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

# SIX STEPS TO SUCCESS

## PROGRAMME FOR CARE HOMES

**How to use this document**

The document is set out with a full programme overview to support the delivery of end of life care in care homes; this overview outlines the content of the 8 workshops and the outcomes to be achieved.

There is a work plan for each workshop as a guide for facilitators, precluding each step workshop you will find the programme covering each topic, with measures and examples of evidence for the six step portfolio; this has been mapped to the End of Life Quality Markers for Care Homes (DOH 2009) and the six step pathway of the National End of Life Care Programme Route to Success guide for care homes.

Care homes should be supplied with or provide a file to collect the portfolio of evidence required. Each workshop is colour matched to the North West End of Life Care Model (NHS North West Healthier Horizons 2008). See Appendix.

# Contents

# Introduction

The Route to Success in end of life care - achieving quality in care homes (2010) was developed as a resource to help care homes identify the processes involved in the provision of high quality end of life care.

Many care homes have the enthusiasm to deliver good end of life care but may need support to identify what is their best practice and what additional systems might enhance their service delivery.

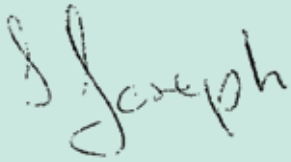
The National End of Life Care Programme document, The Route to Success in end of life care- achieving quality in care homes 2010 was developed to provide basic information about what should be included in the processes of good end of life care delivery.

The Route to Success follows the six steps of the pathway laid out in the national strategy and includes questions for staff and managers to ask themselves about the end of life care provision in their care home.

Many care homes have embraced the document and its pathway approach, using it as a tool to analyse the levels of service delivery within their settings. In order to help with this process the national programme has developed a baseline analysis questionnaire and a data analysis tool for care homes or organisations to use for themselves. Both of these are available to download from: http://www.endoflifecareforadults.nhs.uk/publications/route-to-success-care-homes.

The end of life care, care home co ordinators in the north west of England have taken this process one step further and developed the workshop style training programme which is contained within this document. This is now available as part of the whole package of Route to Success guidance, analysis and

training resources which care homes can access free, downloading all or in part as fits their requirements from: http://www.endoflifecareforadults.nhs.uk/publications/route-to-success-care-homes.



Sheila Joseph - national manager, National End of Life Care Programme.

The programme utilises a care home representative/s from each care home to implement the structured organisational change to deliver the best end of life care based on the National End of Life Care Programme Guidance (2010) – The Route to Success in end of life care - achieving quality in care homes.

It is based on 8 workshops as follows:

Induction workshop
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 care in care homes
Step 5: Care in the last days of life
Step 6: Care after death
Conclusion workshop

The programme is supported by mandatory stand alone education modules which include communication skills (following step 2), advance care planning (following step 2) and Liverpool Care Pathway for the dying patient training (following step 5). The delivery of this education is to be agreed in each local area, delivering the programme. It could also include any other education providing theory and underpinning knowledge for example symptom management.

This programme is mapped to The Route to Success in End of Life Care – achieving Quality in Care Homes (NEoLC2010)The End of Life Care Strategy (DOH 2008), Quality, Innovation, Productivity and Prevention (QIPP), associated Quality Markers and Measures for care homes (DOH 2009), Care Quality Commission guidance(CQC 2010) and the North West End of Life Care Model ( North West Healthier Horizons 2008).

The programme is a collaborative project between Merseyside and Cheshire Cancer Network, Greater Manchester and Cheshire Cancer Network and Cumbria and Lancashire End of Life Network and has receieved support and advice from the National End of Life Care Programme.

Permission is given to use and adapt this programme but please reference the original source.

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Sheila Joseph – national manager, National End of Life Care Programme.

# The pathway to quality end of life care in care homes

| Step 1 | Step 2 | Step 3 | Step 4 | Step 5 | Step 6 |
|---|---|---|---|---|---|
| **Discussions as the end of life approaches** | **Assessment, care planning and review** | **Co-ordination of care** | **Delivery of high quality services in a care home** | **Care in the last days of life** | **Care after death** |
| • Open, honest communication<br>• Identifying triggers for discussion. | • Conduct a holistic assessment<br>• Agreed care plan and regular review of needs and preferences<br>• Assessing needs of carers. | • Co-ordination working with primary and community health services, ambulance/ transport services and social care<br>• Co-ordination of individual patient care<br>• Create adequate communication systems across care settings. | • Dignified environment<br>• Treat with dignity and respect<br>• Access support from other health and social care services<br>• Making best use of resources. | • Identification of the dying phase<br>• Review of needs and preferences for place of death<br>• Support for both patient and carer<br>• Recognition of wishes regarding resuscitation and organ donation. | • Recognition that end of life care does not stop at the point of death<br>• Timely verification and certification of death or referral to coroner<br>• Care and support of carer and family, including emotional and practical bereavement support. |

# Overview of programme

## Implementation of the Six Steps to Success Programme

The programme has been developed to be inclusive of all care homes. Further guidance around the process of recruitment, implementation and all resources and templates (highlighted in bold on the work plans) contained in the programme can be found at www.endoflifecareforadults.nhs.uk/tools/core-tools/rtsresourcepage

The length of time it takes to deliver the programme is flexible and dependent on each local area, for example, one half day workshop per month over eight months. It is suggested the mandatory education, to support this programme, is delivered as follows:

- Communication Skills and Advance Care Planning following workshop step 2
- Liverpool Care Pathway following workshop step 5

The Facilitator has licence to use their professional judgement in the content and delivery of the workshops, ensuring the measures from the programme are achieved at all times. The facilitator should try and integrate local policies and guidance into the programme as much as possible.

Following completion of the programme the local Facilitator/Educator will need to consider sustainability of the programme. It is suggested Care Home Representatives continue to meet as a local forum.

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

| Time | Workshop | Title | Main content | Outcomes to be achieved from workshop |
|---|---|---|---|---|
| | Induction | Induction | • National, Regional, Local End of Life Care driving forces<br>• Introduction to the Six Steps to Success programme<br>• Change management<br>• Audit cycle<br>• Roles and responsibilities of Care Home Representative<br>• Commencement of a Care Home End of Life Policy | • Six Step Quality Marker Pre Audit<br>• Knowledge, Skills and Confidence Audit of Care Home Representative<br>• Post Death Information Audit<br>• Understanding of the driving forces for end of life care<br>• Commencement of policy with production of a philosophy for end of life care |

| Time | Workshop | Title | Main content | Outcomes to be achieved from workshop |
|---|---|---|---|---|
| | Step 1 | Discussions as the end of life approaches | • There is a system in place for identifying residents in the last year of life<br>• Identifying residents at the end of life<br>• All identified residents and their families are involved in discussions around end of life care to the extent they so wish<br>• Continuing the progression of the Care Home End of Life Policy and Six Steps Portfolio | • Recognise residents who are end of life using the North West Model/Tool<br>• Implementation of an End of Life Care Register in practice<br>• Regular team meetings to assess and review all residents<br>• Increased communication with health and social care<br>• Action Plan on how to implement advance care planning in the care home<br>• Progression of Care Home End of Life Policy and collation of evidence for Six Step Portfolio |

| Time | Workshop | Title | Main content | Outcomes to be achieved from workshop |
|---|---|---|---|---|
| | Step 2 | Assessment, care planning and review | • Holistic assessment<br>• Mental Capacity Act<br>• Advance care planning<br>• Collaborative working<br>• Continuing the progression of the Care Home End of Life Policy and Six Steps Portfolio<br><br>Full day workshop to follow Step 2 and before Step 3 to include; Communication Skills, Advance Care Planning (ACP), Mental Capacity Act (MCA) Advance Decision to Refuse Treatment (ADRT), Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Lasting Powers of Attorney (LPA) and Best Interest Decisions | • Holistic assessment of all residents<br>• Assessment of residents mental capacity<br>• Organise awareness sessions to introduce advance care planning<br>• Progression of Care Home End of Life Policy and collation of evidence for Six Step Portfolio |

| Time | Workshop | Title | Main content | Outcomes to be achieved from workshop |
|---|---|---|---|---|
| | Step 3 | Co-ordination of care | • Communication systems<br><br>• Identification of the role of the key worker<br><br>• Anticipated needs at end of life<br><br>• Continuing the progression of the Care Home End of Life Policy and Six Steps Portfolio | • Improving relationships with wider health and social care professionals<br><br>• Improved communication with transfers in and out of the care home<br><br>• Nominated key worker in place for each resident approaching the end of life<br><br>• There are systems in place to respond rapidly to changes in circumstance as the end of life approaches i.e. anticipatory prescribing and obtaining equipment<br><br>• Obtain a list of chemists and other providers that stock end of life care drugs 24/7<br><br>• Obtain referral criteria and referral forms for key professionals to support end of life care<br><br>• Use of the North West End of Life Care Checklist<br><br>• Progression of Care Home End of Life Policy and collation of evidence for Six Step Portfolio |

| Time | Workshop | Title | Main content | Outcomes to be achieved from workshop |
|---|---|---|---|---|
| | Step 4 | Delivery of high quality care in care homes | • Access to support services<br>• Review training needs of staff<br>• Dignity<br>• Environment<br>• Significant event analysis<br>• Continuing the progression of the Care Home End of Life Policy and Six Steps Portfolio | • Contact list of support services to the care home 24/7<br>• Develop training and education plan<br>• Knowledge of any local education available<br>• Implementation of Dignity Champions<br>• Raise the awareness of how the environment impacts on care delivery<br>• Explore hospital transfer Information<br>• Regular significant event analysis<br>• Progression of Care Home End of Life Policy and collation of evidence for Six Step Portfolio |

| Time | Workshop | Title | Main content | Outcomes to be achieved from workshop |
|---|---|---|---|---|
| | Step 5 | Care in the last days of life | • Diagnosing dying<br>• Use of the Liverpool Care Pathway for the dying patient<br>• Care of relatives, significant others, staff and other residents<br>• Religious, Cultural and Spiritual Care<br>• Continuing the progression of the Care Home End of Life Policy and Six Steps Portfolio<br>Full day workshop to address Liverpool care Pathway Training | • Implementation of the Liverpool Care Pathway for the dying patient<br>• There is a system in place for involving families and significant others in some aspects of the care giving and in discussions as death is approaching<br>• There is a system in place to record any particular religious, spiritual and/or cultural needs identified and recorded as part of the end of life planning<br>• Processes are in place to review all transfers into and out of the care home for residents approaching the end of life. Guidance on reducing hospitalisations<br>• Progression of Care Home End of Life Policy and collation of evidence for Six Step Portfolio |

| Time | Workshop | Title | Main content | Outcomes to be achieved from workshop |
|---|---|---|---|---|
| | Step 6 | Care after death | • Care after death for the deceased resident, families and significant others including staff and other residents<br>• Grieving process<br>• Verification and Certification of death<br>• Continuing the progression of the Care Home End of Life Policy and Six Steps Portfolio | • Last Offices guidance<br>• Guidance on how the home supports bereaved relatives and other residents<br>• Post Death Information audit to be completed since commencement of the programme<br>• Progression of Care Home End of Life Policy and collation of evidence for Six Step Portfolio |
| | Conclusion | Way forward | • Audit<br>• Completion of the Care Home End of Life Policy and Six Steps Portfolio<br>• Future support | • Post Programme Knowledge, Skills and Confidence Audit<br>• Post programme Six Step Quality Marker Audit<br>• Post Death Information Audit Report<br>• Dates for future care home forums to be agreed<br>• Continuation of regular audits<br>• Care Home End of Life Policy and completed of Six Step Portfolio of evidence |

# Induction work plan

**Time:** Half day
**Aim:** To commence the Six Steps to Success programme

**Objectives:** By the end of the session the Care Home Representative will be able to:
- Identify the National, Regional and Local end of life care drivers
- Understand the programme
- Commence the audit process
- Have an understanding of their role and responsibilities
- Commence an End of Life Care Policy.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and icebreaker | • Welcome the group and inform them of house keeping arrangements | | • Listen |
| | | • Introduce self | | |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Lead Icebreaker activity | • Prepared icebreaker | • Take part in icebreaker |
| | | • Capture ground rules on a flip chart | • Flip chart and pens | • Agree ground rules |
| | | • Display objectives of the day | • Objectives outlined on work plan above | • Listen |

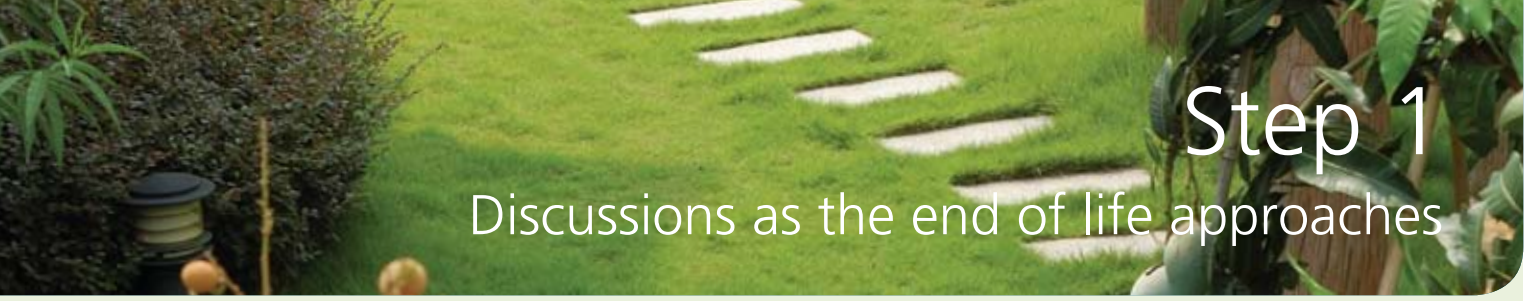
| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | National, Regional and Local end of life care driving forces | • Lecture on National, Regional and Local end of life care drivers – Must include a definition of end of life care | • PowerPoint presentation<br>• Laptop<br>• Projector<br>• **Support sheet 5 and 7** | • Listen<br>• Question and answers |
| | Introduction to the Six Steps to Success programme | • Walk through 'The *Route to Success in End of Life Care- Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) | • **The *Route to Success in End of Life Care- Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010)** | • Listen<br>• Question and answers<br>• Follow the Routes to Success page by page |
| | | • Walk through the overview of the Six Steps to Success, The North West End of Life Care for Care Homes programme | • **Six Steps to Success The North West End of Life Care Home programme overview** | • Follow the Six Steps to Success overview |
| | | • Hand out the Six Steps to Success Portfolio, and Care Home End of Life Policy Template, one per care home | • **Six Step to Success Portfolio** | • Read the portfolio headings |
| | | • Inform Care Home Representatives to bring the Six Steps to Success Portfolio and Care Home End of Life Policy Template to each workshop so ongoing work can be recorded<br>• Explain the workshops will guide and support the Care Home Representative to complete the Care Home End of Life Policy and Six Steps to Success Portfolio | • **Care Home End of Life Policy Template** | |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Change Management | • Brief lecture on change management theory | • PowerPoint presentation<br>• Laptop<br>• Projector | • Listen<br>• Question and answers |
| | | • Divide into groups and ask to consider how change has been implemented in the care home i.e. infection control, dignity, Investors in people | • Flip chart<br>• Pens | • Discussion<br>• Prepare feedback on flip chart<br>• Feedback to the group |
| | Audit Cycle | • Brief lecture on the audit cycle | • PowerPoint presentation<br>• Laptop<br>• Projector | • Listen<br>• Questions and answers |
| | | • Distribute and explain the Knowledge, Skills and Confidence Audit Form | • **Knowledge, Skills and Confidence Audit Form** | • Complete the Knowledge, Skills and Confidence Audit Form |
| | | • Distribute and explain the Pre Programme Six Steps Quality Marker Audit Form | • **Pre Programme Six Steps Quality Marker Audit Form** | • Complete the Pre programme Six Steps Quality Marker Audit Form |
| | | • Distribute and explain the Post Death Information Audit Form capturing residents who have died within the previous six months | • **Post Death Information Audit Form** | • Read and agree to complete before next workshop |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Role and responsibilities of care home representative | • Divide a sheet of flipchart paper into six and add the Six Steps headings (template on CD) explain to the group these are the headings to guide completion of their policy<br><br>• Divide into 3 groups:<br>1 The resident<br>2 The family<br>3 The care home worker<br><br>• Distribute post it notes to each group<br><br>• Ask the group to capture on the post it notes "What is a good death?" from the group headings perspective<br><br>• Ask each group to place their post it notes on the flip chart in the relevant step<br><br>• Allocate two of the steps to each group and ask them to capture what their roles and responsibilities are as a care home representative in relation to the post it notes<br><br>• Hand out Roles and Responsibilities Handout<br><br>• Summarise the discussions, link together elements of a good death, the steps and the Care Home Representatives roles and responsibilities | • **Flip chart sheet** divided into six with each section identifying a step<br><br>• Post it notes<br><br>• Pens<br><br>• **Roles and responsibilities of care home representatives'** | • Work through what is a good death in allocated group Capture on post it notes elements of a good death in relation to the group heading<br><br>• Place post it notes on the flipchart under the relevant step<br><br>• Feedback the roles and responsibility in relation to the allocated steps<br><br>• Listen<br>• Question and answers<br><br>• Record key elements of a good death onto the Care Home End of Life Care Policy Template |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | • End of Life Care policy | • Ask each care home to produce a philosophy for End of Life Care Policy Template based on the last exercise | • Care Home End of Life Care Policy Template | • Discuss and record End of Life Care philosophy on the Care Home End of Life Care Policy Template |
| | • Way forward | • Give out Induction To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions. Remind the group to put collected evidence in their Six Steps to Success Portfolio<br>• Advise Care Home Representatives to store the To Do List in the Six Step to Success Portfolio and bring the Six Step to Success Portfolio and End of Life Care Policy to each workshop<br>• Facilitator to advise and support care homes to engage with GP's and the wider team to improve communication, information sharing and engage in supporting the programme<br>Inform the group to bring their completed Post Death Information Audit Form (of deaths in the last six months) to the next Workshop | • **Induction To Do List** | • Complete Induction To Do List |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | • Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br>• Collect in completed evaluation forms<br>• Confirm date, time and venue of next meeting<br>• Close | • Objectives as displayed at beginning of workshop<br>• **Evaluation Form** | • Review objectives<br>• Complete Evaluation Form<br>• To be recorded on Induction To Do List |



# Step 1

## Discussions as the end of life approaches

Not all care home residents are in the last year of life. The first step on the route to success is about identifying residents who are thought to be in their last year of life so that discussions around end of life care and advance care planning can be initiated.

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 1.1<br>There is a policy or action plan developed within the care home for end of life care | • Staff are aware of the care homes action plan and have contributed and agreed content | • Care Home End of Life Policy | 5.1 |
| 1.2<br>There is a system in place for identifying residents in the last year of life | • Staff understand the 'surprise question' (Department of Health, 2009) and, based on their knowledge of the resident, are able to identify those that may be in the last year of life<br>• Staff are able to recognise and record when a resident's signs and symptoms have increased or his/her condition has deteriorated<br>• Staff are able to take into account triggers such as a recent hospital admission or change from a residential home setting to requiring nursing care<br>• Staff are able to use the North West End of Life Care Tool to aid identification of advancing disease, increasing decline and last days of life | • Use of the North West Model to identify residents who may be in the last year of life<br>• The care home has an End of Life Care Register<br>• Documentation in resident's notes<br>• Example of North West End of Life Care Tool used in practice | 5.3 |

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 1.3<br>All identified residents and their families are involved in discussions around end of life care to the extent they so wish | • Staff are able to identify the appropriate time to open discussions about end of life care<br>• Staff are confident to recognise opportunities to open discussions with residents and their families on end of life care<br>• Staff are able to provide any relevant information that may be required by the resident or their family<br>• Staff are able to recognise communication barriers because of dementia, learning difficulties or other health related impairments | • All residents and families to be made aware of the opportunity to have an advance care planning discussion when appropriate<br>• Policy or guidance on how advance care planning will be implemented in the home<br>• Example of literature used to inform residents and family of end of life care, for example, 'Planning for your future care. A guide' or disease specific information<br>• Appropriate strategies are in place to support communication, for example, a picture board<br>• List of staff who have received Mental Capacity Act training<br>• Regular audit of numbers of residents with a written record of their wishes and preferences for end of life care<br>• Evidence of deceased resident's notes assessing involvement of relatives in end of life care decisions | 5.2<br>5.6 |

**Time:** Half day
**Aim:** The care home representative will identify residents who are entering the last year of life so discussions on end of life care can take place at the appropriate time

**Objectives:** By the end of the session the Care Home Representative will be able to:
- Identify how the North West End of Life Care Model and Tool supports an End of Life Care Register
- Identify when is the appropriate time to undertake end of life care discussions considering capacity and communication barriers
- Develop further the Care Home End of Life Care Policy.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and review | • Welcome the group and inform them of house keeping arrangements<br>• Introduce self | | • Listen |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Display ground rules from Induction workshop | • Ground rules from Induction Workshop | • Listen |
| | | • Display and share objectives of the day | • Flip chart<br>• Pens | • Listen |
| | | • Review of Induction workshop (identify care homes that have not provided any evidence in their Six Step Portfolio from the last Workshop) | • Completed Induction To Do List (held by each care home representative)<br>• Six Step Portfolio (Care Home Copy) | • Feedback on actions from Induction To Do List |
| | | • Collect Post Death Information Audit Form (of deaths in the last six months) and explain to the group to continue completing Post Death Information Audit Forms for future deaths, to be collected in Step 6 (Give out Post Death Information Audit forms to capture data) | • **Post Death Information Audit Form** | • Hand in Post Death Information Audit Form (of deaths in the last six month) |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction to Step 1 | • Ensure all Care Home Representatives have own copy of The *Route to Success in End of Life Care -Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) | • **The Route to Success in End of Life Care-Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010** | • Read through Step 1 of the *Route to Success in End of Life Care-Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | What system needs to be in place to identify residents in the last year of life? | • Divide into groups and give each group the North West Model and the blank North West Tool<br>• 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**<br>• **North West Tool** | • Record group discussion on North West Tool stage 1, 2 and 3 |
| | | • Facilitate feedback | • **North West Tool Facilitator Guide** | • Feedback to whole group |
| | | • Hand out three case studies (long term condition/ dementia/cancer) to each group | • **Step 1 Case Studies** | • Listen |
| | | • Hand out North West Register<br><br>Ask the groups:<br>*"Can you identify where each case study would be on the North West End of Life Care Register"?* | • **North West End of Life Care Register** | • Discuss case studies and record on the North West End of Life Care Register under the appropriate phase. (Use the Prognostic Indicator Guidance (GSF 2008) and the Surprise question) |
| | | Consider the following:<br>*Prognostic Indicator Guidance* (GSF 2008),Surprise question, North West Tool | • **Prognostic Indicator Guidance** (GSF 2008)<br>• **Surprise question** | |
| | | • Facilitate a discussion on the implementation of the North West End of Life Care Register in practice<br><br>Points to consider:<br>Cascading *information to all staff, regular team review*<br><br>Advise the group, Step 3 covers the actions required to support residents at each stage of the North West Model | | • Discussions on completing and implementing the register in practice |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Involving residents and their families in discussions around end of life care | • Lead a discussion based on the case studies to identify triggers to indicate when it would be appropriate to open discussions with residents and their families on end of life care. Record response on flip chart<br><br>Points to consider:<br>*Are you certain you know whether a resident does or does not wish to have a conversation about their future care?*<br>*(Not compulsory)*<br><br>*Discuss some of the issues that may arise relating to relatives being involved and how to address this*<br><br>*Does your resident have the mental capacity to make an informed choice?*<br><br>*How can you facilitate end of life care discussions with residents who may have fluctuating capacity or communication difficulties? Discuss aids and approaches*<br><br>*What currently happens in practice* | • Flip chart<br>• Pens<br><br>• **Step 1 Case Studies**<br><br>• **Planning for your future care. A guide**<br><br>• **NCPC Mental Capacity Act Guide**<br><br>• **Best Interests at End of Life (2008)**<br><br>• **Support sheet 12 and 13** | • Discussion<br><br>• Share current care home practice |
| | End of Life care Policy | • Ask each care home to look at the End of Life Care Policy Template addressing Step 1<br>Points to include:<br>Identification of residents in last year of life, appropriate time to undertake end of life care discussions and implementation of register | • End of Life Care Policy Template (Brought back from each Workshop) | • Record on the End of Life Care Policy Template they have brought with them |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Way forward | • Give out template Step 1 To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions. Remind the group to put collected evidence in their Six Step to Success Portfolio<br><br>• Advise care home representatives to store the To Do List in the Six Step to Success Portfolio and bring the Six Step to Success Portfolio and the Care HomeEnd of Life Policy to each Workshop<br><br>Inform the group to bring assessment tools used in practice to the next workshop | • **Step 1 To Do List** | • Complete Step 1 To Do List |
| | Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br><br>• Collect in completed evaluation forms<br><br>• Confirm date, time and venue of next meeting<br><br>• Close | • Objectives as displayed at beginning of workshop<br><br>• **Evaluation Form**<br><br>• Step 1 To Do List | • Review objectives<br><br>• Complete Evalation Form<br><br>• To be recorded on Step 1 To Do List |

# Step 2

## Assessment, care planning and review

The second step on the route to success is about the early assessment of a resident's needs and wishes as they approach the last year of life. The aim is to establish their preferences and choices as well as identify areas of unmet need. It is important to explore the physical, psychological, social, spiritual, cultural and environmental needs and wishes of each resident.

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 2.1<br>There is a system in place to discuss, record and communicate the wishes and preferences of those approaching the end of life | • Staff are able to undertake an holistic assessment for end of life care needs and preferences in partnership with residents and, where appropriate, their relatives and friends | • Completed care plan showing holistic assessment | 5.3 |
| | • Staff are able to explore and respond sensitively to the social, psychological, cultural and spiritual needs and wishes of residents as well as their physical care needs and, where appropriate, their environmental needs | • Information on cultural and spiritual needs of residents who are End of Life<br>• Evidence of tools used, for example, HOPE (spiritual assessment) and Hospital Anxiety Depression Scale (depression assessment)<br>• Checklist of equipment that may be required for comfort (i.e. profiling bed) | |
| | • Staff will identify, record and respond to resident's personal wishes and preferences<br>• Staff will be able to share information with the wider Primary Healthcare and Social Care Teams (with permission or best interest decision). This may include an Advance Care Plan (ACP), Advance Decision to Refuse Treatment (ADRT) and Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR) in an appropriate format | • Environmental assessment<br>• Policy or template in place to discuss, record and communicate those wishes and preferences (Advance Care Planning)<br>• Examples of documentation used to share information, for example, Out of Hours Proforma<br>• Contact list of other services which may be required to support the home and resident | |

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 2.2<br>The need's of residents are assessed and reviewed on an ongoing basis | • Staff understand the 'surprise question' (Department of Health, 2009) and, based | • Written evidence of regular review of needs as death approaches, including if any changes in desired place of death or Advance Decision to Refuse Treatment | 5.3 |

**Time:** Half day

**Aim:** The care home representative 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 Care Home Representative will be able to:
- Recognise the importance of holistic care planning
- An awareness of assessing a residents mental capacity
- Produce an action plan to implement a system to support advance care planning
- Develop further the Care Home End of Life Care Policy.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and review | • Welcome the group and inform them of house keeping arrangements<br>• Introduce self | | • Listen |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Display ground rules from Induction Workshop | • Ground rules from Induction Workshop | • Listen |
| | | • Display and share objectives of the day | • Flip chart<br>• Pens | • Listen |
| | | • Review of Step 1 Workshop (identify care homes that have not provided any evidence in their Six Step to Success Portfolio from the last workshop) | • Completed Step 1 To Do List (held by each care home representative)<br>• Six Step to Success Portfolio (Care Home Copy) | • Feedback on actions from Step 1 To Do List |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction to Step 2 | • Ensure all care home representatives have own copy of The Route to Success in End of Life Care-Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010) | • **The Route to Success in End of Life Care-Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010** | • Read through Step 2 of the Route to Success in *End of Life Care-Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) |
| | Holistic assessment | • Lecture on what is holistic assessment<br><br>• Facilitate a discussion on current assessment tools used in the care home. Introduce examples of assessment tools<br><br>• Divide into four groups:<br>1. Physical<br>2. Psychological<br>3. Spiritual<br>4. Social<br><br>• Distribute Step 2 case study and template step 2 care plan to each group. Ask each group to discuss care planning from their group heading perspective, in relation to the case study, and record on the care plan<br><br>• Facilitate feedback from each group | • PowerPoint presentation<br>• Laptop<br>• Projector<br><br>• **Holistic common assessment of supportive and palliative care needs for adults requiring end of life care 2010**<br><br>• Assessment tools e.g. Hope / Hospital anxiety and Depression scale/ Abbey/ Visual Analogue Scale/ 2 stage test for mental capacity<br><br>• **Step 2 case Study**<br><br>• **Step 2 care plan** | • Listening<br><br>• Question and answers<br><br>• Group to share examples of assessment tools used in practice as requested in Step 1<br><br>• Read group case study<br><br>• Complete allocated section of care plan<br><br>• Feedback to group<br><br>• Listen and have a plan to implement any new assessment tools |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Assessing mental capacity | • Ask the group:<br>*Have you considered how you might holistically assess a resident who struggles to communicate, perhaps because of dementia or stroke?*<br><br>*Are they aware of the 2 stage test to assess mental capacity within the holistic assessment process*<br><br>• Define Advance Care Planning and Best Interest Decision Making | • **Two Stage Test of Capacity**<br><br>• **Best Interest Document**<br><br>• **Support Sheet 4, 12 and 13** | • Discussion on what processes the care homes have in place to assess mental capacity<br><br>• Listen |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | System to support advance care planning | • Facilitate a discussion on what the care homes currently do in practice to assess, record and communicate a residents wishes and preferences. This may include an Advance Decision to Refuse Treatment and/or Do Not Attempt Cardio Pulmonary Resuscitation statement<br><br>• Facilitate a discussion on how to raise awareness about the possibility of expressing personal wishes and preferences with residents and families | • Flip chart<br>• Pens<br><br>• **Planning for your future care, A guide**<br><br>• **Advance Care Planning: A Guide for Health and Social Care Staff**<br><br>• **Support sheet 3 and 4** | • Feedback<br><br>• Discuss ideas on raising awareness and how to plan a residents and relatives meeting on advance care planning |
| | Collaborative working in relation to Advance Care Planning<br><br>Reassessment and review | • Draw a spider diagram on flip chart and ask the group to identify the Health and Social Care Professionals who maybe involved in a residents care at end of life<br><br>• Divide into groups and ask the following:<br>"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 North West End of Life care Register<br><br>• Save spider diagram for workshop 3 | • Flip chart<br>• Pens<br><br>• **North West End of Life Care Register** | • Group to record a plan of how they will offer advance care planning within their care home<br><br>• Listen, discuss and feedback |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | End of Life Care policy | • Ask each care home to look at the Care Home End of Life Policy Template addressing Step 2<br>Points to include:<br>Holistic assessment, assessing mental capacity and advance care planning within the home | • Care Home End of Life Policy Template (Brought back from each Workshop) | • Record on the Care Home End of Life Policy Template that they have brought with them |
| | Way forward | • Give out template Step 2 To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions. Remind the group to put collected evidence in their Six Step Portfolio<br>• Advise Care Home Representatives to store the To Do List in the Six Step Portfolio and bring the Six Step Portfolio and Care Home End of Life Policy to each workshop | **Step 2 To Do List** | • Complete Step 2 To Do List |
| | Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br>• Collect in completed evaluation forms<br>• Confirm date, time and venue of next meeting<br>• Close<br>Full day workshop to follow Step 2 and before Step 3 to include; Communication Skills, Advance Care Planning (ACP), Mental Capacity Act (MCA) Advance Decision to Refuse Treatment (ADRT), Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Lasting Powers of Attorney (LPA) and Best Interest Decisions | • Objectives as displayed at beginning of workshop<br>• **Evaluation Form** | • Review objectives<br>• Complete Evaluation form<br>• To be recorded on Step 2 To Do List |

# Step 3
## Co-ordination of care

The third step is about co-ordinating services. Once a care plan has been agreed it is important that all the services required are effectively co-ordinated. A lack of co-ordination can mean a resident's needs and preferences are not met.

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 3.1<br>There is a robust communication system in place to ensure all staff members and external health and social care professionals are fully informed of the plan of care | • A member of staff is identified within the home that can develop strong working relationships with those key professionals who may be needed to meet the end of life care plan, for example, Specialist Palliative Care Team, District Nurses, General Practitioners, Community Matrons and chemists<br><br>• Staff have a record of all key contacts across the provider services, voluntary bodies and social care sector<br><br>• Staff are able to access appropriate documentation to refer to other services for support and advice to inform General Practitioners, District Nurses, Out of Hours Services and Specialist Palliative Care Team of changes in resident's status | • Identified member of staff<br><br>• List of contacts with referral criteria and referral forms available of all key health professionals<br><br>• List of local chemists stocking end of life care drugs required for anticipatory prescribing<br><br>• Evidence of communication with Out of Hours services, for example, General Practitioners, District Nurses and the Ambulance service | 5.2 |

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 3.2<br>There is a nominated key worker for each resident approaching the end of life | • Staff have a good understanding of the role of the key worker and implement accordingly | • Documentation showing all residents identified as end of life have a named key worker<br>• Audit of the proportion of residents identified as end of life with a documented key worker<br>• Evidence of how the key worker has acted as the link between services | 5.4 |
| 3.3<br>There are systems in place to respond rapidly to changes in circumstances as end of life approaches | • Staff will know who their key contacts are across the provider services and how to access<br>• Staff are able to idetify those residents with a prognosis of weeks and anticipatory drug prescribing is addressed<br>• The resident has been assessed for any specialist equipment they may require (i.e. syringe driver) | • Evidence of referral within the resident's case notes<br>• Evidence that anticipatory prescribing has been addressed<br>• North West End of Life Care Checklist | 5.3 |

## **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 Care Home Representative will be able to:
- Recognise the importance of sharing information with the wider multidisciplinary team
- Define the role of a Key Worker
- Identify the appropriate time to request anticipatory prescribing of End of Life Care medication and equipment
- Develop further the Care Home End of Life Care Policy.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and review | • Welcome the group and inform them of house keeping arrangements<br>• Introduce self | | • Listen |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Display ground rules from Induction Workshop | • Ground rules from the Induction Workshop | • Listen |
| | | • Display and share objectives of the day | • Flip chart<br>• Pens | • Listen |
| | | • Review of Step 2 Work-shop (identify care homes that have not provided any evidence from the last workshop in their Six Step to Success Portfolio) | • Completed Step 2 To Do' list (held by each care home representative)<br>• Six Step to Success Portfolio (Care Home Copy) | • Feedback on actions from Step 2 To Do List |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction to Step 3 | • Ensure all Care Home Representatives have own copy of The Route to Success in End of Life Care - Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010) | • **The Route to Success in End of Life Care -Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010** | • Read through Step 3 of the Route to Success in End of Life Care -Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010) |
| | Commun-ication Systems | • Present spider diagram from Step 2 Workshop<br>• Divide into groups and ask them to discuss referral to the identified professionals on the spider diagram 24/7<br>• Facilitator to source local information i.e 24 hour ad-vice line, referral criteria and referral forms<br>Facilitate discussions on how care homes can access information about residents i.e. are they on the GP End of Life Care Register, can they access medical information to support their care | • Spider diagram (from Step 2 Workshop)<br>• **Support Sheet 1**<br>• Flip chart<br>• Pens<br>• Examples of OOH forms, copies of referral criteria and referral forms for services, | • Listen<br>• Discuss<br>• Feedback<br>• Listen |
| | Care Home End of Life Care Checklist | • Facilitator to distribute the Care Home End of Life Care Checklist and explain its use in practice, walking through each stage of the checklist to ensure the needs of residents in the last year of life are met | • **Care Home End of Life Care Checklist** | • Discussion |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Key Worker | • Facilitate a group discussion to identify the role of a key worker<br><br>Points to consider:<br>*Regular review of residents needs, communicating with resident, relatives and health and social care professionals, link between services for a designated resident*<br><br>• Listen to the feedback and continue with group discussions if any responsibilities omitted<br><br>• Direct the group to record the designated key worker on the Care Home End of Life Care Register | • Flip chart<br>• Pens<br><br>• **Support sheet 10 and 14**<br><br>• **Key Worker Policy Cancer Network**<br><br>• **Care Home End of Life Care Register** | • Discuss and record the responsibilities of a key worker<br><br>• Feedback<br><br>• Read |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Anticipatory prescribing and equip-ment | • Facilitate discussions on what happens currently in practice in relation to anticipatory prescribing | • Flip chart<br>• Pens | • Discuss |
| | | • Distribute Step 3 case study | • **Step 3 Case Study** | |
| | | • Ask in pairs to discuss appropriate timings regard-ing anticipatory prescribing and equipment in relation to Step 3 case study | | • Discuss case study |
| | | • Facilitate Feedback | | • Feedback |
| | | • Ask the full group what system are in place to obtain end of life drugs 24/7 | | • Feedback |
| | | • Facilitator to source local guidance on anticipatory prescribing. If local guid-ance is unavailable ask the group to develop | • **Local policy on accessing End of Life Care drugs and equipment 24/7** (Source locally) | • Review local guidance or develop guidance on anticipatory prescribing and equipment |
| | | • Source information on chemists who stock end of life care drugs | • **List of local chemists stocking End of Life Care drugs required for anticipa-tory prescribing** (Source locally) | • Listen |
| | | • Highlight on the North West End of Life Care Checklist the appropriate time to request anticipatory medication | • **North West End of Life Care Checklist** | |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Care Home End of Life Policy | • Ask each care home to look at the Care Home End of Life Policy Template addressing Step 3<br>Points to include:<br>*Collaborative working, implement the key worker system, anticipatory prescribing and obtaining necessary equipment* | • Care Home End of life Policy Template (Brought back from each Workshop) | • Record on the Care Home End of Life Policy Template that they have brought with them |
| | Way forward | • Give out template Step 3 To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions. Remind the group to put collected evidence in their Six Step to Success Portfolio<br>• Advise Care Home Representatives to store the To Do List in the Six Step to Success Portfolio and bring the Six Step to Success Portfolio and Care Home End of Life Policy to each workshop | • **Step 3 To Do List** | • Complete Step 3 To Do List |
| | Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br>• Collect in completed evaluation forms<br>• Confirm date, time and venue of next meeting<br>• Close | • Objectives as displayed at beginning of workshop<br>• **Evaluation Form** | • Review objectives<br>• Complete Evaluation Form<br>• To be recorded on Step 3 To Do List |

# Step 4

## Delivery of high quality care in care homes

Residents and their families may need access to a complex combination of services across a number of different settings. Step 4 on the route to success is about the delivery of high quality care and the expectation that residents should receive the same level of care regardless of whether they live independently at home or in a care home.

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 4.1<br>How to access a combination of complex services 24/7 | • Staff will be aware of who and how to contact services with an understanding of the appropriate information required | • Contact list and example of use<br>• Examples from care notes of evidence of accessing appropriate services for the individual resident<br>• Hospital and other settings transfer information | 5.12 |
| 4.2<br>There is a process in place to identify the training needs of all workers especially those involved in discussing end of life care with residents, families and carers | • Staff will have access to end of life care training<br>• Staff will have an awareness and understanding of end of life care principles and values<br>• Staff will be able to consider the environment in which end of life care and support are delivered, for example, facilities for relatives<br>• Staff will be aware of internal or external training and support for End of Life Care including e-learning | • Documentary evidence of an educational needs analysis<br>• All staff to have access to training including:<br>- Communication Skills<br>- Advance Care Planning<br>- Liverpool Care Pathway<br>• Evidence of relevant training<br>• Evidence of provision, for example, statements, photos, and thank you letters. Reflections from staff on environment DVD<br>• List of providers of relevant education to support end of life care within their locality | 5.3 |

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 4.3<br>The environment within the care home offers privacy, dignity and respect for individuals, families as end of life approaches | • Staff will demonstrate how the environment offers privacy, respect and dignity for the resident<br><br>• Staff will be able to support residents to maintain their maximum levels of independence, choice and control as long as possible | • The care home has a dignity policy<br><br>• The home has a nominated dignity champion<br><br>• Evidence of how the environment provides privacy, dignity and respect for residents<br><br>• Documented evidence in care plans showing residents choices and wishes are respected<br><br>• Evidence of how choice and independence has been maintained for residents in relation to the Mental Capacity Act (2005) | 5.2 |

## **Time:** Half day
## **Aim:** Achieve high quality care in care homes

**Objectives:** By the end of the session the Care Home Representative will be able to:
- Identify a training plan for all staff in End of Life Care
- Identify how to access a complex combination of services across different settings
- Develop further the Care Home End of Life Care Policy.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and review | • Welcome the group and inform them of house keeping arrangements<br>• Introduce self | | • Listen |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Display ground rules from Induction Workshop | • Ground rules from Induction Workshop | • Listen |
| | | • Display and share objectives of the day | • Flip chart<br>• Pens | • Listen |
| | | • Review of Step 3 Workshop (identify care homes that have not provided any evidence from the last workshop in their Six Step to Success Portfolio) | • Completed Step 3 To Do list (held by each care home representative)<br>• Six Step to Success Portfolio (Care Home Copy) | • Feedback on actions from Step 3 To Do List |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction to Step 4 | • Ensure all Care Home Representatives have own copy of *The Route to Success in End of Life Care -Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) | • **The Route to Success in End of Life Care -Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010** | • Read through Step 4 of the *Route to Success in End of Life Care -Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) |
| | Complex combination of services across a number of different settings | • Facilitate a group discussion on their experiences of various end of life scenarios which have occurred out of hours<br>• Record on flip chart the frequent challenges raised<br>• Using the feedback ask the group how they could minimise the distress for residents? | • Flip chart<br>• Pens | • Discuss<br>• Feedback<br>• Discuss |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Education and training of staff | • Facilitate a discussion on the following question:<br>*How can all care home staff access relevant end of life care training? (internal/external)* | | • Discussion<br>• Listen<br>• Question and answers |
| | | Facilitator to have sourced any relevant end of life care local education or training available and distribute to the group. Education may include the following:<br>*Principles of Palliative Care*<br>*Communication skills*<br>*Assessment and care planning*<br>*Mental Capacity Act*<br>*Advance care planning*<br>*Symptom management*<br>*Comfort and wellbeing*<br>*Dignity*<br>*Liverpool Care Pathway*<br>*Syringe Driver*<br>*Verification of Death*<br>*Bereavement and Loss*<br>*Tribal Training*<br>*Skills for Health*<br>*Foundations in Palliative Care (Macmillan Pack)*<br>*E-learning relevant to end of life care*<br>*Higher Education Courses* | • Information on all training available (Source locally) | |
| | | • Ask the group how they are going to identify training needs of all staff | | • Discuss how they are going to assess training needs within the Care Home |
| | | • Distribute Knowledge, Skills and Confidence Audit Form | • **Knowledge, Skills and Confidence Audit Form** | |
| | | • Facilitate feedback | | |
| | | • Divide into groups and give each group a flip chart sheet. Ask them to produce a training plan for end of life care to include all of their staff | • Flip chart<br>• Pens | • In groups produce a training plan for End of Life Care |
| | | • Facilitate feedback | | • Feed back completed product to large group |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Dignity | • Show the RCN dignity DVD and facilitate feedback using the handbook | • **RCN Dignity Pack**<br>• **Support Sheet 6** | • Watch DVD<br>• Discuss |
| | Environment | • Show the National End of Life Care Programme Environment DVD | • **National End of Life Care Programme Environment DVD**<br>• **Support Sheet 15** | • Watch DVD<br>• Discuss |
| | Care Home End of Life policy | • Ask each care home to look at the Care Home End of Life Policy Template addressing Step 4<br>Points to include:<br>*Services across settings 24/7*<br>*Education and training needs*<br>*Dignity*<br>*Environment* | • Care Home End of life Policy Template (brought back from each Workshop) | • Record on the Care Home End of Life Policy Template that they have brought with them |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Way forward | • Give out Step 4 To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions. Remind the group to put collected evidence in their Six Step to Success Portfolio<br>• Advise Care Home Representatives to store the To Do List in the Six Step to Success Portfolio and bring the Six Step to Success Portfolio and the End of Life Policy to each Workshop<br>Ask the group to bring literature they use in practice to support relatives, friends and significant others when residents are at end of life to the next workshop | • **Step 4 To Do List** | • Complete Step 4 To Do List |
| | Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br>• Collect in completed evaluation forms<br>• Confirm date, time and venue of next meeting<br>• Close | • Objectives as displayed at beginning of workshop<br>• **Evaluation Form** | • Review objectives<br>• Complete Evaluation Form<br>• To be recorded on Step 4 To Do List |

# Step 5
## Care in the last days of life

The point comes when the resident enters the dying phase. It is vital that staff recognise the person is dying and take the appropriate action. How someone dies remains a lasting memory for relatives, friends and care staff involved.

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 5.1 Processes are in place to review all transfers into and out of the care home for residents approaching the end of life. | • Staff are able to ensure the resident's views, rights and preferences are considered and the choices they make are supported as much as possible<br>• Staff will be confident to act as the residents advocate if admission to hospital would be inappropriate in the dying phase<br>• Staff will be able to participate in a significant event analysis to help provide constructive feedback to support continuous practice | • The home has guidance on reducing inappropriate hospital admissions within their end of life care policy<br>• Audit of hospital transfers and deaths since commencement of the programme, including place of death<br>• Documentation by care homes of patients who are appropriately transferred and admitted to hospital, with the date of transfer, the date of return to the care home and the date of death<br>• Communication between care home and the acute sector to facilitate rapid discharge home<br>• Local Do Not Attempt Cardiopulmonary Resuscitation guidance/policy if available<br>• Examples of an anonymous significant event analysis and completed action plan | 5.1<br>5.8<br>5.12 |

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 5.2 Residents who are dying are entered onto a care pathway | • Staff are able to recognise the resident's condition is deteriorating and are aware of the changes that may occur in a resident's condition during the dying phase | • Documented evidence of a team decision that residents have entered the dying phase and all reversible causes have been considered | 5.5 |
| | • General Practitioner review initiated and all end of life care drugs are addressed | • Photocopy of an anonymous prescription showing end of life care drugs | |
| | • Staff will implement the Liverpool Care Pathway in collaboration with the Primary Health Care Team | • Liverpool Care Pathway training is undertaken by all staff | |
| | | • Liverpool Care Pathway anonymised documentation | |
| | | • Syringe driver policy available | |
| | | • Analysis of Post Death Information Audit Form | |
| | • Staff will be able to have open discussions to ensure relatives are fully informed of patients status and use of Liverpool Care Pathway | • Documented evidence that an advance care plan review has been undertaken | 5.2 |
| | • Where possible, staff will aim to prevent the resident from dying alone | | |
| | • Staff are aware of any specific wishes or preferences identified by the resident at this time | | |

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 5.3<br>There is a system in place for involving families and significant others in some aspects of the care giving and in discussions as death is approaching | • Staff will be able to support relatives by providing, where possible, accommodation, meals and emotional support | • Guidance for staff on supporting relatives and significant others<br>• Documented evidence from Liverpool Care Pathway involving families and significant others in end of life care and decisions<br>• Examples of supporting literature available i.e. leaflets | 5.6 |
| 5.4<br>There is a system in place to record any particular spiritual or cultural needs identified and recorded as part of the end of life care planning | • Staff will have knowledge of the specific needs of various cultures and religions when caring for someone who is at the end of life<br>• Staff will have an understanding of the concept of spirituality<br>• Staff will anticipate and be prepared for any specific religious, spiritual or cultural needs a resident may require | • Information available showing different cultural requirements<br>• Contacts of spiritual leaders relevant to the care homes locality | 5.2<br>5.3 |

## **Time:** Half day
## **Aim:** It is recognized the resident is entering the last days of life, and best practice is provided

**Objectives:** By the end of the session the Care Home Representative will be able to:
- Recognise the difference between an appropriate and inappropriate hospital admissions at end of life
- Recognise the point when the resident enters the dying phase
- Review advance care planning documents when the Liverpool Care Pathway is implemented
- Have an understanding of the use of the Liverpool Care Pathway document
- Know how to care for relatives, significant others, staff and other residents with dignity when a resident enters the dying phase
- Develop further the care home End of Life Care policy.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and review | • Welcome the group and inform them of house keeping arrangements<br>• Introduce self | | • Listen |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Display ground rules from Induction Workshop | • Ground rules from Induction Workshop | • Listen |
| | | • Display and share objectives of the day | • Flip chart<br>• Pens | • Listen |
| | | • Review of Step 4 Workshop (identify care homes that have not provided any evidence from the last workshop in their Six Step to Success Portfolio) | • Completed Step 4 To Do List (held by each care home representative)<br>• Six Step to Success Portfolio (Care Home Copy) | • Feedback on actions from Step 4 To Do List |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction to Step 5 | • Ensure all Care Home Representatives have own copy of The *Route to Success in End of Life Care-Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) | • **The *Route to Success in End of Life Care -Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010** | • Read through Step 5 of the Route to Success in End of Life Care -Achieving Quality in Care Homes (National End of Life Care Programme Improving end of life care DoH, 2010) |
| | Decision making on appropriate/ inappropri-ate hospital admissions | • Divide group and give out Significant Event Analysis Template | • **Significant Event Analysis Template** | • Group discussion on a case study and work through a significant event analysis |
| | | • Ask the group to work through a case study of a recent death of a resident who died in hospital<br><br>Points to consider:<br>*Did the resident die in the appropriate setting?*<br><br>*Was it the setting of their choice?*<br><br>*Have any specific wishes or preferences been identified by the resident/family to add to clinical discussions?* | • Case studies provided by group<br><br>• **999 Poster** | • Discuss case study and record using the Significant Event Analysis Template |
| | | • During feedback identify what would support decision making at the end of life:<br>*Advance Care Planning*<br>*Out of Hours handover*<br>*GP review*<br>*Holistic assessment*<br>*Communication with acute sector* | • Flip chart<br>• Pens | • Discussion and feedback |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Diagnosing dying and when to use the Liverpool Care Pathway (or alternative) | • Lecture<br><br>Address signs and symptoms of the dying resident, consider the impact of different diseases | • PowerPoint presentation<br>• Laptop<br>• Projector | • Listen<br><br>• Question and answer |
| | | • Facilitate a discussion on the appropriate action to take when recognising dying and how this relates to the Care Home End of Life Care Checklist | • **Care Home End of Life Care Checklist** | • Discuss |
| | | • Record feedback on flip chart<br><br>Points to consider:<br>*DNACPR*<br>*Review of Advance Care Plan*<br>*Nutrition/hydration*<br>*Communication Family an Professional*<br>*GP review* | • **Flip chart**<br>• **Pens** | • Feedback |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Care of relatives, friends and significant others | • Facilitate a discussion on how the care homes currently care for relatives, friends and significant others at this time<br><br>Points to consider:<br>*Transport*<br>*Accommodation*<br>*Meals*<br>*Emotional support*<br>*Possessions*<br><br>• Provide local literature to support relatives, friends and significant others | • **Support sheets 8 and 9**<br><br>• Local Literature to support relatives, friends and significant others | Discuss Feedback<br><br>• Review local literature and care home literature to support relatives, friends and significant others |
| | Religious, Cultural and Spiritual Care | • Lecture<br><br>• Points to consider:<br>Different faiths, belief and spiritual needs pre and post death | • PowerPoint presentation<br>• Laptop<br>• Projector | • Listen<br>• Question and answers |
| | Care Home End of Life Policy | Ask each care home to look at the Care Home End of Life Policy Template addressing Step 5<br>Points to include:<br>*Decreasing inappropriate hospitalisations*<br>*Cultural and Spirituality needs*<br>*Dignity*<br>*Environment* | • Care Home End of Life Policy Template (Brought back from each Workshop) | • Record on the Care Home End of Life Policy Template that they have brought with them |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Way forward | • Give out template Step 5 To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions. Remind the group to put collected evidence in the Six Step to Success Portfolio<br>• Advise Care Home Representatives to store the To Do List in the Six Step to Success Portfolio and bring the Six Step to Success Portfolio and the Care Home End of Life Policy to each Workshop | • **Step 5 To Do List** | • Complete Step 5 To Do List |
| | Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br>• Collect in completed evaluation forms<br>• Confirm date, time and venue of next meeting<br>• Close<br>Full day workshop after Step 5 and before Step 6 to include training on the Liverpool Care Pathway | • Objectives as displayed at the beginning of the workshop<br>• **Evaluation Form** | • Review objectives<br>• Complete Evaluation Form<br>• To be recorded on Step 6 To Do List |

# Step 6
## Care after death

Good end of life care does not stop at the point of death. The support and care provided for relatives will help them cope with their loss and is essential for achieving a "good death". It is also important for staff, many of whom will become emotionally connected to the resident.

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 6.1 Systems are in place for providing good practice for the care and viewing of the body | • Staff will demonstrate an awareness of best practice in the after care of the deceased resident | • Protocol for Last Offices | 5.1 |
| 6.2 Systems are in place to provide appropriate information and support to relatives, significant others and staff post bereavement | • Staff will openly acknowledge that a resident has died and will provide residents, staff and relatives the opportunity to pay their respects in their own way<br>• Staff will be aware of the grieving process and bereavement policy and support relatives accordingly<br>• Staff will be aware of verification and certification policies and procedures<br>• The home will provide a comfortable environment in which staff can feel supported to discuss or share feelings as needed | • The care home has a bereavement policy<br>• Contact numbers of bereavement support agencies<br>• Evidence of support the home provides for bereaved relatives<br>• Evidence of leaflets used, for example, 'What to do after a death?, grieving leaflet<br>• Trained staff to obtain verification of expected death training if available and linked to local policy.<br>• Evidence of significant event analysis following death/s<br>• Staff support | |

| Topic | Measures | Evidence for Six Steps Portfolios | Quality markers |
|---|---|---|---|
| 6.3<br>Other residents are supported following a death in a care home | • Staff will be able to recognise and support the needs of other residents following a death<br>• Staff will be able to recognise that a resident's death may be more significant to some than others and they may require additional support<br>• Staff will be able to obtain bereavement counselling for residents if required | • Evidence of how the home provides staff, residents and relatives with the opportunity for remembrance and to show their respect<br>• Documented evidence of support offered to grieving residents in case notes<br>• Example of leaflets given with contact numbers | 5.7 |
| 6.4<br>The quality of end of life care is sustained, audited, and reviewed | • Staff will collaborate with members of the Primary Health Care Team to continually audit pathways<br>• Quality end of life care is sustained within the home | • Completed Six Steps Quality Marker Audit Forms (pre and post programme)<br>• Results from Care Home Post Death Information Audit Report<br>• Knowledge, Skills and Confidence Audit<br>• Evidence of Care Home Representative attendance at Care Home Forum<br>• New staff induction includes the Six Steps to Success programme principles | 5.8 |

**Time:** Half day
**Aim:** Provide excellent support and care after death

**Objectives:** By the end of the session the Care Home Representative will be able to:
- Identify good practice for the deceased resident (Last Offices)
- Give practical support and information to families, significant others, staff and other residents
- Respect individual faiths and beliefs to address individual wishes
- Have an action plan to implement a bereavement policy.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and review | • Welcome the group and inform them of house keeping arrangements<br>• Introduce self | | • Listen |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Display ground rules from Induction Workshop | • Ground rules from Induction Work-shop | • Listen |
| | | • Display and share the objectives of the day | • Flip chart<br>• Pens | • Listen |
| | | • Review of Step 5 Workshop (identify care homes that have not provided any evidence in their Six Step to Success Portfolio from the last workshop) | • Completed Step 5 To Do List (held by each care home representative)<br>• Six Step Portfolio (Care Home Copy) | • Feedback on actions from Step 5 To Do List |
| | | • Collect Post Death Information Audit Forms (of ongoing deaths as requested in Workshop 1). Explain to the group to continue completing Post Death Information Audit Forms for future deaths, to be collected by local arrangements.<br>• Analyse post death information and prepare a report for each care home in preparation for the Conclusion Workshop | **Post Death Information Audit Form** | • Hand in Post Death Information Audit Forms completed since Workshop 1 |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction to Step 6 | • Ensure all Care Home Representatives have own copy of *The Route to Success in End of Life Care-Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) | ***The Route to Success in End of Life Care - Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010** | • Read through Step 6 of the *Route to Success in End of Life Care - Achieving Quality in Care Homes* (National End of Life Care Programme Improving end of life care DoH, 2010) |
| | Care after death for the deceased resident, families, significant others, staff and other residents | • Divide into three groups:<br>1. Resident<br>2. Families and Significant Others<br>3. Other Residents<br><br>Ask each group to discuss care after death in relation to their group heading include cultural and spiritual needs, possessions and Last Offices<br><br>Please Consider:<br>*Have the relatives been provided with appropriate support material?*<br><br>*Do mechanisms exist to support non-family members, such as staff, other residents and friends, who may also be affected by death?*<br><br>• Facilitate feedback | • Flip chart<br>• Pens<br><br>• Support sheet 9<br><br>• Leaflet: *'What to do after a death in England and Wales'(or other information material*<br><br>• Suggestion to invite local funeral director | • Discuss<br><br>• Feedback to the whole group |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Grieving process | • Lecture on theory(s) of grief<br>- Normal Grief<br>- Abnormal grief<br>- When to refer to the appropriate services<br><br>• Source information on local bereavement support services | • PowerPoint presentation<br>• Laptop<br>• Projector<br><br>• Handout on local bereavement support services with contact details (Source Locally) | • Listen<br><br>• Questions and answers<br><br>• Read |
| | Verification of expected death and certification of death | • Lecture to identify the difference and responsibilities between verification of expected death and certification of death<br><br>• Signpost to verification of expected death training if available and supported by local policy | • PowerPoint presentation<br>• Laptop<br>• Projector<br><br>• Verification of expected death policy (Source locally) | • Listen<br><br>• Question and Answers<br><br>• Read |
| | Care Home End of Life Policy | • Ask each care home to look at the Care Home End of Life Policy Template addressing Step 6<br><br>Points to include:<br>*Last Offices, Verification of expected death and Certification of death. Care after death for the deceased resident, Family, significant others, staff and other residents*<br><br>Ask Care Home Representatives to produce their completed Six Step Portfolio in the established care home policy format and bring to the Conclusion Workshop | • Care Home End of Life Policy Template (Brought back from each Workshop) | • Record on the Care Home End of Life Policy Template that they have brought with them |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Way forward | • Give out Step 6 To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions. Remind the group to put collected evidence in their Six Step to Success Portfolio<br>• Advise Care Home Representatives to store the To Do List in the Six Step Portfolio and bring the Six Step Portfolio and the End of Life Policy to each Workshop | • **Step 6 To Do List** | • Complete Step 6 To Do List |
| | Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br>• Collect in completed evaluation forms<br>• Confirm date, time and venue of next meeting<br>• Close | • Objectives as displayed at the beginning of the workshop<br>• **Evaluation Form** | • Review objectives<br>• Complete Evaluation form<br>• To be recorded on Step 6 To Do List |

# Conclusion work plan

**Time:** Half day
**Aim:** To evaluate if the North West Six Steps to Success programme has been implemented in practice

**Objectives:** By the end of the session the Care Home Representative will be able to:
- Describe the End of Life Care Policy implemented within the individual care home
- Analyse audit figures
- Understand the importance of a completed portfolio and demonstrate its contents
- Demonstrate, through the completed portfolio, that they have fulfilled their roles and responsibilities.

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

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Introduction, welcome and Review | • Welcome the group and inform them of house keeping arrangements<br>• Introduce self | | • Listen |
| | | • Take a register of attendance | • **Attendance Register** | • Complete attendance register |
| | | • Display and share the ground rules from Induction Workshop | • Flip chart from Induction Workshop displaying ground rules | • Listen |
| | | • Display and share the objectives of the day | • Flip chart<br>• Pens | • Listen |
| | | • Review of Step 6 Workshop (identify care homes that have not provided any evidence in their Six Step to Success Portfolio from the last workshop) | • To Do List from Step 6<br>• Six Step to Success Portfolio (Care Home Copy) | • Feedback on actions from step 6 To Do List |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Audit | • Distribute Post Programme Six Steps Quality Marker Audit Form | • **Post Programme Six Step Quality Marker Audit Form** | • Complete Post Programme Six Steps Quality Marker Audit Form |
| | | • Distribute the Knowledge, Skills and Confidence Audit Form | • **Knowledge, Skills and Confidence Audit Form** | • Complete Knowledge, Skills and Confidence Audit Form |
| | | • Distribute the analysis from the Post Death Information Audit Forms to each care home | Individual care home Post Death Information Report (to be prepared locally) | • Read |
| | | • Facilitate a group discussion on Post Death Information Audit findings | | • Discuss findings<br>• Read and discuss |
| | | • Facilitate a discussion on the groups experience implementing the programme in practice addressing how they have fulfilled their end of life care role and responsibilities | • **Role and Responsibilities of the Care Home Representative** | |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Portfolio of evidence | • Walk through each step in the Six Step to Success Portfolio of evidence, discuss the examples of evidence to be included. | • The Six Step to Success Portfolio of evidence (Care Home Copy)<br>• **Six Steps to Success The North West End of Life Care Home programme overview** | • Each individual care home to bring their Six Step to Success Portfolio of evidence<br>• Follow each step and discuss evidence provided to meet the outcome required |
| | Care Home End of Life Policy | • Ask each care home to present their Care Home End of Life Policy<br>• Identify care homes that do not have a completed Six Step Portfolio and arrange further support | • Care Home End of Life Policy (Brought back from each Workshop) | • Present Care Home End of Life Policy |
| | Way forward | • Give out template Conclusion To Do List and ask individuals to complete how they will achieve the printed actions and add any further actions | • **Conclusion To Do List** | • Complete Conclusion To Do List |

| Time | Topic | Facilitators activities | Resources | Group activity |
|---|---|---|---|---|
| | Revisit objectives, evaluation and close | • Check with the group the objectives have been met<br>• Collect in completed evaluation forms<br>• Confirm date, time and venue of next meeting<br>• Close<br>• Consider using this opportunity to present a certificate to Care Home Representatives who have attended all the workshops and a certificate to the care homes who have completed their portfolio of evidence and implemented the Six Step programme | • Objectives as displayed at the beginning of the workshop<br>• **Evaluation Form** | • Review objectives<br>• Complete Evaluation form<br>• To be recorded on Conclusion Workshop To Do List |

## References

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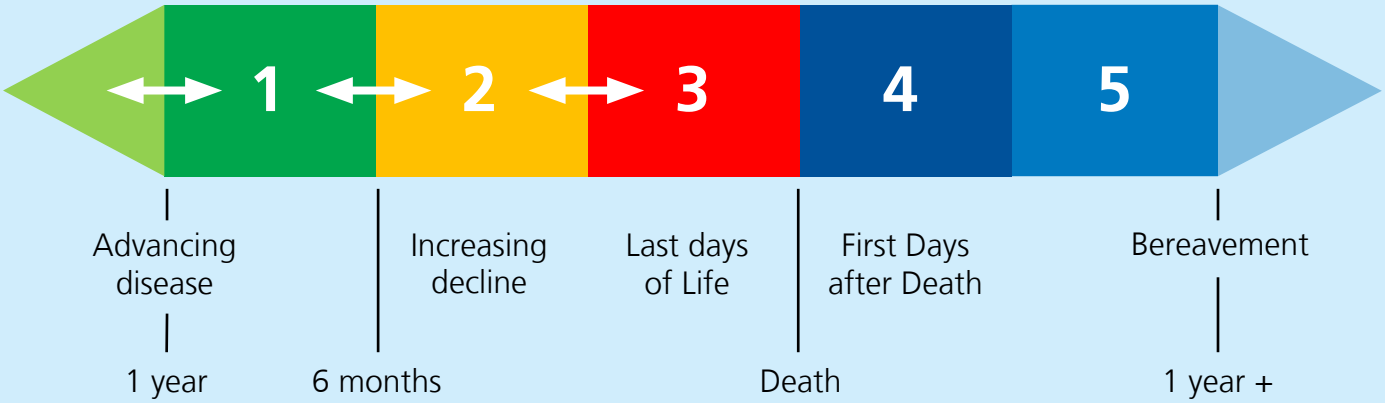
## The North West End of Life Care Model

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:-




The model comprises five phases as described below with some examples of practice highlighted:

1 **Advancing disease** – timeframe 1 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** – timeframe 6 months [approximate]. 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** – timeframe 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 Liverpool Care Pathway (LCP) implemented

4 **First days after death** – timeframe first few days. Examples of practice required include prompt verification and certification of death, relatives being given information on what to do after a death (including DWP1027 leaflet), how to register the death and how to contact funeral directors

5 **Bereavement** – timeframe 1 year or more. Examples of practice required include access to appropriate support and bereavement services if required.

NHS

Cumbria and Lancashire
End of Life Care Network

NHS

National End of Life
Care Programme

Merseyside and Cheshire NHS
Cancer Network

Greater Manchester and Cheshire
Cancer Network NHS

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