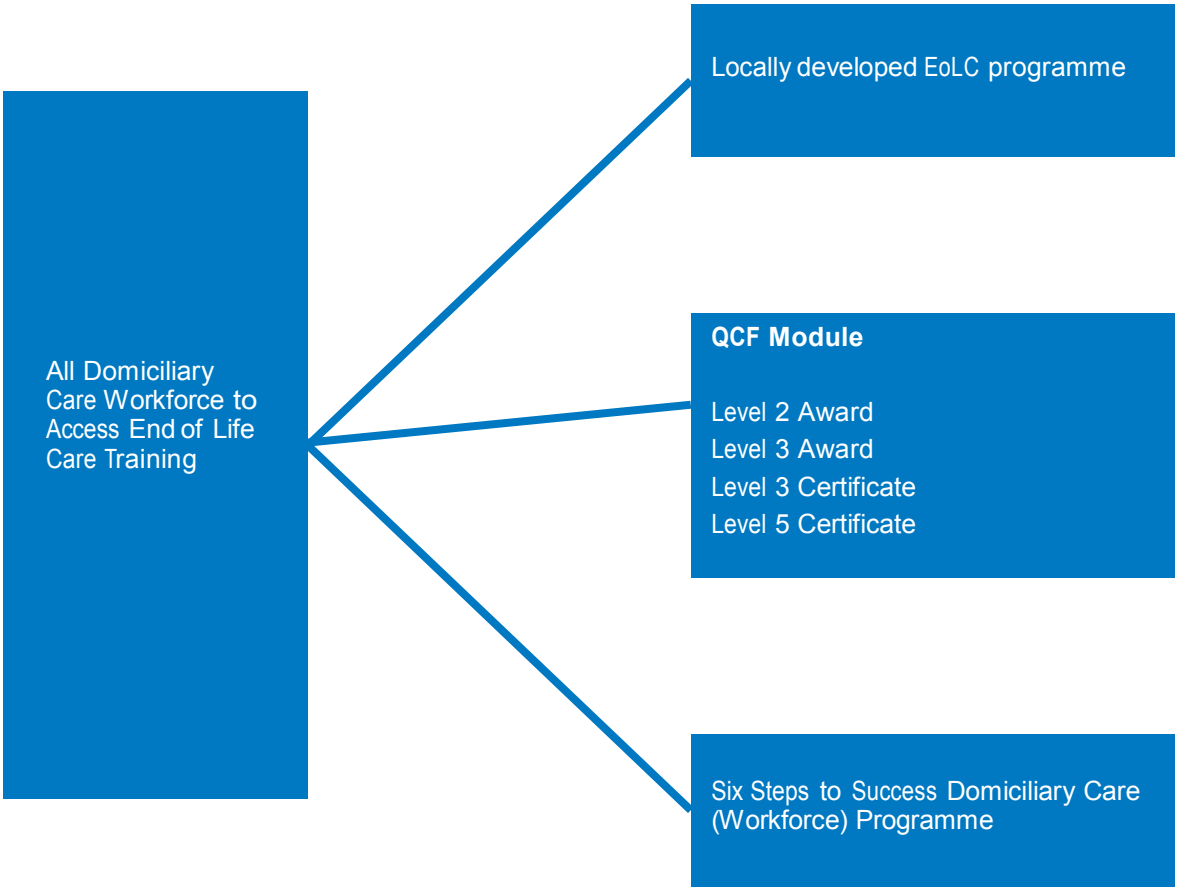
Six Steps
to success
The North West End of Life Care
Programme for Domiciliary Care

Six Steps to Success

End of Life Domiciliary Care Programme For the Workforce

Options for Domiciliary Care Workforce Training



Overview of the Six Steps to Success Programme (workforce)

The length of time it takes to deliver the programme is flexible and dependent on each local area. The Domiciliary Care Programme for the Workforce is delivered in six workshops. These may be delivered in half or full days.

Permission is given to adapt this programme but please reference the original source. The Facilitator has licence to use their professional judgment in the content and delivery of the workshops, ensuring outcomes from the programme are achieved at all times. The Facilitator should try to integrate local policies and guidance into the programme where possible.

Workshop and title	Main Content	Outcomes to be achieved from workshop	EoLC Quality Markers No.	CQC Essential Standards Outcome No.	NICE Quality Standards for EoL Statement No.
Step 1 Induction	• The driving forces for national, regional and local end of life care	• Able to identify the driving forces for end of life care			
	• Introduction to the Six Steps to Success programme for Domiciliary Care Workers	• Able to recognise the Six Steps for Domiciliary Care Workers Programme	8		
	• Initial audit	• Knowledge, Skills and Confidence audit of Domiciliary Care Workers	8, 10		15/16
	• Roles and responsibilities of the Domiciliary Care Worker on Six Steps to Success programme	• Awareness of role and responsibilities			

Workshop	Main Content	Outcomes to be achieved from workshop	EoLC Quality Markers No.	CQC Essential Standards Outcome No.	NICE Quality Standards for EoL Statement No.
Step 1 Discussions as the end of life approaches	• Changes in signs and symptoms of individuals in the last year of life, to enable identification of individuals at the end of life	• Recognition when changes in individual's signs and symptoms indicate their condition is deteriorating	2	4	1/11
		• Awareness of the North West Model	2		1/11
	• Appropriate time and who is involved in end of life care discussions	• Awareness of North West Supportive Care Record	2	1, 4	1/11
	• Communication skills	• Increased awareness, knowledge and confidence in communicating with an individual who wishes to discuss end of life care and acknowledgement of relevant team involvement in discussions	4		2
		• Increased communication skills awareness, knowledge and confidence			15

Workshop	Main Content	Outcomes to be achieved from workshop	EoLC Quality Markers No.	CQC Essential Standards Outcome No.	NICE Quality Standards for EoL Statement No.
Step 2 Assessment, care planning and review	• Holistic assessment	• Contribution to and awareness of holistic assessment of all individuals in end of life care	3,4	1,2,4,6	3,7
	• Mental Capacity Act	• Contribution to and awareness of assessment of individuals mental capacity in end of life care		1,2,4,6	2
	• Advance care planning (Advance Decision to Refuse Treatment, Do Not Attempt Resuscitation, etc.)	• Increased awareness of advance care planning and the implications for individuals and domiciliary care workers	3	1,2,21	2,3,4
	• Collaborative working	• Contribution to and awareness of key partnerships in care and support for the individual in end of life care	6	4,13,	15

Workshop	Main Content	Outcomes to be achieved from workshop	EoLC Quality Markers No.	CQC Essential Standards Outcome No.	NICE Quality Standards for EoL Statement No.
Step 3 Co-ordination of care	• Communication systems	• Improved communications and relationships with health and social care professionals within the wider multi-disciplinary team	6	6	8
		• Awareness of referral criteria and policies in place for access to key professionals to support end of life care	6,7	6,12	
	• The role of the key worker	• Awareness of nominated key worker for individuals approaching end of life	6	6,12	8,9,10,11
	• Anticipated needs at end of life	• Awareness of systems in place to respond rapidly to changes in circumstance as the end of life approaches (referrals, support, equipment, change in care needs)	7,3	4,6,13	8,9,10,11
		• Identify own contact list of support services for 24/7 cover in place (chemists, palliative care teams, GP, etc.)	7	6	9,10,
	• Decision making on hospital admissions	• Aware of guidance for planned and unplanned hospitalisation		4,6,12	15

Workshop	Main Content	Outcomes to be achieved from workshop	EoLC Quality Markers No.	CQC Essential Standards Outcome No.	NICE Quality Standards for EoL Statement No.
Step 4 Delivery of high quality care in domiciliary care	• Complex combination of services across settings in end of life care	• Awareness of the complexity and input of services required to support individuals in end of life care, and how to support contacts	6,7	6,12	8,9,10,11
	• Significant event analysis	• Ability to reflect on significant events and develop practice		14	15
	•Training needs of the domiciliary care worker	• Awareness of policy, role and responsibilities in end of life care. Can identify own training needs	8	12,14	15
	•Dignity	• Increased awareness of dignity factors. Confidence to promote role of Dignity Champions		1,4,7	15,16
		• Ability to promote independence, choice and control	4	1,4	5
	•Environment	• Able to identify features and raise awareness of how the environment can impact on care delivery (privacy/dignity/safety)	4	10	15
	•Family/carers /significant others	•Identify the role and contribution of the family/carer and significant others	5	21	7
		• Appreciate and recognise family/carer feedback to support improvements in care	5	16	15
		• Awareness of changes as end of life approaches and information necessary for family/carer	5	1,2,4	7

Workshop	Main Content	Outcomes to be achieved from workshop	EoLC Quality Markers No.	CQC Essential Standards Outcome No.	NICE Quality Standards for EoL Statement No.
Step 5 Care in the last days of life	• Recognising the changes that occur in the dying phase	• Awareness of symptoms and changes as end of life approaches	6	4	11,15
	• Understanding the role of the Domiciliary Care Worker during the final days of life	• Awareness of roles and limitations of the Domiciliary Care Worker in supporting end of life care		12	15
		• Awareness of systems in place to support communication with other health and social care services in the last days of life	6	6	8
	• Understand End of Life Care Plans (or local equivalent)	• Awareness of End of Life Care Plans (or local equivalent) and the care of the individual with a syringe driver	9	6	8,9,11
	• Care of family and significant others, staff and other individuals	• Awareness of systems in place for involving families and significant others in some aspects of the care giving and in discussions as death is approaching	5	1,2,4,21	2,7
	• Supporting Religious, Cultural and Spiritual Care	• Awareness of systems in place to record any particular religious, spiritual and/or cultural needs identified and recorded as part of the end of life planning	7,3	4,6,21	6

Workshop	Main Content	Outcomes to be achieved from workshop	EoLC Quality Markers No.	CQC Essential Standards Outcome No.	NICE Quality Standards for EoL Statement No.
Step 6 Care after death	• Care after death for the deceased individual, families/carers and significant others, including care staff	• Aware of final care guidance/Last Offices		12,14	12
		• Aware of collection of equipment guidance			
		• Awareness of own role of how the domiciliary care worker supports bereaved relatives and colleagues	5		15
	• Requirements and actions following a death	• Aware of guidance on the boundaries and limitations of the domiciliary care worker following death of individuals on care caseload		12	15
		• Aware of local policies for verification and certification of death		12	13
		• Awareness of the grieving process and care of self			
		• Recognition of need to acknowledge own feelings		14	14,15
Conclusion	• Revisit audit	• Knowledge, Skills and Confidence audit of Domiciliary Care Workers revisited	8, 10	16	15,16
	• Six Steps for Domiciliary Care Workers Programme reflection	• Revisit programme overview and end of life care principles in domiciliary care	8		
		• Awareness and understanding of organisation's end of life care policy	1		

Step 1 – Work plan
Discussions as the end of life approaches

Time: Half day
Aim: To commence the Six Steps to Success programme
The Domiciliary Care Worker will recognise when changes in an individual's signs and symptoms indicate their condition is deteriorating
Objectives: By the end of the session, the End of Life Domiciliary Care Worker will be able to-

- Identify the national, regional and local end of life care drivers
- Recognise the Six Steps to Success programme
- Have knowledge of their role and responsibilities caring for service users who are end of life
- Recognise how the North West End of Life Care Model underpins the North West Supportive Care Record
- Recognise when is the appropriate time and who should be involved in undertaking end of life care discussions
- Identify the necessary Communications skills required for Domiciliary Care Workers in end of life discussions

Facilitator to assess and insert realistic timings and comfort breaks in relation to the group size

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction, welcome and icebreaker	Welcome the group and inform them of housekeeping arrangements		Listen
		Introduce self		
		Take a register of attendance	**Attendance Register**	Complete attendance register
		Lead ice breaker activity	Prepared ice breaker	Take part in icebreaker
		Capture ground rules on a flipchart (ensure confidentiality is included)	Flipchart and pens	Agree ground rules
		Display objectives of the day	Objectives outlined above	Listen

Discussions as the end of life approaches

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction to *The Route to Success in End of Life Care-Achieving Quality in Domiciliary Care* Introduction to the Six Steps to Success Workforce Programme	Distribute 'The Route to Success in *End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011) Advise the group this is the document the programme is based on. Walk through the overview of the Six Steps to Success Workforce Programme Overview Hand out a Six Steps to Success personal development file, one per care worker	***The Route to Success in End of Life Care*-achieving quality in domiciliary care** (NEoLCP 2011) **Six Steps to Success Workforce Programme Overview** Six Steps to Success personal development file	Read Listen Question and answers Follow the Six Steps to Success Workforce Programme overview
	Pre programme knowledge, skills and confidence audit	Distribute and explain the knowledge, skills and confidence audit form. Collect to analyse post programme	**Knowledge, Skills and Confidence Audit Form**	Complete and submit the knowledge, skills and confidence audit form

Discussions as the end of life approaches

Time	Topic	Facilitator Activities	Resources	Group activity
	Role and responsibilities	Distribute 'roles and responsibilities' handout and discuss	**Roles & Responsibilities Handout**	Discuss.
		Summarise the discussions about the Six Steps to Success and the expected participant's roles and responsibilities		Active discussion and contribution
		Distribute Six C's handout. Discuss existing practice on end of life care from participants via discussion based on the 6 C's	**Six C's Handout**	
		Points to consider: *Has the organisations end of life care philosophy/policy been shared* *Encourage the care worker to obtain a copy of the end of life care policy and become familiar with its content*		Listen
		Introduce Step 1 PowerPoint to support the following delivery and activity (some facilitators may prefer not to use PowerPoint support)	**Step 1 PowerPoint Presentation**	
		Refer and discuss *The Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011) Step 1	Own copy of The Route to Success for domiciliary care	Read and discuss Step 1 of the *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011)

Discussions as the end of life approaches

Time	Topic	Facilitator Activities	Resources	Group activity
	Recognition of changes in signs and symptoms of individuals in the last year of life	Divide into groups and give each group the North West Model and the blank North West Model	**North West Template** **North West Model**	
		Ask the group(s) to consider observations they may recognise in relation to stage **1, 2 and 3** on the North West Tool	**North West Model Facilitator Guide**	Record group discussion on North West Tool stage 1, 2 and 3
		Facilitate feedback		Feedback to whole group
		Hand out three case studies (long term condition / dementia / cancer) to each group	**Step 1 Cancer Case Studies** **Step 1 LTC Case Study** **Step 1 Dementia Case Study**	Case study discussions
		Hand out North West Supportive Care Record - discuss the use and benefits of the record and explore with participants if they are aware of their organisation using this tool	**Supportive Care Record**	Discussion
	Surprise Question	Ask the groups; "Can you identify where each case study would be on the North West Supportive Care Record? Consider the following; Prognostic Indicator Guidance (GSF 2011), Surprise question, North West Tool Facilitate a discussion on the above, with use of the North West Supportive Care Record in practice **Points to consider:** *How is information cascaded to colleagues, regular team reviews* Advise the group, Step 3 covers the actions required to support individuals at each stage of the North West Model	**Prognostic Indicator Guidance** **Surprise Question**	Discuss case studies and record on the North West Supportive Care Record under the appropriate phase (use the Prognostic Indicator Guidance (GSF 2011) and the Surprise Question)

Discussions as the end of life approaches

Time	Topic	Facilitator Activities	Resources	Group activity
	Discussions around end of life care with individuals and their families	Lead a discussion based on the step 1 case studies to identify triggers to indicate when discussions may occur on end of life care. Record responses on flip chart **Points to consider:** *Change in circumstance prompts (i.e. death of friend/relative, recent hospital admissions or health changes)* *Does the individual wish to have a conversation about their future care and wishes?* *If the individual or family member chooses the Domiciliary Care Worker to have this discussion, what skills and limitations exist?* *Is it appropriate for the Domiciliary Care Worker to engage in discussion, or is there a more appropriate team member?* *What issues may arise with relatives being involved in discussions and how to address this? (Ethical/legal/choice)* *Does the individual have the mental capacity to make an informed choice?* *How can you respond to end of life care discussions with individuals who may have fluctuating capacity or communication difficulties? (Dysphasia, deafness, learning disabilities, stroke, dementia, etc.) Discuss aids and approaches* Facilitator to consolidate discussion and re-enforce the care worker role in advance care planning (referring to the appropriate person where required)	Flip chart/pens Step 1 case studies	Discussion Share current practice Discussion

Discussions as the end of life approaches

Time	Topic	Facilitator Activities	Resources	Group activity
	Communication skills	Lecture on communication skills. Consider interactive exercise for delivery *Facilitator to include:* barriers, difficult situations, good communication methods, listening skills, non-verbal skills, responding to questions and limitations of discussion	Step 1 PowerPoint Presentation **Communication Skills Handout** **Active Listening Skills Handout**	Listen / discuss
		Facilitator to distribute 'Step 1 Your role as a care worker' handout and lead discussion	**Step 1 - 'Your Role as a Care Worker'**	Read / discuss
	Revisit objectives	Check with the group the objectives have been met	Objectives as displayed at beginning of workshop	Review objectives
	Way forward	Give out: Step 1 home activity sheet and advise to complete and bring for discussion to workshop 2 Give out: Step 1 'To Do' List, and ask participants to complete prior to next workshop and file in the Six Step to Success personal development file. Remind the group to bring the Six Steps to Success personal development file to each workshop	**Step 1 Home Activity Sheet** **Step 1 'To Do' List**	Complete home activity sheet and bring back to next workshop File Step 1 'To Do 'List Complete before next workshop
	Evaluation and close	Distribute and collect in session evaluation forms Confirm date, time and venue of next meeting ask care worker to record on the To Do List Close	**Evaluation Form** Step 1 'To Do' List	Complete Evaluation Form To be recorded on 'To Do' List

Step 2 – Work plan
Assessment, care planning and review

Time: Half day

Aim: The Domiciliary Care Worker will understand holistic assessment and its relevance to advance care planning. They will explore systems to discuss, record, review and share assessments appropriately

Objectives: By the end of the session, the End of Life Domiciliary Care Worker will be able to -

- Recognise the importance of holistic care assessment and planning
- Show awareness of key features for assessment of an individual's mental capacity
- Show awareness of the key features of advance care planning
- Recognise collaborative working methods
- Be aware of the physical effects of illness on the service user

Facilitator to assess and insert realistic timings and comfort breaks in relation to the group size

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction, welcome and review	Welcome the group and inform them of housekeeping arrangements Introduce self		Listen
		Take a register of attendance	**Attendance Register**	Complete attendance register
		Display ground rules from Workshop 1	Ground rules from Workshop 1	Listen
		Review of Step 1 Workshop and progress with 'To Do' List and reflections *Facilitators to remind participants that this is evidence of learning and development, and further evidence for QCF qualifications* *(N.B. Home activity is the first group activity of session)*	Completed Step 1 'To Do' List Six Steps to Success personal development file	Feedback on actions from Step 1 'To Do' List and reflections

Assessment, care planning and review

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction to Step 2	PowerPoint to support the following delivery and activity *(some facilitators may prefer not to use PowerPoint support)* Display and share objectives of the day Introduce Step 2 of The Route to Success Ensure all participants have own copy of The *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011)	**Step 2 PowerPoint Presentation** Objectives for session **The *Route to Success –achieving quality in domiciliary care (own copy)***	Listen Read and discuss Step 2 of the *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011

Assessment, care planning and review

Time	Topic	Facilitator Activities	Resources	Group activity
	What makes a good death?	Divide a sheet of flipchart paper into six and add the Six Steps headings, explain to the group these are the headings used in the programme to guide policy. Divide into 3 groups, 1 The individual 2 The family 3 The domiciliary care worker Distribute post it notes to each group Ask the group to capture on the post it notes "What is a good death?" from the group headings perspective. Participant's home activity can be used as reference guide. Ask each group to place their post it notes on the flip chart in the relevant step Allocate two of the steps to each group and ask them to capture what their roles and responsibilities are as a participant in relation to the post it notes Summarise discussion with reference back to Role & Responsibilities handout discussed in workshop 1	**Flipchart Sheet** Post it notes Pens Flipchart Pens Role and Responsibilities handout	Work through 'what is a good death' in allocated groups. Capture on post it notes elements of a good death in relation to the group heading Place post it notes on the flipchart under the relevant step Discussion List roles and responsibilities of the care worker for the allocated Steps

Assessment, care planning and review

Time	Topic	Facilitator Activities	Resources	Group activity
	Holistic assessment	Lecture on holistic assessment	PowerPoint Presentation Laptop Projector	Listening Question and answers
		Facilitate a discussion on current assessment tools used in the domiciliary care organisation. Show examples of assessment tools e.g. Abbey/ Visual Analogue Scale/ Hope Divide into four groups 1 Physical 2 Psychological 3 Spiritual 4 Social	**Support sheet 16** **Holistic common assessment of supportive and palliative care needs for adults requiring end of life care (2010)** (Facilitator Reference)	Group to share examples of assessment tools used in practice
		Distribute Step 2 case study and template step 2 care plans to each group. Ask each group to discuss care planning from their group heading perspective, in relation to the case study, and record thoughts onto the care plan	**Step 2 case study** **Step 2 care plan**	Read group case study Complete allocated section of care plan
		Facilitate feedback from each group		Feedback Listen/Discuss
		Presentation or interactive exercise on symptom management	PowerPoint Presentation	Listen/Discuss

Assessment, care planning and review

Time	Topic	Facilitator Activities	Resources	Group activity
	Linking holistic assessment to Advance Care Planning	Ask the group to think about how holistic assessment takes place for an individual who has communication difficulties, perhaps because of learning disability, dementia or stroke	Pen and paper **Best Interest at End of Life (2008)** (facilitator reference) **Support sheet 12** **Support sheet 13**	List thoughts / Discuss what current practice is to assess mental capacity Listen, Q&A
	Recognition of mental capacity	Ask the group are they aware of the 2 stage test to assess mental capacity within the holistic assessment process – discuss/clarify	**Two Stage Test of Capacity**	Discussion
	What is Advance Care Planning?	Lecture on Advance Care Planning, Preferred Priorities for Care, Advance Decision to Refuse Treatment, Do Not Attempt Resuscitation, etc. *Define Advance Care Planning and Best Interest Decision Making* Facilitator to discuss support sheets as handed out Facilitate a discussion on what the domiciliary care organisations currently do in practice to assess, record and communicate/share an individual's wishes and preferences Split into groups of 3-4. Groups to identify changes which may indicate a need to review care plans and initiate referrals to other teams/persons Facilitate feedback and ensure all topics covered	PowerPoint presentation Laptop/projector **Support sheet 4** **Preferred Priorities For Care Preferred Priorities for Care Guide** **Planning for your future care: A guide (2012)** **Care Capacity & Advance Care Planning (2011)** (Facilitator Reference) **Support sheet 3** **Support sheet 18** Pens Paper	Listen Questions & answers Review documents Discuss In groups draw up a list of changes and present back for discussion

Assessment, care planning and review

Time	Topic	Facilitator Activities	Resources	Group activity
	Collaborative working in Advance Care Planning	Draw a spider diagram on flip chart and ask the group to identify the Health and Social Care Professionals who may be involved in an individual's care at end of life Discuss the following: "What mechanisms are in place to discuss, record and (where appropriate) communicate the wishes and preferences of those approaching the end of life? How often are needs assessed and reviewed? *Incorporate the Supportive Care Record*	Flip chart Pens **Supportive Care Record**	Discussion Listen/Discuss
		Facilitator to distribute Step 2 'Your role as a care worker' handout and read through	**Step 2 'Your role as a care worker'**	
	Revisit objectives	Check with the group the objectives have been met	Objectives as displayed at beginning of workshop	Review objectives
	Way forward	Give out: Step 2 'To Do' List, and ask participants to complete prior to next workshop and file in the Six Step to Success personal development file. Remind the group to the bring the Six Steps to Success personal development file to each workshop	**Step 2 'To Do' List**	File Step 2 'To Do 'List Complete before next workshop
	Evaluation and close	Distribute and collect in session evaluation forms Confirm date, time and venue of next meeting ask care worker to record on the 'To Do' List Close	**Evaluation Form** Step 2 'To Do' List	Complete Evaluation form To be recorded on Step 2 'To Do' List

Step 3 – Work plan
Co-ordination of care

Time: Half day
Aim: A system is in place to ensure co-ordination of care takes place
Objectives: By the end of the session, the End of Life Domiciliary Care Worker will be able to -

- Identify the value of good communication systems in end of life care
- Recognise the importance of sharing information with the wider multidisciplinary team
- Recognise the key features and values of the role of a Key Worker
- Be aware of aspects of anticipatory needs at the end of life
- Identify necessary and unnecessary admissions to acute care

Facilitator to assess and insert realistic timings and comfort breaks in relation to the group size

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction, welcome and review	Welcome the group and inform them of housekeeping arrangements Introduce self Take a register of attendance Display ground rules from Workshop 1 Review of Step 2 Workshop and progress with 'To Do' List and reflections *Facilitators to remind participants that this is evidence of learning and development, and further evidence for QCF qualifications*	**Attendance Register** Ground rules from the Induction Workshop Completed Step 2 "To Do" list Six Steps to Success personal development file	Listen Complete attendance register Listen Feedback on actions from Step 2 'To Do' List
	Introduction to Step 3	PowerPoint to support the following delivery and activity *(some facilitators may prefer not to use PowerPoint support)* Display and share objectives of the day Ensure all participants have own copy of The Route to Success in End of Life Care-achieving quality in domiciliary care (NEoLCP 2011) Introduce Step 3 of The Route to Success	**Step 3 PowerPoint Presentation** Laptop Projector Objectives for session **Route to Success in End of Life Care-achieving quality in domiciliary care** (NEoLCP 2011) (Own copy)	Listen Read through Step 3 of the Route to Success in End of Life Care-achieving quality in domiciliary care *(NEoLCP 2011)* Listen

Co-ordination of care

Time	Topic	Facilitator Activities	Resources	Group activity
	Communication Systems	Present spider diagram from Step 2 Workshop Divide into groups and ask them to discuss referral systems to the identified professionals on the spider diagram 24/7 Facilitate discussion of effective communication systems with care teams ***Points to consider:*** *Consider: who do they communicate with, how, why and when?* *Confidentiality, gaining consent* *Invite supporting professionals to present on their role: DN,SPCN,GP* Facilitate discussions on how the Domiciliary Care Worker can access information about individuals i.e. are they on the GP End of Life Care/GSF Register? Can they access information to support their care, via the organisation? E.g. equipment, etc. Discuss benefits and risks of effective/ineffective communication in end of life care *Re-iterate the importance of effective community partnerships and role limitations / blurred boundaries*	Spider diagram (from Step 2 Workshop) Flip chart Pens **Support sheet 1** Flipchart/ Pens	Listen Discuss Feedback Listen/Discussion Discussion

Co-ordination of care

Time	Topic	Facilitator Activities	Resources	Group activity
	End of Life Care Good Practice Guide	Facilitator to distribute the End of Life Care Good Practice Guide and explain its use in practice, walking through each stage of the guide, ensuring the care worker is aware of what should be in place for the service user in the last year of life	**Good Practice Guide**	Listen/Discussion
	Key Worker roles	Facilitate a group discussion to identify the role of a key worker ***Points to consider:*** *Regular review of individual's needs, communicating with the individual, relatives and health and social care professionals, link between services for a designated individual.* Listen to the feedback and continue with group discussions if any responsibilities omitted Review Supportive Care Record for where the key worker is to be recorded **Facilitator to re-iterate importance of care workers not carrying out new duties without training and organisation agreement, key worker role is likely to be a senior /manager within the organisation **	Flip chart/pens **Support sheet 10** **Key Worker Role & responsibilities** **Visual Key Worker Summary** **Supportive Care Record**	Discuss and record the responsibilities of a key worker Identify key worker(s) – if used, within own organisation Feedback

Co-ordination of care

Time	Topic	Facilitator Activities	Resources	Group activity
	Anticipating needs at the end of life	Facilitate discussions on what currently happens in practice in relation to anticipation of needs and complex changes. ***Points to Consider:*** The care worker role, *informing health and social care professionals, discussing how their role should continue as the client deteriorates, key contacts, awareness of any specific drug regime or equipment ensuring appropriate training. Workers to identify who family should contact if they need support*	Flip chart/pens	Discuss
		Distribute Step 3 case study Ask pairs to discuss timings regarding planning ahead in relation to case study *- to what extent is the Domiciliary Care Worker involved?*	**Step 3 Anticipatory Case Study** **Step 3 Anticipatory Needs Activity**	Discuss case study
		Facilitate Feedback		Feedback
		Ask the full group what systems are in place to respond **rapidly** to complex changes as the end of life approaches ***Points to consider:*** *Referrals* *Additional support* *Medications* *Equipment* *Contact lists*		Discussion Feedback Listen

Step 3 – Work plan

Co-ordination of care

Time	Topic	Facilitator Activities	Resources	Group activity
	Decision making on hospital admissions	Divide group and distribute hospital admission case studies. Groups to discuss key events within case study ***Points to consider:*** *Did the person die in the appropriate setting?* *Was it the setting of their choice?* *Have any specific wishes or preferences been identified by the individual/family to add to discussions?* *What could have gone better?* During feedback pull out what would support decision making at the end of life: ***Points to consider:*** *Advance Care Planning* *Out of Hours handover* *GP review* *Holistic assessment* *Communication with acute sector and other health & social care professionals* Discuss own experiences of hospital admissions for individuals in end of life care. Distribute Prompt Cards	Hospital Admission **Step 3 Case Study 1** **Step 3 Case Study 2** **Step 3 Case Study 3** Flip chart/pens **Domiciliary Care Worker Prompt Card**	Group discussion on hospital admission case study recorded on flip chart Feedback Discussion and feedback
		Facilitator to distribute Step 3 'Your role as a care worker' handout and read through	**Step 3 'Your Role as a Care Worker'**	Read Discuss
	Revisit objectives	Check with the group the objectives have been met	Objectives as displayed at beginning of workshop	Review objectives

Time	Topic	Facilitator Activities	Resources	Group activity
	Way forward	Give out: Step 3 'To Do' List, and ask participants to complete prior to next workshop and file in the Six Step to Success personal development file. Remind the group to bring the Six Steps to Success personal development file to each workshop	**Step 3 'To Do' List**	File Step 3 'To Do 'List Complete before next workshop
	Evaluation and close	Distribute and collect in session evaluation forms Confirm date, time and venue of next meeting ask care worker to record on the To Do List Close	**Evaluation Form** Step 3 'To Do' List	Complete Evaluation Form To be recorded on Step 3 'To Do' List

Step 4 – Work plan
Delivery of high quality care in domiciliary care

Time: Half day
Aim: Achieve high quality care in Domiciliary Care
Objectives: By the end of the session, the End of Life Domiciliary Care Worker will be able to -

- Recognise the complex combination of services across a number of different settings
- Recognise the importance of Significant Event Analysis
- Recognise the need for training on end of life care
- Identify aspects surrounding dignity, the environment, family and carers at the end of life

Facilitator to assess and insert realistic timings and comfort breaks in relation to the group size

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction, welcome and review	Welcome the group and inform them of housekeeping arrangements Introduce self Take a register of attendance Display ground rules from Induction Workshop Review of Step 3 Workshop and progress with 'To Do' List and reflections *Facilitators to remind participants that this is evidence of learning and development, and further evidence for QCF qualifications*	 **Attendance Register** Ground rules from the Induction Workshop Completed Step 3 'To Do' list Six Steps to Success personal development file	Listen Complete attendance register Listen Listen Feedback on actions from Step 3 'To Do' List

Delivery of high quality care in domiciliary care

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction to Step 4	PowerPoint to support the following delivery and activity *(some facilitators may prefer not to use PowerPoint support)*	**Step 4 PowerPoint Presentation** Laptop Projector	Listen
		Display and share objectives of the day	Objectives for session	Listen
		Introduce Step 4 of The Route to Success		
		Ensure all participants have own copy of *The Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011)	***The Route to Success in End of Life Care - achieving quality in domiciliary care*** (NEoLCP 2011) (own copy)	Read and discuss Step 4 of the *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011)

Delivery of high quality care in domiciliary care

Time	Topic	Facilitator Activities	Resources	Group activity
	Complex combination of services across a number of different settings Proactive planning to prevent a crisis (including out of hours)	Facilitate a group discussion on their experiences of various end of life scenarios which have occurred out of hours - record on flip chart the frequent challenges raised Using the feedback ask the group how they could minimise the distress for individuals? Facilitator may source local information i.e. local advice/support phone lines, availability of out of hours pharmacies, etc. **Facilitator may consider inviting a Community Nurse for a short talk on their role*	Flip chart/pens Information on local services and contacts	Discuss Feedback Discuss
	Significant Event Analysis	In small groups (3-4), ask groups to identify "significant events": how this is defined, recorded and reviewed? Using the Significant Event Analysis, encourage groups to make notes on the event Facilitator to co-ordinate feedback Facilitator to consolidate thoughts and encourage reflection on practice cycle Display templates in room for participants to review	**Significant Events Analysis Template** *(A3 paper size if possible)*	Explore, discuss listen Complete template Feedback to wider group Discuss the benefits of use Review

Delivery of high quality care in domiciliary care

Time	Topic	Facilitator Activities	Resources	Group activity
	Education, training and development	Facilitate a discussion on the following question: What education, training and skills are needed to provide quality end of life care, within the domiciliary care setting? Facilitator to explore the variety of local end of life care education and training available. May include: *Access to QCF units* *Principles of Palliative Care* *Communication skills* *Mental Capacity Training* *Dignity/compassion and care* *E-learning i.e. SCIE* Ask the group to consider their own training needs Facilitate feedback	Flip chart / whiteboard/pens Give out information on training available	Discuss Listen Question and answers Discuss how they are going to assess their own further training needs within their role
	Dignity	Show dignity film of choice and facilitate feedback Facilitator to promote the role of Dignity Champion (SCIE) Distribute handout 'What do you see Nurse' poem	Dignity film **Support sheet 6** Link website: **http://www.dignityincare.org.uk/** **'What Do You See Nurse' Poem Handout** **RCN Definition of Dignity**	Watch dignity film Discuss Read
	Environment	Facilitate discussion on the environments experienced within the domiciliary care setting – include challenges and personal choice (privacy/dignity/ safety)	**Support sheet 15** **Routes to Success in End of Life Care- achieving quality environments for care at end of life** (Facilitator reference)	Discuss

Delivery of high quality care in domiciliary care

Time	Topic	Facilitator Activities	Resources	Group activity
	Family / carers / significant others	Direct groups to identify roles and extent of care participation of the family members in care delivery at the end of life Co-ordinate feedback. Discuss how participants evaluate feedback to support improvements in care Discuss how they could support the individual and their family in understanding the changes which could occur as end of life approaches	Flip charts/pens Record on flipcharts	Active discussion and record findings Discussion Explore, discuss listen
	Role of Care Worker	Facilitator to distribute Step 4 'Your role as a care worker' handout and read through	**Step 4 'Your Role as a Care Worker'**	Listen
	Revisit objectives	Check with the group the objectives have been met	Objectives as displayed at beginning of workshop	Review objectives
	Way forward	Give out: Step 2 'To Do' List, and ask participants to complete prior to next workshop and file in the Six Step to Success personal development file. Remind the group to the bring the Six Step to Success personal development file to each workshop *Ask the group to bring literature (if any in use) that they use in practice to support relatives, friends and significant others when individuals are at end of life to the next workshop*	**Step 4 'To Do' List**	File Step 4 'To Do 'List Complete before next workshop
		Distribute and collect in completed session evaluation forms Confirm date, time and venue of next meeting Close	**Evaluation Form** Step 4 'To Do' List	Complete Evaluation form To be recorded on Step 4 'To Do' List

Step 5 –Work plan
Care in the last days of life

Time: Half day
Aim: It is recognized the individual is entering the last days of life
Objectives: By the end of the session, the Domiciliary Care Worker will be able to -

- Recognise the changes that occur in the dying phase
- Identify the role of the Domiciliary Care Worker in the dying phase
- Have an understanding of the use of individualised End of Life Care Plans (or equivalent)
- and the care of the individual on a syringe driver
- Know how to care for relatives, significant others, other individuals and colleagues with professionalism and sensitivity
- Support religious, cultural and spiritual needs

Facilitator to assess and insert realistic timings and comfort breaks in relation to the group size

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction, welcome and review	Welcome the group and inform them of housekeeping arrangements Introduce self Take a register of attendance Display ground rules from Workshop 1 Review of Step 4 Workshop and progress with 'To Do' List and reflections *Facilitators to remind participants that this is evidence of learning and development, and further evidence for QCF qualifications*	 **Attendance Register** Ground rules from the Induction Workshop Completed Step 4 'To Do' List Six Steps to Success personal development file	Listen Complete attendance register Listen Feedback on actions from Step 4 'To Do' List and reflections

Care in the last days of life

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction to Step 5	PowerPoint to support the following delivery and activity *(some facilitators may prefer not to use PowerPoint support)* Display and share objectives of the day Ensure all participants have own copy of The *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011)	**Step 5 PowerPoint Presentation** Laptop/Projector Objectives for session **The *Route to Success in End of Life Care-achieving quality in domiciliary care*** (NEoLCP 2011) (Own copy)	Listen Listen Read through Step 5 of the *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011)
	The dying phase	Lecture *Address signs and symptoms of the dying individual; consider the impact of different diseases. Include unexpected improvements, who to report changes to and syringe driver usage*	PowerPoint Presentation Laptop/Projector **Support Sheet 8 Physical Changes Handout** **Care in the Last Days Handout**	Listen Question and answer
	End of Life Care Plans (or equivalent)	Facilitate a discussion on the appropriate action to take when recognising dying and how this relates to the Good Practice Guide Facilitator to lead discussion on End of Life Care Plans (or equivalent) and the impact to the care worker's role Record key thoughts ***Points to consider:*** *DNACPR* *Review of Advance Care Plan, Nutrition/hydration, Syringe drivers, Communication with family and professionals, GP/DN reviews*	**Good Practice Guide** Local example of Individualised End of Life Care Plans (or equivalent) Flip chart/pens	Discuss Discuss Review document Feedback thoughts

Care in the last days of life

Time	Topic	Facilitator Activities	Resources	Group activity
	Care of relatives, friends and significant others	Facilitate a discussion on how the Domiciliary Care Worker can support relatives, friends and significant others in the last days of life ***Points to consider:*** *Transport* *Accommodation* *Meals* *Emotional support* *Possessions* *Pets* *Neighbours* *Involvement of relatives, friends and significant others* *To what level does the individual wish for others to be involved in care or discussions?*	Flipchart / Pens	Discuss Feedback
	Religious, Cultural and Spiritual Care	Divide into groups and allocate one custom/ religion to each group to review ***Points to consider:*** *Different faiths, belief and spiritual needs pre and post death* Facilitator to capture any missed points and discuss importance of different beliefs and needs	**Customs and Religious Protocols Handout** **MCCN Religious Needs Resource** **http://queenscourt.org.uk/spirit/**	Review allocated religion/custom and feedback key points to group Listen Question and answers
	Role of Care worker	Facilitator to distribute Step 5 'Your role as a care worker' hand-out and read through	**Step 5 'Your Role as a Care Worker'**	Discuss

Care in the last days of life

Time	Topic	Facilitator Activities	Resources	Group activity
	Revisit objectives	Check with the group the objectives have been met	Objectives as displayed at the beginning of the workshop	Review objectives
	Way forward	Give out: Step 5 'To Do' List, and ask participants to complete prior to next workshop and file in the Six Step to Success personal development file. Remind the group to the bring the Six Step to Success personal development file to each workshop	**Step 5 'To Do' List**	File Step 5 'To Do 'List Complete before next workshop
	Evaluation and close	Distribute and collect in completed evaluation forms Confirm date, time and venue of next meeting Close	**Evaluation Form** Step 5 'To Do' List	Complete Evaluation Form To be recorded on Step 5 'To Do' List

Step 6 – Work plan
Care after death

Time: Half day
Aim: Provide excellent support and care after death
Objectives: By the end of the session, the Domiciliary Care Worker will be able to -

- Identify necessary actions for care after death
- Offer practical support and information to families, significant others, colleagues and other individuals
- Recognise aspects of grief and bereavement
- Respect individual faiths and beliefs to address individual wishes
- Explore support mechanisms to protect self

Facilitator to assess and insert realistic timings and comfort breaks in relation to the group size

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction, welcome and review	Welcome the group and inform them of housekeeping arrangements Introduce self Take a register of attendance Display ground rules from Workshop 1 Review of Step 5 Workshop and progress with 'To Do' List and reflections *Facilitators to remind participants that this is evidence of learning and development, and further evidence for QCF qualifications*	 **Attendance Register** Ground rules from Workshop 1 Six Steps to Success personal development file	Listen Complete attendance register Listen Feedback on actions from Step 5 'To Do' List and reflections

Care after death

Time	Topic	Facilitator Activities	Resources	Group activity
	Introduction to Step 6	PowerPoint to support the following delivery and activity (some facilitators may prefer not to use PowerPoint support) Display and share the objectives of the day Ensure all Participants have own copy of The Route to Success in End of Life Care-achieving quality in domiciliary care (NEoLCP 2011) Review of Step 5 Workshop	**Step 6 PowerPoint Presentation** Laptop/Projector Objectives for the session ***The Route to Success in End of Life Care-achieving quality in domiciliary care*** (NEoLCP 2011) (Own copy)	Listen Listen Read through Step 6 of the *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011) Listen
	Care after death for the deceased individual, families / significant others, colleagues and other individuals	Divide into three groups 1. The individual 2. Families and Significant Others 3. Domiciliary Care Worker Ask each group to discuss care after death in relation to their group heading include cultural and spiritual needs, possessions and Last Offices ***Points to Consider:*** *Care of the deceased person* *Have the relatives been provided with appropriate support material?* *Do mechanisms exist to support non-family members, such as neighbours, staff, other individuals and friends, who may also be affected by death?* *Have concerns or needs of relatives been addressed?* Facilitate feedback	Flip chart/pens **Guidance for staff responsible for care after death** ***'What to do after a death in England and Wales' (or other information material)*** ***Support After Death Handout***	Discuss Feedback to the whole group

Care after death

Time	Topic	Facilitator Activities	Resources	Group activity
	Requirements and actions following a death	Lecture to identify the actions that need to be taken if present at the time of death ***Consider:*** *Final care* *Verification and certification process* *Contacting funeral directors* *Registering a death* *(advice and support for families)* **Facilitator may consider inviting a Funeral Director to deliver a short talk on their role*	PowerPoint Presentation Laptop/Projector **Support sheet 9** Local policy Funeral Director	Listen Question and Answers
	Grieving process	Lecture on grief processes – Normal Grief – Abnormal grief – When to refer to the appropriate services – Ways of paying respect Source information on local bereavement support services Care of self and support available Divide the group into pairs, distribute Stress Buster handout. Ask the pairs to highlight issues that they consider stress triggers. Ask them to set 3 targets for change Facilitate feedback Follow grounding exercise	PowerPoint Presentation Laptop/Projector Local bereavement support services with contact details (Source locally) **Care of Self Hand-out** **Stress Buster Hand-out** **Grounding Exercise Hand-out**	Listen Questions and answers Read Discuss Read, discuss Feedback Participate

Care after death

Time	Topic	Facilitator Activities	Resources	Group activity
	Role of care worker	Facilitator to distribute Step 6 'Your role as a care worker' hand-out and read through	**Step 6 'Your Role as a Care Worker'**	Read
	Revisit objectives	Check with the group the objectives have been met	Objectives as displayed at the beginning of the workshop	Review objectives
	Way forward Evaluation	Give out: Step 6 'To Do' List, and ask participants to complete independently and file in the Six Step to Success personal development file. Advise participants to store the 'To Do' List in the Six Step file Distribute and collect session evaluation form	**Step 6 'To Do' List** **Evaluation form**	File Step 6 'To Do 'List Complete actions Complete evaluation form
	Programme review	Walk through each step in the Six Step to Success programme overview and consolidate content and evidence of learning Facilitator to emphasise that attendance on the programme and completion of the 'To do' Lists and reflections form part of personal and professional development hours. Consider presentation from Skills for Care/QCF training provider re access to awards, diplomas and certificates	**Six Steps to Success Programme Overview**	Read and discuss
	Audit revisited	Distribute and explain the post programme Knowledge, Skills and Confidence Audit Form. Ask the group to complete individually and collect completed audits. Analyse pre and post programme results	**Post Programme Knowledge, Skills and Confidence Audit Form**	Complete and submit the post programme knowledge, skills and confidence audit form

Care after death

Time	Topic	Facilitator Activities	Resources	Group activity
	Final evaluation and close	Hand out evaluation forms for full Six Steps for Domiciliary Care Workers programme Consider a celebration event to distribute certificate to those that have attended all 6 workshops. Points to consider: Those that have missed workshops may receive part certification. Care workers should be encouraged to attend workshops they have missed on future programmes Local agreement required Encourage care workers to discuss vocational qualifications with their managers. Close	**Programme Evaluation Form** **Six Steps to Success Certificate for the Domiciliary Care Worker**	Complete programme evaluation form and submit to facilitator

End of Life Care Further Qualifications

Skills for Care has developed end of life care qualifications in conjunction with a wide range of employers. The qualifications aid social care employers to support the National End of Life Care Strategy, and build on the work of the common core competencies and principles for end of life care (Skills for Care). Indicative recognition of learning is demonstrated below. Should participants complete all 'To Do' lists and reflection assignments, evidence should offer reasonable contribution to qualification evidence.

Participants who are undertaking Level 2 and 3 diplomas on the QCF framework may be able to claim further evidence from the programme completion.

QCF Cross referencing

Participants may choose to progress onto completion of the QCF unit HSC3048 "Support individuals at the end of life'. This unit offers 7 credits at level 3. The unit contains a requirement for both knowledge and competency in end of life care. There are 10 learning outcomes within the unit. 5 of the learning outcomes must be assessed within the **real work environment.** The remaining outcomes relate to knowledge and understanding and the underpinning knowledge is embedded within the Six Steps Programme for Domiciliary Care Workers. Signposting to indicative QCF unit HSC3048 outcomes is offered below.

Participants who are undertaking Level 2 and 3 diplomas on the QCF framework may be able to claim further evidence from the programme completion. In addition, participants may choose undertake a Level 2 or 3 Award in Awareness of End of Life Care or Level 3 Certificate in Working in End of Life Care.

Participants will require registration with an awarding body and to be enrolled with an accredited centre in order to achieve the QCF qualifications. A cost will be attached to this.

Level / Award / Unit	Mapped to learning outcome (LO)	
Level 2 Award: Awareness of End of Life Care	All outcomes may be met	
Unit EOL 201: Understand how to work in end of life care	LO1 – AC 1.1, 1.2, 1.3, 1.4 LO2 – AC 2.1, 2.2, 2.3, 2.4, 2.5, 2.6	LO3 – AC 3.1, 3.2, 3.3, 3.4, 3.5 LO4 – 4.1, 4.2, 4.3, 4.4
Level 3 Award: Awareness of End of Life Care	All outcomes may be met	
Unit EOL 201: Understand how to work in end of life care	LO1 – AC 1.1, 1.2, 1.3, 1.4 LO2 – AC 2.1, 2.2, 2.3, 2.4, 2.5, 2.6	LO3 – AC 3.1, 3.2, 3.3, 3.4, 3.5 LO4 – 4.1, 4.2, 4.3, 4.4
Unit EOL 301: Understand how to provide support when working in end of life care	LO1 – AC 1.1, 1.2, 1.3 LO2 – AC 2.1, 2.2, 2.3, 2.4 LO3 – AC 3.1, 3.2, 3.3, 3.4	LO4 – AC 4.1, 4.2, 4.3, 4.4 LO5 – AC 5.1, 5.2, 5.3, 5.4 LO6 – AC 6.1, 6.2, 6.3, 6.4
Unit EOL 307: Understand how to support individuals during last days of life	LO1 – AC 1.1, 1.2, 1.3, 1.4 LO2 – AC 2.1, 2.2, 2.3 LO3 – AC 3.1, 3.2, 3.3, 3.4	LO4 – AC 4.1, 4.2, 4.3, 4.4, 4.5 LO5 – AC 5.1, 5.2
Level 3 Certificate: Working in End of Life Care		
Unit EOL 301: Understand how to provide support when working in end of life care	LO1 – AC 1.1, 1.2, 1.3 LO2 – AC 2.1, 2.2, 2.3, 2.4 LO3 – AC 3.1, 3.2, 3.3, 3.4	LO4 – AC 4.1, 4.2, 4.3, 4.4 LO5 – AC 5.1, 5.2, 5.3, 5.4 LO6 – AC 6.1, 6.2, 6.3, 6.4
Unit EOL 302: Managing symptoms in end of life care (competence unit)	LO1 – AC 1.1, 1.2, 1.3 LO2 – N/A competency AC	LO3 – AC 3.1, 3.3P, 3.4P LO4 – N/A competency AC
Unit EOL 660: Understand advance care planning	LO1 – AC 1.1, 1.2, 1.3, 1.4P, 1.5, 1.6 LO2 AC – 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7,	LO 3 – AC 3.1, 3.2, 3.3, 3.4, 3.5 2.8, 2.9, 2.10,
Unit EOL 305: Support individuals with loss and grief before death (competence unit)	LO – AC 1.1, 1.2, 1.3, 1.4 LO –N/A competency AC	LO2 – N/A competency AC

Level / Award / Unit	Mapped to learning outcome	
Unit EOL 310: Support individuals with specific communication needs (competence unit)	LO1 – AC 1.1, 1.2P, 1.3, 1.4P, 1.5P, 1.6P LO2 – N/A competency AC LO3 – N/A competency AC	LO4 – N/A competency AC LO5 - not covered LO6 – N/A competency AC
Level 5 Certificate: Leading and Managing Services to Support End of Life and Significant Life Events		
Optional Unit: Unit EOL 303: Understand Advance Care Planning (knowledge unit)	LO1 – AC 1.1, 1.2,1.3,1.4,1.5, 1.6, LO2 – AC1.1,1.2, 1.3,1 .4,1.5,1.6,1.7,1.8,1.9,1 .10, 2.1, 2.3, 2.4, 2.5, 2.9, 2.10	LO3 – AC3.1,3.2,3.3,3.4,3.5
Optional Unit: EOL 307: Understand how to support individuals during the last days of life (knowledge unit)	LO1 – AC 1.1, 1.2, 1.3, 1.4, LO2 – AC 2.1, 2.2 2.3	LO3 – AC 3.1, 3.2, 3.3, 3.4 LO4 – AC 4.1, 4.2, 4.3, 4.4, 4.5

References

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Department of Health (2010) The Routes to Success in End of Life Care: achieving quality in domiciliary care. National End of Life Care Programme. Department of Health, London.

NHS North West (2008) Healthier Horizons for the North West. Our NHS, Our Future. NHS North West Manchester.

Further information on the Qualification Credit Framework can be found at:
http://www.skillsforcare.org.uk/Document-library/Skills/End-of-life-care/NationalendoflifequalificationsandSixStepsprogramme.pdf

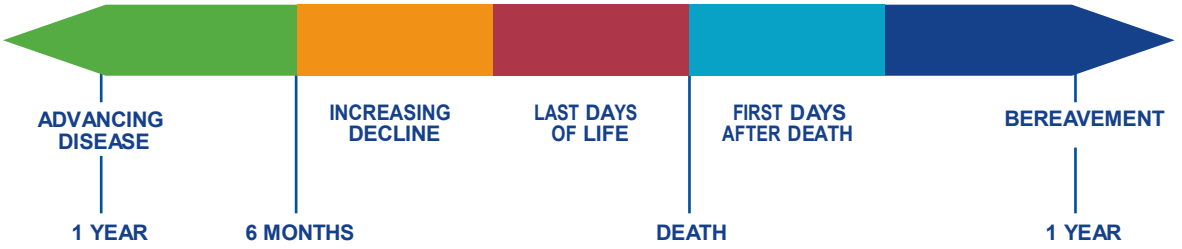
http://www.skillsforcare.org.uk/Qualifications-and-Apprenticeships/Adult-social-care-qualifications/Adult-social-care-vocational-qualifications.aspx

The North West End of Life Care Model

The model of delivery advocated by the North West Clinical Pathway Group uses a whole systems approach for all adults with a life limiting disease regardless of age and setting, moving from recognition of need for end of life care to care after death.

In order to apply the model, staff across organisations are required to understand the needs and experiences of people and their carers.

The pathway model identifies five key phases:



1. Advancing disease

A timeframe of one year or more

Example of practice required – the person is placed on a supportive care register in General Practitioner (GP) practice/care home and information is shared.

2. Increasing decline

A timeframe of approximately six months

Example of practice required – DS1500 eligibility review of benefits, Preferred Priorities for Care (PPC) noted, Advance Care Plan (ACP) in place and trigger for continuing healthcare funding assessment.

3. Last days of life

A timeframe of the last few days

Examples of practice required – primary care team/care home inform community and out of hours services about the person who should be seen by a doctor. End of life drugs prescribed and obtained, and End of Life Care Plan (or equivalent) implemented.

4. First days after death

A timeframe of the first few days

Examples of practice – prompt verification and certification of death, relatives being given information on what to do after a death (including DWP011 booklet), how to register the death and how to contact funeral directors.

5. Bereavement

A timeframe of one year or more

Examples of practice – access to appropriate support and bereavement services if required.

Cheshire and Merseyside
Strategic Clinical Networks

Greater Manchester, Lancashire and South Cumbria
Strategic Clinical Networks

National End of Life
Care Programme

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