who care for and support me make a special effort to understand my life.	I am supported to understand my choices and to set and achieve my goals.
	Subject 4: Community skills development in end of life care	Clinical treatment and decision making - Id like to understand what will happen to me - Outcome patient understand what options have been considered and why recommendations for a particular course of treatment have been made, They know how to prepare for the treatment and have a better understanding of associated short, medium and longer term treatment consequences. Patients feel more engaged in their treatment plan.	People who care for and support me and people who are important care for "the whole of us" .	Taken together my care and support help me live the life I want to the best of my ability.
	Subject 5: Support for the individual in relation to feelings associated with approaching the end of life	Acknowledge me if I'm in urgent need of support I like not be ignored outcome patients care needs are acknowledged, but they also understand that others might be in more urgent need of care and that they might have to wait for staff to support.	I can remain in control as much as possible. This is recognised as a key goal in my care.	I work with my team to agree a care and support plan.
	Subject 6: Promoting health and wellbeing for individuals at the end of life	Control over personal space and environment Id like to feel comfortable - outcome patients are able to express their comfort needs, have these needs met and be cared for in a clean environment.	Everyone who cares for and support me works together so that I, and the people who are important to me, can make the most of the times we have left together.	I know what is my care and support plan. I know what to do if things change or go wrong.

	Subject 7: Assessment and care planning for individuals, their family and carers	Managing on my own don't want to feel alone in this - Outcome patients are enabled to manage their own care and recognise the normal tolerances of their condition. Patients feel better able to control and manage their condition and to maintain their independence, whilst also understanding when and who to refer to should they be in need of support.	I can continue to achieve leisure or work related goals that are important to me for as long impossible.	I have as much control of planning my care and support as I want.
	Subject 8: Symptom management in end of life care	Getting care right my concerns can be acted upon - outcome patients feel able to make complaints in an environment where complaints are welcome and their experience of care are enhanced as result.	I can maintain social contacts.	I can decide the kind of support I need and how to receive it.
	Subject 9: Working in partnership with other professionals		I am supported to managed my symptoms and conditions as successfully as a possible.	My care plan is clearly entered on my record.
	Subject 10: Support for family and carers		I am able to live as actively and independently as possible at all stages of my care and treatment.	I have regular reviews of my care and treatment and of care and support plan.
	Subject 11: Maintain own health and wellbeing when caring for someone at the end of life		I have time to say goodbyes and to do things which are important to me	I have regular comprehensive reviews of my medicines.
	Subject 12: Caring for a deceased individual		My preference for my place to be cared for and to die is respected.	When something I planned it happens.
	Subject 13: Law, ethics and safeguarding		I am supported as much as possible to stay where I want to be.	I can plan ahead and stay in control in emergencies.
	Subject 14: Leading end of life care services and organisations		I have timely and honest conversations with those engaged in my care support and treatment.	I have system in place to get help at an early stage to avoid crisis.
	Subject 15: Improving quality in end of life care through policy, evidence and reflective practice		I am confident that staff and professional share able to have difficult conversations with me, in order for us to decide the best treatment, care and support together.	I tell my story once.
			The professional is meet check that these conversations are happening and enter them onto my record.	I am listened to about what works for me in my life
			I can expect these conversations to be followed up and revisited at key times during the course of my care and treatment.	I am always kept informed about what the next steps will be
			I and my carers are always given an explanation of the terms that are new to us like palliative.	The professionals involved in my care talk to each other. We all work as a team.
			I and the people who are important to me, including my carer are informed about and understand our options in relation to, the illness and its uncertainties, the risk, likelihood and unpredictability of dying, what will happen in the future.	I always know who is coordinating my care.
			I have information, in the format I need and what I understand about all aspects of end of life care, including how to make choices and decisions in advance. This includes how it decide on things that I don't want to happen this information will include, advance care plan, advance decisions, creating a lasting power of attorney for my property and finances, creating a lasting power of attorney for my health and welfare, organ and tissue donation.	I have one first point of contact. They understand both me and my conditions. I can go to them with questions at any time.
			I am informed that even where I have made advance plans and choices, I have the right to change my mind at any point.	I have the information and support to use it that I need to make decisions and choices about my care and support.

			I can understand the impact of my health and care on my finances and make informed decision.	I have the information and support to use it that helps me to manage my conditions.
			I can decide the people who are most important to me and how involved I wish them to be in decisions about my care.	I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.
			I may choose to put care and support from the people who are important to me including my carers at the centre of my care plan. If so their care, treatment and support fits around us and our preferences.	Information is given to me at the right times. Its is appropriate to my conditions and circumstances. It is provided in a way that I can understand.
			If I do not have an unpaid carer, this is recognised in my care plan and the organisation of my care and support takes account of it.	I am told about other services that are available to someone in my circumstances including support organisations.
			The people who are important to me including my carers are given information, advice and support to care for me and to ensure that their own needs are met.	I am not left alone to make sense of information. I can meet/phone/email professional when I need to ask more questions or discuss the options.
			My carers are recognised as partners in my care. They are respected for their skills and for the vital knowledge they have about me, my condition and my preferences.	I am as involved in discussions an decision about my care support and treatment as I want to be.
			Whether I am at home , or somewhere else such as care home hospice or in hospital the people who are important to me including my carers are welcomed, supported and respect, made to feel part of the team, given timely information, involved in discussions and decision's.	My family or carer is also involved in these decisions as much as I want them to be.
			My carers are appropriately informed about what is involved in caring for a dying person at home and given permission and support to make choices about their role.	I have help to make informed choices if I need and want it.
			My carers receive the training they want and need to care for me. This may include personal care and some nursing or clinical tasks such as giving pain relief and managing medicines.	I know the amount of money available to me for care ad support needs and I can determine how this is used (whether its my own money, direct payment or a personal budget from the NHs or council)
			I am satisfied that my carers are informed about how to balance work and care at all stages.	I am able to get skilled advice to understand costs and make the best use of my budget.
			My carers are signposted to information about how to access services that provide respite form their caring role.	I can get access to the money quickly without over complicated procedures.
			I am confident that the people who are important to me will have the opportunity to get support with bereavement before and after my death	When I use a new service my care plan is known in advance and respected.
			My care plan is designed to meet my faith, spiritual need or other values and beliefs.	When I move between services and settings, there is plan in place for happens next

			<p>Taken together the information care and support I receive helps me feel at peace about what will happen in the future , things like the likely course of illness, what is involved in the dying process, anything practical I should have done but haven't got round to, money, what will happen to me after I die, what will happen to my body, how the people I are about will cope.</p>	<p>I know if advance where I am going, what is will be provided with and who will be my main point of professional contact</p>
			<p>Wherever I am cared for I am helped to feel, safe, in control of my pain, comfortable and dignified, with as little fear as possible.</p>	<p>I am given information about any medicines I take - their purpose how to take them and potential side effects.</p>
			<p>There is someone at hand to help with my worries and fears or those who are the people who are important to me.</p>	<p>If I still need contact with previous services/professionals, this is made possible.</p>
			<p>I have a care coordinator who supports me through decision making and acts as problem solver to get things right</p>	<p>If I move across geographical boundaries I do not lose my entitlements to care and support.</p>
			<p>Help is available to meet my needs at any time, day or night from people who know about me.</p>	
			<p>Wherever I am , I have access to pain relief and help to manage difficult symptoms.</p>	
			<p>I have a GP practice that is aware of me, anticipates my needs and commits to acting quickly and helping to coordinate my care.</p>	
			<p>There are nurses available to me when I am at home. They have enough time for my care. They have time to train my carer if this is wanted.</p>	
			<p>In the time before my death, I and all those caring for me are backed up by access to specialist advice at any time of the day or night.</p>	
			<p>Things that happen, do so quickly.</p>	
			<p>If my ability to communicate or to make decision deteriorates, those working with me understand my needs. They support me to remain as involved in my care as possible.</p>	
			<p>When appropriate, I have the opportunity to visit a hospice and or to experience hospice care at home.</p>	
			<p>When I am in hospital there are facilities designed for people in my situation, especially for the last days and hours of my life.</p>	
			<p>The hospital can accommodate people who are important to me with palace to rest and sleep and the chance to mix with other people doing similar caring.</p>	
			<p>Support and advice from people who been through the same experience is recognised as an important service and we are given the opportunity to use it.</p>	
			<p>I can have access to a personal care budget that is easy it understand and use.</p>	