Six Steps to Success

End of Life Domiciliary Care Programme
For the Organisation
Handbook
This handbook includes the work plans required to support the delivery of the Six Steps to Success organisational change programme to domiciliary care agencies. There is a full programme overview which outlines the content of the workshop and outcomes to be achieved.

There is a work plan for each workshop as a guide for facilitators.

Domiciliary care organisations should supply or be provided with a Six Steps to Success file to collect workshop content and evidence personal development and implementation into practice.

The Six Steps to Success programme may be used as underpinning knowledge for End of Life Care qualifications (unit/award/certificate) on the Qualification Credit Framework (see Appendix 1).

- Level 2 Award in Awareness of End of Life Care
- Level 3 Award in Awareness of End of Life Care
- Level 3 Certificate in working in End of Life Care
- Level 5 Certificate in Leading and Managing Services to Support End of Life Care and Significant Life Events

In addition, Knowledge and evidence within the programme may also support the Qualification and Credit Framework (QCF) units within level 2 and level 3 diploma mandatory units.

In order to ensure this evidence is acceptable, educators and facilitators delivering the Six Steps Programme should work in partnership with accredited assessment centres that are registered with awarding organisations. Only assessors registered with these centres can confirm that the evidence produced does support the learning outcomes and assessment criteria within the core units. Contact your local Further Education College or end of life care qualification learning provider to discuss this further.

Permission is given to use and adapt this programme but please reference the original source. Amending may affect the mapping against the Qualification Credit Framework.
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Foreword

Since the launch of the National End of Life Care Strategy in 2008, followed by ‘Supporting People to Live and Die Well: a framework for social care at the end of life’ in 2010, there has been increasing recognition of the vital role that domiciliary care providers, their managers and staff have in providing good quality end of life care support for people in their own homes. Over 400,000 domiciliary care workers are now employed in England to support more adults and older people with complex health and social care needs in a diverse service sector that is recognisable from what it was twenty years ago. Domiciliary care staff regularly supports people on a daily basis, often over an extended period of time, providing personal care. They build close relationships with service users and families, and often care for people who live alone and are isolated. In doing so they can provide an important link to the outside world and local community networks. They have a central role as part of a multi-disciplinary team alongside community nurses and other professionals in delivering personalised packages of care and support. As more people have the opportunity to make informed choices about receiving end of care in their own homes their role will continue to be vital in providing end of life care support.

With support from the National End of Life Care Programme and the development of regional and local partnerships across health and social care the ‘Routes to Success Guide and Six Steps to Success Programme for Domiciliary Care’ has addressed the training requirements in this sector and has proved to be effective in supporting domiciliary care providers in two main areas: developing a policy structure in their organisations for making sustainable improvements in end of life care; and giving staff and managers the opportunity to attend development programmes that have equipped them with the right knowledge and skills to deliver good quality end of life care. The National End of Life Care Programme, through its work with end of life care facilitators in the regions, has been able to document significant benefits to this approach. Managers and staff in the sector have been able to reflect on the way end of life care is delivered, contribute to the wider service improvement agenda and develop confidence in their care and support roles.

This new guide now builds on the learning, research and success of recent years about ‘what works well’ in end of life care domiciliary care training to now extend its coverage. This will ensure more sustainable and far reaching improvements, supported by accredited courses in end life care. There is also confidence that these programmes can be extended to personalised packages of support where service users have opted to employ personal assistants.

Importantly the guide also provides a working example of a future model of service improvement as we move forward with the health and social care reforms. This is because it has comprehensively harnessed the shared interests, talents and commitment of health and social care staff across a wide range of disciplines in putting personalised support, dignity and compassion at the centre of end of life care. We wish providers and staff every success when using this guide.

Rick O Brien  
Social Care Lead, National End of Life Care Programme

Margaret Holloway  
Social Care Lead, National End of Life Care Programme  4/2/2013
The pathway to quality end of life care

**Step 1**
Discussions as the end of life approaches
- Open, honest communication
- Identifying triggers for discussion.

**Step 2**
Assessment, care planning and review
- Agreed care plan and regular review of needs and preferences
- Assessing needs of carers.

**Step 3**
Co-ordination of care
- Strategic co-ordination
- Co-ordination of individual care
- Rapid response services.

**Step 4**
Delivery of high quality care in different settings
- High quality care provisions in all settings
- Acute hospitals, community care homes, extra care housing hospices, community hospitals, prisons, secure hospitals and hostels
- Ambulance services.

**Step 5**
Care in the last days of life
- Identification of the dying phase
- Review of needs and preferences for place of death
- Support for both the individual and carer
- Recognition of wishes regarding resuscitation and organ donation.

**Step 6**
Care after death
- Recognition that end of life care does not stop at the point of death
- Timely verification and certification of death or referral to coroner
- Care and support of carer and family, including emotional and practical bereavement support.
“Individuals have a right to receive high quality and dignified care to meet their needs at the end of life, we need to be ready – knowledgeable, skilled and confident to respond as necessary to their wishes and preferences”
Kay, Domiciliary Care Worker

“Often the domiciliary teams can be overlooked in their role in end of life care. This programme is welcomed and much needed”
Domiciliary Care Manager

“Ensuring domiciliary care workers are supported with training and development, particularly in such a complex and emotive area is vital in achieving success of high quality end of life care within the community setting, their roles must be recognised as significantly contributable in end of life care”
Sarah, Trainer / Facilitator

“Completing this programme has increased my knowledge, skills and confidence on how best to support a person in end of life care, in their own home”
Jennie, Domiciliary Care Worker

“My mother received care for several years from a domiciliary care organisation. When she deteriorated, it was important to us that she continued with support from the same domiciliary care workers, who worked with the other multi-disciplinary teams to ensure continuity and professionalism was preserved. Mum’s wish to die with dignity, in her own home – with her family and possessions around her was important to us all”
Relative

“The only crumb of comfort I have is that my wife died at home, where she wanted to... with dignity, choice, control and comfort”
Relative

“I just want to die in my own home with my own things around me - my family, my pets – familiarity and dignity. It’s the last choice I can make so I rely on others to support me and ensure that happens, particularly when I can’t speak for myself”
Peggy, Individual/User of Services
Introduction

This service improvement programme supports Domiciliary Care organisations to implement structured organisational change required to deliver the best end of life care based on the National End of Life Care Programme Guidance (2011) – The Route to Success in end of life – achieving quality in domiciliary care.

Once the programme has been implemented there is a further Six Steps Programme available to support the organisations’ care workers to develop knowledge, skills and confidence to deliver the best possible standard and quality of end of life care for individuals choosing to stay in their own homes at the end of life.

The programme is based on six key workshops as follows:

| 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 domiciliary care |
| Step 5: Care in the last days of life |
| Step 6: Care after death |

Education within the programme includes Advance Care Planning, communication skills and care of the dying patient. The programme is also flexible to include any other education, theory and underpinning knowledge, for example symptom management, dependent upon participant need.

Further embedded within the programme is the supportive underpinning knowledge for the Skills for Care end of life care qualifications (unit, award, certificate). Participants may also undertake further qualifications, with additional registration and assessment requirement.


The programme is a collaborative project with Cheshire and Merseyside Palliative & End of Life Care Network, Greater Manchester & Cheshire Cancer Network, Cumbria & Lancashire End of Life Care Network, Cheshire Hospices Education, Wirral Metropolitan College.

The Domiciliary Care (organisation) programme has been adapted from the Six Steps to Success End of Life Care Programme for care homes by: Lyne Partington, Deputy Director of Education, Cheshire Hospices Education, St Luke’s Hospice, Cheshire.

The Domiciliary Care (workforce) programme has been adapted by: Sarah Hodson, Trainer & Assessor, Wirral Metropolitan College.

Acknowledgements

Kathy Pantelides
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Elaine Horgan
Greater Manchester, Lancashire & South Cumbria Strategic Clinical Network & Senate
Rick O’Brien
National End of Life Care Programme
Implementation of the Six Steps to Success Programme (Organisation)

The programme has been developed to be inclusive of all domiciliary care settings (including extra care housing).

The pre programme implementation plan should always consider sustainability.

Points to consider:
- Ensure the nominated delegate has the authority to implement change within the organisation.
- Engagement and agreement from local authorities and CCG’s.
- Raising awareness within health and social care.
- Consider what integrated working will look like in practice within the locality.
- On-going support and dissemination of information to the organisations post programme e.g. End of Life Care Forums.
- On-going collection and analyses of Post Death Information Audits.

The length of time it takes to deliver the programme is flexible and dependent on each local area, e.g. 3½ - 4 hours monthly for the organisations. The programme Facilitator may assess and insert realistic timings and comfort breaks in relation to the group size. The Facilitator has licence to use their professional judgment in the content and delivery of the workshops, ensuring the measures from the programme are achieved at all times. Adapting the programme may affect the mapping against the Qualification Credit framework (QCF). The Facilitator should try and integrate local policies and guidance into the programme as much as possible.

The workshops always start with an overview from the Route to Success guide to ensure the representatives understand their role in delivering high quality end of life care.

The workshops conclude with a ‘To Do’ list for the representatives to action before attending the next workshop. Facilitators will be able to identify at the earliest opportunity organisations that require extra support from reviewing progress on the ‘To Do’ list.

Within each workshop the organisation has the opportunity to develop an end of life care policy based on the content of the workshop.

The resource column identifies the resources available to support the programme in bold. The PowerPoint Presentations are reference only as a suggested way of delivering sessions and facilitators may adapt accordingly.

It is suggested the organisations are given an agreed timeframe to embed the programme and complete the portfolio of evidence e.g. 3-6 months.

To promote organisational change and ensure there is management support for end of life care it is advisable to deliver the Six Steps to Success Programme (Organisation) before the Six Steps to Success Programme (Workforce).
Some tips and hints for setting up the Six Steps Domiciliary Care Organisation Programme

1. Take time to find out and understand the role and work of Domiciliary Care Organisations. They have new and emerging roles to play in End of Life Care which may vary from area to area, so it’s worth finding out how they function and what their roles are in specific areas.

2. Work collaboratively with others. Think about who Domiciliary Care Organisations already engage with and gain support and input for the programme. This may include Social Services, GPs, GP practices and community nurses, Specialist Palliative Care teams as well as others. Let others know about the programme before it starts.

3. Introduce core concepts around End of Life Care especially at the beginning of the programme. Many aspects may be familiar to those in health care or working regularly in End of Life Care, but for others, the terms, language and approaches may be new knowledge.

4. Support the Organisations to make the programme their own. Encourage them to identify both their strengths and areas for development and take what they need from the programme. In-house education can be made available to the specific needs of each Organisation.

5. Use the policy and portfolio as working tools. They should be able to be used by the Organisations for their own purposes at the end of the programme to provide evidence of their development. Likewise, the audits are not just there for ‘number crunching’, but to help to identify gaps in practice and evidence positive changes.

6. Recognise that the Six Steps Domiciliary Care Organisational Programme may feel like putting a jigsaw puzzle together. It may not make sense until some of the pieces have been slotted together and it might be several ‘Steps’ until the bigger picture becomes clear.

Be prepared to learn as you go along and develop your own tips and hints.
Additional Resources for the Six Steps (Organisation) Programme

Recruitment guidance and resources
Resources below and within the Work Plans can be accessed by double clicking the bold text.

Guidance for facilitators
This document provides guidance for facilitators on recruitment, implementation of the programme and guidance for evaluating the organisation's portfolio.

Recruitment flyer
This flyer can be used in the recruitment process to provide information to prospective organisations and the wider multidisciplinary team. There is space to add your local details.

Invitation letter to domiciliary care organisations
This letter provides an overview of the programme and can be used to invite organisations to a local information event. There is space to add your local information and can be adapted to meet your needs.

Presentation
This presentation provides an overview of the programme and the drivers behind it.

Attendance Register

Application form
This form is given to organisations to register their interest in the programme. Facilitators can add their local details.

Participation criteria
The Six Steps to Success Programme will be open to most organisations however it does ask for full support from the organisation and collaboration in the audit processes. This document outlines the minimum participation criteria and should be signed by each party before joining the programme. Facilitators can add local criteria if required.

Roles and responsibilities of the domiciliary care organisations representative
This document outlines the roles and responsibilities and should be made available to any prospective representatives.

Health and social care communication
This letter can be used by the organisation to inform health and social care colleagues of the programme.

Resource list
Download or order to support delivery of the programme.
Six Steps to Success Audits

In this section you will find the guidance and tools required to undertake the three key audits that are distributed, collected and analysed over the course of the programme.

- Quality Markers and Measures Audit
- Knowledge, Skills and Confidence Audit
- Post Death Information Audit

Quality Markers and Measures Audit

The Quality Markers and Measures Audit allows the domiciliary care organisation and facilitator to monitor how the end of life care delivery fits with the outcomes of the Six Steps to Success Programme and the National End of Life Care Quality Markers and Measures (DH 2009) Audit tools have been developed to allow data collection and analysis pre and post programme of the representative and the cohort.

Quality Markers and Measures Audit Tool Guidance (Individual Organisation and Cohort)

This document provides an overview of the Quality Markers and Measures Audit which is undertaken by each organisation pre and post programme. It also contains instructions on how to use the audit tool which has been developed to support the collection and analysis of the audit results of a single organisation and cohort.

Quality Markers and Measures Audit Tool Pre programme – paper version

Quality Markers and Measures Audit Tool Post programme – paper version

The two documents above are the pre and post programme parts of the audit tool in a format which can be printed and completed by hand.

Quality Markers and Measures Audit Analysis Tool (Individual)

This tool has been developed to support the collection and analysis of the data collected from each individual organisation.

Quality Markers and Measures Audit Analysis Tool (Cohort)

This tool has been developed to allow the analysis of a cohort of organisations to give an indication of how the cohort has developed over the course of the programme according to the Quality Markers and Measures.
Knowledge, Skills and Confidence Audit

The Knowledge, Skills and Confidence Audit has been designed so that data can be collected from each domiciliary care representative around their abilities across sixteen key areas of end of life care. The audit should assist in preparing feedback to the representatives and in developing reports to evaluate the implementation of the Six Steps to Success Programme. There are several audit tools which support collation and analysis of the data.

Knowledge, Skills and Confidence Analysis Audit Tool Guidance (Individual and cohort)
This document provides an overview of the Knowledge, Skills and Confidence Audit which is undertaken by each representative from the organisation at the beginning and end of the programme. The document also contains instructions on how to use the analysis audit tool which has been developed to support the collection and analysis of the audit results.

Knowledge, Skills and Confidence Audit Tool Pre Programme – paper version

Knowledge, Skills and Confidence Audit Tool Post Programme – paper version
The two documents above are the pre and post programme parts of the audit tool in a format which can be printed and completed by hand.

Knowledge, Skills and Confidence Audit Analysis Tool (Individual)
This spread sheet allows data entry of the information collated from the pre-programme and post-programme Knowledge, Skills and Confidence Audit (paper copy). Once the data is entered the tool will analyse and produce graphs for feedback for each individual. Information about the use of this tool can be found in the Knowledge, Skills and Confidence Analysis Audit Tool Guidance.

Knowledge, Skills and Confidence Audit Analysis Tool (Cohort)
This spread sheet will allow you to use the data collected from multiple domiciliary care representatives in the Knowledge, Skills and Confidence Audit Analysis Tool to quickly analyse a cohort of domiciliary care representatives to give an indication of how the cohort has developed over the course of the programme. This tool will use averages to analyse the knowledge, skills and confidence of cohorts.
Post Death Information Audit

It is important to capture post death information to demonstrate the effectiveness of the Six Steps to Success Programme and identify the outcomes of the programme have been met.

Pre programme the domiciliary care organisations are asked to collect information on the deaths of their last six service users. Throughout the programme the representatives continue to collect this information. The pre programme data should be analysed against six deaths post programme (after the organisations have successfully completed their portfolio of evidence). The facilitator should ensure there is a system in place to collect and analyse post programme information to ensure the programme is sustained and identify at the earliest opportunity those organisations that require further support.

It is important to capture this data to demonstrate the programme has been embedded and support sustainability. Several tools have been developed to support the collection and analysis of this information.

Post Death Information Audit Tool Guidance
This document provides guidance on the completion of the Post Death Information Audit and instructions on how to use the audit tool to provide analysis of the information collected from each domiciliary care organisation.

Post Death Information Pre Programme Audit Tool – paper version
Post Death Information Interim Audit Tool – paper version
Post Death Information Post Programme Audit tool – paper version

The three documents above are the pre, interim and post programme parts of the Post Death Information Audit Tool in a format which can be printed and completed by hand. The data collection forms should be completed each time a service user dies in order to gather vital information which can help identify any developments and challenges in the provision of end of life care.

Post Death Information Audit Tool
The audit tool has been developed to allow a comparison of pre programme deaths and post programme deaths. The analysis will help to highlight areas where the organisation has made improvements in the provision of end of life care and also areas where there may be challenges. Guidance on how to use this tool can be found in the Post Death Information Audit Tool Guidance.

Consideration should be given to how this audit is collected and analysed on an on-going basis post programme. This will enable facilitators to quickly identify those organisations who require further support.
### Overview of the Six Steps to Success Programme (Organisation)

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<tr>
<th>Workshop</th>
<th>Main Content</th>
<th>Outcomes to be achieved from workshop</th>
<th>Quality Markers No.</th>
<th>CQC Essential Standards Outcome No.</th>
<th>NICE Quality Standards for EoL Statement No.</th>
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<tr>
<td>Induction</td>
<td>• The driving forces for national, regional and local end of life care</td>
<td>• Understanding of the driving forces for end of life care</td>
<td>10</td>
<td>16</td>
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<td></td>
<td>• Introduction to the Six Steps to Success programme for Domiciliary Care Organisations</td>
<td>• Six Step Quality Marker Pre Audit</td>
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<td></td>
<td>• Change management</td>
<td>• Knowledge, Skills and Confidence Audit of Domiciliary Care Organisation Representative</td>
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<td>• Audit cycle</td>
<td>• End of Life Care Audit</td>
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<td>• Roles and responsibilities of the Domiciliary Care Organisation Representative</td>
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<td>• Commencement of a End of Life Care Policy for the Domiciliary Care Organisation</td>
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| Step 1 | Discussions as the end of life approaches | - There is a system in place for liaising with health and social care teams to identify individuals in the last year of life  
- Identifying individuals at end of life  
- A system to recognise whether all identified individuals and their families have been involved in discussions around end of life care and how these wishes are recorded  
- Supporting the role of health and social care teams in end of life discussions with individuals  
- *Continuing the progression of the Domiciliary Care Organisation End of Life Care Policy and Six Steps Portfolio* | - Recognise individuals who are at the end of life using the North West Model/Tool  
- Implementation of a system/record which identifies and records which individuals may be approaching end of life  
- Regular team meetings to assess and review all individuals  
- Increased communication with health and social care  
- Action plan on how to support advance care planning in the Domiciliary Care Organisation  
- *Progression of Domiciliary Care Organisation End of Life Care Policy and collation of evidence for Six Steps Portfolio* | 2  
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<td>Step 2 Assessment, care planning and review</td>
<td>• Holistic assessment in conjunction with health and social care teams &lt;br&gt; • Awareness of advance care planning in relation to individuals’ personal wishes and preferences &lt;br&gt; • Mental Capacity Act &lt;br&gt; • Advance Decision to Refuse Treatment, Do Not Attempt Cardiopulmonary Resuscitation &lt;br&gt; • Collaborative working &lt;br&gt; • <em>Continuing the progression of the Domiciliary Care Organisation End of Life Care Policy and Six Steps Portfolio</em></td>
<td>• Holistic assessment in conjunction with health and social care teams &lt;br&gt; • Increased awareness of advance care planning and the implications for individuals and domiciliary care staff &lt;br&gt; • Use of the North West End of Life Care Checklist &lt;br&gt; • Assessment of individuals’ mental capacity &lt;br&gt; • Regular Significant Event Analysis &lt;br&gt; • Progression of Domiciliary Care Organisation End of Life Care Policy and collation of evidence for Six Step Portfolio</td>
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<td>• Communication systems&lt;br&gt;• Communication skills and knowledge&lt;br&gt;• Co-ordination of Care&lt;br&gt;• Identification of the role of the key worker&lt;br&gt;• Continuing the progression of the Domiciliary Care Organisation End of Life Care Policy and Six Steps Portfolio</td>
<td>• Improving communications and relationships with health and social care professional and with individuals receiving care and support from the Domiciliary Care Organisation&lt;br&gt;• Review and develop systems to refer to other key professionals to support end of life care&lt;br&gt;• Contact list of available support services 24/7&lt;br&gt;• Nominated key worker (or review of existing key worker scheme) for each individual approaching the end of life&lt;br&gt;• Have systems in place to respond to changing needs&lt;br&gt;• Progression of Domiciliary Care Organisation End of Life Care Policy and collation of evidence for Six Step Portfolio</td>
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| Step 4 Delivery of high quality care in domiciliary care | • Anticipating needs at end of life (supports Step 3)  
• Access to support services  
• Review training needs of staff  
• Dignity  
• Environment  
• Support of family and significant others  
• Significant Event Analysis | • There are systems in place to respond rapidly to changes in circumstance as the end of life approaches i.e. increased care needs, complex care needs  
• Explore admissions to hospital at end of life  
• Develop Training and Education Plan  
• Knowledge of any local education available  
• Support and development of dignity champions  
• Raise the awareness of how the environment impacts on care delivery  
• Progression of Domiciliary Care Organisation End of Life Care Policy and collation of evidence for Six Step Portfolio | 6/7  
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| Step 5   | Care in the last days of life | • Recognising the changes that occur in the dying phase  
• Understanding the role of the Domiciliary Care Organisation during the final few days of life  
• Communicating with other health and care services  
• Care of family, significant others, staff and other individuals  
• Supporting Religious, Cultural and Spiritual needs  
• Knowledge regarding the care of the dying person and Syringe Pumps  
• Continuing the progression of the Domiciliary Care Organisation End of Life Care Policy and Six Steps Portfolio  
There is a system in place to support communication with other health and care services  
• 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  
• 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  
• Processes are in place to review all admissions to hospital for individuals approaching the end of life and enabling staff to support the individuals choice of place of care/death  
• Knowledge regarding the care of the dying person and Syringe Pumps  
• Progression of Domiciliary Care Organisation End of Life Care Policy and collation of evidence for Six Step Portfolio | 6  
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<tr>
<td>Step 6 Care after death</td>
<td>• Awareness of the processes following a death, such as verification and certification of death, contacting funeral directors, registration of death&lt;br&gt;• Care after death for the deceased individual, families and significant others including staff&lt;br&gt;• Awareness of the grieving process&lt;br&gt;• Continuing the progression of the Domiciliary Care Organisation End of Life Care Policy and Six Steps Portfolio</td>
<td>• Guidance around care of the individual following death&lt;br&gt;• Guidance on how the organisation supports bereaved relatives and staff&lt;br&gt;• Progression of Domiciliary Care Organisation End of Life Care Policy and collation of evidence for Six Step Portfolio</td>
<td>5</td>
<td>15</td>
<td>18</td>
</tr>
<tr>
<td>Workshop</td>
<td>Main Content</td>
<td>Outcomes to be achieved from workshop</td>
<td>Quality Markers No.</td>
<td>CQC Essential Standards Outcome No.</td>
<td>NICE Quality Standards for EoL Statement No.</td>
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</tr>
<tr>
<td>Conclusion Way forward</td>
<td>• Audit&lt;br&gt;• Completion of the Domiciliary Care Organisation End of Life Care Policy and Six Steps Portfolio&lt;br&gt;• Future support</td>
<td>• Post programme Knowledge, Skills and Confidence Audit&lt;br&gt;• Post programme Six Step Quality Marker Audit&lt;br&gt;• Domiciliary Care Organisation Post Death Information Audit Report&lt;br&gt;• Dates for future Domiciliary Care Organisation forums to be agreed&lt;br&gt;• Continuation of regular audits&lt;br&gt;• Domiciliary Care Organisation – End of Life Care Policy and Six Steps portfolio of evidence</td>
<td>8 10 10 10 10</td>
<td>25 16 16 16 16</td>
<td>15/16</td>
</tr>
</tbody>
</table>
Induction Work plan

**Time:**  Half day  
**Aim:** To commence the Six Steps to Success programme  
**Objectives:** By the end of the session, the End of Life Domiciliary Care Organisation Representative will be able to:  - Identify the National, regional and local end of life care drivers  - Understand the Six Steps for domiciliary care programme  - Commence the audit process  - Have knowledge 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

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator Activities</th>
<th>Resources</th>
<th>Group activity</th>
</tr>
</thead>
</table>
|      | Introduction, welcome and icebreaker | Welcome the group and inform them of housekeeping arrangements  
Introduce self  
Take a register of attendance  
Lead icebreaker activity  
Capture ground rules on a flipchart  
Display objectives of the day | Attendance Register  
Prepared ice breaker  
Flipchart/pens  
Objectives outlined on work plan above | Listen  
Complete attendance register  
Take part in ice breaker  
Agree ground rules  
Listen |
|      | 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  
Laptop  
Projector  
Support sheet 5  
Support sheet 7 | Listen  
Question and answers |
### Induction Work plan

<table>
<thead>
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</table>
|      | Introduction to the Six Steps to Success programme | Distribute and walk through ‘The Route to Success in End of Life Care-achieving quality in domiciliary care’ (NEoLCP 2011)  
Walk through the overview of the Six Steps to Success. The North West End of Life Care for Domiciliary Care Organisation programme  
Hand out a Six Steps to Success Portfolio, (see file insert/ dividers if needed) Portfolio Guidance and Domiciliary Care Organisation End of Life Policy Template (one per Domiciliary Care Organisation)  
Inform the Domiciliary Care Organisation Representatives to bring the Six Step to Success Portfolio and Domiciliary Care Organisation End of Life Care Policy Template to each Workshop so on-going work can be recorded  
Explain the Workshops will guide and support the Domiciliary Care Organisation Representative to complete the Domiciliary Care Organisation End of Life Care Policy and Six Steps to Success Portfolio of Evidence | The Route to Success in End of Life Care-achieving quality in domiciliary care (NEoLCP 2011)  
Six Steps to Success the North West End of Life Domiciliary Care Organisation Programme Overview  
Six Steps to Success Portfolio  
Front Insert for File Cover  
Portfolio Dividers  
Domiciliary Care Organisation Portfolio Guidance  
Facilitator Guidance for Portfolio Evaluation  
Domiciliary Care Organisation End of Life Policy Template | Read  
Listen  
Question and answers  
Follow the Route to Success page by page  
Follow the Six Steps to Success Overview  
Read |
<table>
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</thead>
<tbody>
<tr>
<td>Change</td>
<td>Management</td>
<td>Brief lecture on change management theory</td>
<td>PowerPoint Presentation</td>
<td>Listen</td>
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<tr>
<td></td>
<td></td>
<td>Divide into groups and ask to consider how change has been implemented in the Domiciliary Care Organisation i.e., Personalisation Agenda, Re-ablement, Dignity, Investors in People</td>
<td>Laptop Projector</td>
<td>Question and answers</td>
</tr>
<tr>
<td></td>
<td>Audit Cycle</td>
<td>Brief lecture on the audit cycle</td>
<td>PowerPoint presentation Laptop</td>
<td>Discussion</td>
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<tr>
<td></td>
<td></td>
<td>Explain the Pre Programme Knowledge, Skills and Confidence Audit</td>
<td>Projector</td>
<td>Prepare feedback on flip chart</td>
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<td>Explain the Pre Programme Six Steps Quality Marker Audit</td>
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<td>Feedback to the group</td>
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<td></td>
<td></td>
<td>Explain the Pre Programme Post Death Information Audit capturing the last 6 individuals who have died. Request completion and bring to next workshop</td>
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<td></td>
<td></td>
<td>NB. Consider providing links to the audits (either on-line or agree to send excel versions)</td>
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<td></td>
<td></td>
<td>Pre Programme Knowledge, Skills and Confidence Audit</td>
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<tr>
<td></td>
<td></td>
<td>Pre Programme Six Steps Quality Marker Audit</td>
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<td></td>
<td></td>
<td>Pre Programme Post Death Information Audit</td>
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<td>Resources</td>
<td>Group activity</td>
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<td></td>
<td>Role and responsibilities of Domiciliary Care Organisation Representative</td>
<td>Divide a sheet of flipchart paper into six and add the Six Steps headings. Explain to the group these are the headings to guide completion of their 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 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 Domiciliary Care Organisation Representative in relation to the post it notes Hand out Roles and Responsibilities Hand-out</td>
<td>Flipchart Sheet Post it notes/pens</td>
<td>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 Place post it notes on the flipchart under the relevant step Feedback the roles and responsibility in relation to the allocated steps</td>
</tr>
</tbody>
</table>
## Induction Work plan

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<tr>
<td></td>
<td>End of Life Care Policy</td>
<td>Summarise the discussions, link together elements of a good death, the steps and both the Domiciliary Care Organisation and the Representatives roles and responsibilities. Discuss Compassion in Practice, Our Vision and Strategy (DH 2012) and ensuring the Six C’s are part of the organisations ethos.</td>
<td>Compassion in Practice&lt;br&gt;Six C’s Handout&lt;br&gt;Domiciliary Care Organisation End of Life Care Policy Template (to be brought to each workshop)</td>
<td>Listen&lt;br&gt;Question and answers&lt;br&gt;Record key elements of a good death onto the Domiciliary Care Organisation End of Life Care Policy Template. Discuss how the Six C’s can be integrated into practice&lt;br&gt;Discuss and record End of Life Care philosophy on the Domiciliary Care Organisation End of Life Care Policy Template</td>
</tr>
<tr>
<td></td>
<td>Way forward</td>
<td>Facilitator to advise and support Domiciliary Care Organisations to engage with the broader team to improve communication, information sharing and engage in supporting the programme. Facilitator to email letter to organisations for distribution Give out Induction ‘To Do’ List and ask individuals to complete how they will achieve the listed actions and add any further actions. Remind the group to put collected evidence in their Six Steps to Success Portfolio</td>
<td>Health &amp; Social Care Communication Letter&lt;br&gt;Induction ‘To Do’ List</td>
<td>Read, personalise and distribute to relevant professionals post workshop</td>
</tr>
<tr>
<td>Time</td>
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</table>
|                       | Way forward                              | Advise Domiciliary Care Organisation 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  
Inform the group to bring a copy (or submit electronically) their completed Post Death Information Audit (of the last six deaths) to the next Workshop |                                                                           |                              |
|                       | Revisit objectives, evaluation and close  | Check with the group the objectives have been met  
Distribute evaluation forms  
Collect in completed evaluation forms. Review, reflect and debrief on the session  
Confirm date, time and venue of next meeting  
Close | Objectives as displayed at beginning of Workshop  
**Evaluation Form**  
Induction ‘To Do’ List | Review objectives  
Complete evaluation form  
To be recorded on Induction ‘To Do’ List |
Step 1 – Work plan

Discussions as the end of life approaches

Time: Half day

Aim: The Domiciliary Care Organisation Representative will identify individuals who are entering the last year of life so discussions on end of life care are supported to take place at the appropriate time

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

- Identify how the North West End of Life Care Model supports a system/record which identifies and records which individuals may be approaching end of life
- Identify how they will support and participate in end of life care discussions considering capacity and communication barriers
- Develop further the Domiciliary Care Organisation End of Life Care Policy

Facilitator to assess and insert realistic timings and comfort breaks in relation to the group size
### Discussions as the end of life approaches

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
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<th>Resources</th>
<th>Group activity</th>
</tr>
</thead>
</table>
| **Introduction, welcome and review** | Welcome the group and inform group of house-keeping arrangements  
  Introduce self  
  Take a register of attendance  
  Display ground rules from Induction Workshop  
  Display and share objectives of the day  
  Review of Induction Workshop (identify any Domiciliary Care Organisations that have not completed their ‘To Do’ list.  
  Collect Pre Programme Post Death Information Audits (if not already submitted) and explain to the group to complete Interim Post Death Information Audit for future deaths, to be collated in Step 6 |  
  **Attendance Register**  
  Ground rules from Induction Workshop  
  Flip Chart/pens  
  Completed Induction ‘To Do’ List (held by each Domiciliary Care Organisation Representative)  
  **Interim Post Death Information Audit** |  
  Read Listen Question and answers | Listen  
  Complete attendance register  
  Listen  
  Listen  
  Feedback on actions from Induction ‘To Do’ List  
  Discuss Post Death Information Audit (last six deaths) |
| **Introduction to Step 1** | Ensure all Domiciliary Care Organisation Representatives have own copy of The Routes to Success in End of Life Care – achieving quality in domiciliary care (NEoLCP 2011) Walk through step 1 |  
  **The Route to Success in End of Life Care- achieving quality in domiciliary care** (NEoLCP 2011) | | |

Step 1 – Work plan

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## Step 1 – Work plan

### Discussions as the end of life approaches

<table>
<thead>
<tr>
<th>Time</th>
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</thead>
</table>
|      | What systems need to be in place to identify individuals in the last year of life? | Discussion for this session supported by a PowerPoint Presentation  
Divide into groups and give each group the North West Model and the blank North West Model template  
Ask the group(s) to consider observations they may recognise in relation to stage 1, 2 and 3 on the North West Tool  
Facilitate feedback  
Hand out two case studies (neurological disease/cancer) to each group  
Hand out Supportive Care Record. Ask the groups to identify and record where each case study would be on the Supportive Care Record  
Distribute the following tools; ‘Surprise question’, Prognostic Indicator Guidance (GSF 2011) or equivalent  
Facilitate a discussion on the implementation of a system/record which identifies and records which individuals may be approaching end of life and how this can be utilised in practice  
Points to consider: Cascading information to all staff and regular team review  
Advise the group that other workshops cover the actions required to support individuals at each stage of the North West Model | PowerPoint Presentation  
Laptop  
Projector  
North West Model  
North West Model template  
North West Model Facilitator Guide  
Step 1 Case Study A  
Step 1 Case Study B  
Supportive Care Record  
Surprise Question  
Prognostic Indicator Guidance | Listen  
Questions & Answers  
Record group discussion on North West Template stage 1, 2 and 3  
Feedback to whole group  
Listen  
Read  
Read and complete activity  
Discuss and feedback |
### Discussions as the end of life approaches

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</table>
|      | Supporting and participating in discussions around end of life care with individuals and their families | Lead a discussion based on the case studies to identify triggers to indicate when it would be appropriate to support and participate in discussions with individuals and their families on end of life care. Record responses on flip chart. | Flip chart/pens  
Step 1 Case Studies  
Mental Capacity Act Guide  
Best Interest at End of Life (2008)  
Support sheet 12  
Support sheet 13  
Support sheet 17 | Discussion  
Share current Domiciliary Care Organisation practice |
Step 1 – Work plan

Discussions as the end of life approaches

<table>
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<tr>
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<th>Group activity</th>
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</thead>
<tbody>
<tr>
<td>End of Life Care Policy</td>
<td>Ask each Domiciliary Care Organisation to look at the End of Life Care Policy Template addressing Step 1 Points to include: Identification of individuals in last year of life, appropriate time to undertake end of life care discussions and implementation of system/record</td>
<td>End of Life Care Policy Template (Brought back from each Workshop)</td>
<td>Record on the Domiciliary Care Organisation End of Life Care Policy Template</td>
<td></td>
</tr>
<tr>
<td>Way forward</td>
<td>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 Steps to Success Portfolio Advise Domiciliary Care Organisation Representatives to store the ‘To Do’ List in the Six Steps to Success Portfolio and bring the Six Steps to Success Portfolio and the Domiciliary Care Organisation End of Life Care Policy to each Workshop Inform the group to bring any type of assessment tools used in practice to the next Workshop</td>
<td>Step 1 ‘To Do’ List</td>
<td>Complete Step 1 ‘To Do’ List Implement before next workshop</td>
<td></td>
</tr>
<tr>
<td>Revisit objectives, evaluation and close</td>
<td>Check with the group the objectives have been met Distribute evaluation forms Collect in completed evaluation forms Review, reflect and debrief on the session Confirm date, time and venue of next meeting Close</td>
<td>Objectives as displayed at beginning of Workshop Evaluation Form</td>
<td>Review objectives Complete Evaluation Form</td>
<td>To be recorded on Step 1 ‘To Do’ List</td>
</tr>
</tbody>
</table>
### Step 2 – Work plan

**Assessment, care planning and review**

<table>
<thead>
<tr>
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<th>Group activity</th>
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<tbody>
<tr>
<td></td>
<td>Introduction, welcome and review</td>
<td>Welcome the group and inform them of housekeeping arrangements</td>
<td>Attendance Register</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduce self</td>
<td>Ground rules from Induction Workshop</td>
<td>Complete attendance register</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take a register of attendance</td>
<td>Flip Chart /pens</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Display ground rules from Induction Workshop</td>
<td>Completed Step 1 ‘To Do’ List (held by each Domiciliary Care Organisation Representative)</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Display and share objectives of the day</td>
<td>Feedback on actions from Step 1 ‘To Do’ List</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review of Step 1 Workshop Identify any Domiciliary Care Organisations that have not completed their ‘To Do’ list</td>
<td></td>
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<tr>
<td></td>
<td>Introduction to step 2</td>
<td>Ensure all Domiciliary Care Organisation Representatives have own copy of <em>The Route to Success in End of Life Care</em> achieving quality in domiciliary care (NEoLCP 2011)</td>
<td><em>The Route to Success in End of Life Care</em> achieving quality in domiciliary care (NEoLCP, 2011)</td>
<td>Read Listen Questions and answers</td>
</tr>
</tbody>
</table>
### Step 2 – Work plan

**Assessment, care planning and review**

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<tbody>
<tr>
<td>Holistic assessment</td>
<td>Lecture on what is holistic assessment in conjunction with health and social care teams: Include needs of LGBT and BAME individuals. Facilitate a discussion on any current assessment tools used in Domiciliary Care Organisations or wider. Introduce examples of assessment tools used locally: Consider: Assessment tools e.g. HOPE / Abbey/ Visual Analogue Scale/ 2 stage test for mental capacity. Divide into four groups: Physical Psychological Spiritual Social</td>
<td>PowerPoint Presentation Laptop Projector Holistic common assessment of supportive and palliative care needs for adults requiring end of life care (2010) Support sheet 16 Route to Success in end of life care - achieving quality for lesbian, gay, bisexual and transgender people (2012) Palliative and End of Life Care for Black, Asian and Minority Groups in the UK (2013) (Facilitator Reference) Step 2 Case Study (Part A) Step 2 Care Plan</td>
<td>Listening Question and answers Group to share examples of any assessment tools used in practice as requested in Step 1 Read group case study (part A) Complete allocated section of care plan Feedback to group Listen and have a plan to implement any new assessment tools</td>
<td></td>
</tr>
</tbody>
</table>
### Step 2 – Work plan

#### Assessment, care planning and review

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<tbody>
<tr>
<td></td>
<td>Assessing mental capacity</td>
<td>Ask the group: Have you considered how you might holistically assess an individual who struggles to communicate, perhaps because of dementia or stroke? Ask the group if they are aware of the 2 stage test to assess mental capacity within the holistic assessment process and what processes the Domiciliary Care Organisations have in place to assess mental capacity.</td>
<td>Two Stage Test of Capacity</td>
<td>Discussion Listen</td>
</tr>
<tr>
<td></td>
<td>Advance Care Planning</td>
<td>Lecture on what is Advance Care Planning including Advance Decision to Refuse Treatment and/or Do Not Attempt Cardio Pulmonary Resuscitation statements. Define Advance Care Planning and Best Interest Decision Making including role of IMCAs</td>
<td>Power Point Presentation Laptop Projector Best Interest Document Preferred Priorities for Care Document Support sheet 4 Support sheet 12 Support sheet 13 Support sheet 18</td>
<td>Listening Question and answers Listen, discuss and feedback Contribute to discussion</td>
</tr>
</tbody>
</table>
### Step 2 – Work plan

**Assessment, care planning and review**

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<td></td>
<td>Collaborative working in relation to Advance Care Planning</td>
<td>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 who may be involved in Advance Care Planning. Divide into groups and ask 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? Points to consider: Inclusion on the Supportive Care Record. Discuss ideas on raising awareness and how to plan an individual's and families meeting on Advance Care Planning.</td>
<td>Flipchart/pens</td>
<td>Supportive Care Record, Support sheet 3, Care, Capacity and Advance Care Planning A Guide for Health &amp; Social Care Staff (2012)</td>
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### Step 2 – Work plan

#### Assessment, care planning and review

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<td></td>
<td>System to support Advance Care Planning</td>
<td>Ask the groups how their organisation will support the advance care planning process and how this can be recorded on the register&lt;br&gt;Distribute Step 2 case Study Part Facilitate a discussion on how to raise awareness about the possibility of expressing personal wishes and preferences with individuals and families&lt;br&gt;Return to Step 2 case study (Part B). Ask smaller groups to discuss the ACP needs&lt;br&gt;Facilitate feedback from each group</td>
<td>Step 2 Case Study (Part B)</td>
<td>Contribute to discussion&lt;br&gt;Step 2 Case study (Part B)</td>
</tr>
<tr>
<td></td>
<td>End of Life Care policy</td>
<td>Ask each Domiciliary Care Organisation to look at the Domiciliary Care Organisation End of Life Care Policy Template addressing Step 2 Points to include: Holistic assessment, assessing mental capacity and advance care planning within Domiciliary Care Organisation</td>
<td>Domiciliary Care Organisation End of Life Care Policy Template (Brought back from each Workshop)</td>
<td>Record on the Domiciliary Care Organisation End of Life Care Policy Template</td>
</tr>
</tbody>
</table>
## Step 2 – Work plan

### Assessment, care planning and review

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<td></td>
<td>Way forward</td>
<td>Give out Step 2 ‘To Do’ List and ask individuals to consider how they will achieve the printed actions before the next workshop, adding any further actions. Remind the group to put collected evidence in their Six Steps Portfolio</td>
<td>Step 2 ‘To Do’ List</td>
<td>Complete Step 2 ‘To Do’ List Implement before next workshop</td>
</tr>
<tr>
<td></td>
<td>Revisit objectives, evaluation and close</td>
<td>Check with the group the objectives have been met</td>
<td></td>
<td>Review objectives</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distribute evaluation forms</td>
<td>Objectives as displayed at beginning of Workshop</td>
<td>Complete Evaluation form</td>
</tr>
<tr>
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<td>Collect in completed evaluation forms. Review, reflect and debrief on the session</td>
<td>Evaluation Form</td>
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<td></td>
<td></td>
<td>Confirm date, time and venue of next meeting</td>
<td>Step 2 ‘To Do List’</td>
<td>To be recorded on Step 2 ‘To Do’ List</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Close</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 Organisation Representative will be able to -
- Identify the value of good communication within the organisation  
- Recognise the importance of sharing information with the wider multi-professional team  
- Explore/redefine the role of a Key Worker to include end of life care  
- Develop further the Domiciliary Care Organisation End of Life Care Policy

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator Activities</th>
<th>Resources</th>
<th>Group activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Introduction, welcome and review</td>
<td>Welcome the group and inform them of housekeeping arrangements</td>
<td></td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduce self</td>
<td></td>
<td>Complete attendance register</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take a register of attendance</td>
<td></td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Display ground rules from Induction Workshop</td>
<td></td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Display and share objectives of the day</td>
<td></td>
<td>Feedback on actions from Step 2 “To Do” List</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review of Step 2 Workshop. Identify any Domiciliary Care Organisations that have not completed their “To Do” list</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|                           | Introduction to Step 3                    | Ensure all Domiciliary Care Organisation Representatives have own copy of The *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP, 2011)  
Walk through Step 3 | *The Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP 2011) | Read Listen Questions and answers |
## Step 3 – Work plan

### Co-ordination of care

<table>
<thead>
<tr>
<th>Time</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Communication Systems</td>
<td>Present spider diagram from Step 2 Workshop</td>
<td>Spider diagram (from Step 2 Workshop)</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td>Communicating with others</td>
<td>Divide into groups and ask them to discuss referral to the identified professionals on the spider diagram i.e., what systems are in place to access services 24/7 for sudden change of circumstances at end of life</td>
<td>Flip chart/pens</td>
<td>Support sheet 1 Support sheet 10 Support sheet 14 Discuss</td>
</tr>
<tr>
<td></td>
<td>Co-ordination of Care</td>
<td>Facilitate discussions on how Domiciliary Care Organisations can access information about individuals i.e., are they on the GP End of Life Care Register, (GSF), can they access information to support care Distribute the End of Life Care Good Practice Guide and Checklist. Explain its use in practice and the role of the organisation, walking through each stage of the guide and checklist to ensure the needs of individuals in the last year of life are met</td>
<td>End of Life Care Good Practice Guide Domiciliary Care Review List</td>
<td>Discuss</td>
</tr>
</tbody>
</table>
### Step 3 – Work plan

## Co-ordination of care

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Keyworker</td>
<td>Facilitate a group discussion to identify the role of a key worker and how this may already function within the organisation and how to include end of life care into the role. Points to consider: Regular review of individual’s needs, communicating with the individual, families 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. Facilitator to distribute the Role of the Keyworker document and Domiciliary Care End of Life Care Keyworker Guide and explain its use in practice and the role of the organisation, walking through each stage of the guide to ensure the needs of individuals in the last year of life are met. Direct the group to record the designated key worker (or equivalent) on the Supportive Care Record.</td>
<td>Role of the Keyworker Domiciliary Care End of Life Care Keyworker Guide</td>
<td>Discuss</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Listen</td>
</tr>
</tbody>
</table>
### Co-ordination of care

<table>
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</thead>
<tbody>
<tr>
<td>Communication in practice</td>
<td>Lecture on the importance and value of good communication and the elements that make up good communication. Introduction to ‘PREPARED’ – an acronym to assist with End of Life and other discussions.</td>
<td>PowerPoint Presentation Laptop Projector Support Sheet – ‘PREPARED’ Support sheet 2</td>
<td><strong>Case Study 3</strong> Case Study 3 Facilitator Guide Step 3 Case Study Transcripts</td>
<td>Listening Question and answers Read and observe Feedback</td>
</tr>
<tr>
<td></td>
<td>Distribute case study 3 and use a short interactive demonstration or recorded role play to demonstrate 2 different approaches to communication (1 non-effective/1 effective)</td>
<td>Through discussion, facilitator to elicit from group, an awareness of effective and non-effective communication techniques</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domiciliary Care Organisation End of Life Policy</td>
<td>Ask each Domiciliary Care Organisation to look at the Domiciliary Care Organisation End of Life Care Policy Template addressing Step 3 Points to include: Collaborative working, Good communication, Implementing the key worker system (or demonstrating use of existing system)</td>
<td>Domiciliary Care Organisation End of Life Care Policy Template (Brought back from each Workshop)</td>
<td></td>
<td>Record on the Domiciliary Care Organisation End of Life Care Policy Template</td>
</tr>
</tbody>
</table>
## Step 3 – Work plan

### Co-ordination of care

<table>
<thead>
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</tr>
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<tbody>
<tr>
<td>Way forward</td>
<td></td>
<td>Give out Step 3 ‘To Do’ List and ask individuals to consider how they will achieve the printed actions before the next workshop, adding any further actions. Remind the group to put collected evidence in their Six Steps Portfolio. Remind group to bring the Six Steps Portfolio and Domiciliary Care Organisation End of Life Care Policy to each Workshop</td>
<td>Step 3 ‘To Do’ List</td>
<td>Complete Step 3 ‘To Do’ List Implement before next workshop</td>
</tr>
<tr>
<td>Revisit objectives, evaluation and close</td>
<td></td>
<td>Check with the group the objectives have been met. Distribute evaluation forms. Collect in completed evaluation forms. Review, reflect and debrief on the session. Confirm date, time and venue of next meeting. Close</td>
<td>Evaluation Form</td>
<td>Review objectives. Complete Evaluation Form To be recorded on Step 3 ‘To Do’ List</td>
</tr>
</tbody>
</table>
# Step 4

**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 Organisation Representative will be able to -  
- Recognise the complex combination of services across a number of different settings and how to access appropriate services  
- Identify a training plan template for all staff in End of Life Care  
- Recognise the importance of Significant Event Analysis  
- Develop further the Domiciliary Care Organisation End of Life Care Policy

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

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<th>Group activity</th>
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</table>
|     | 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  
Display and share objectives of the day  
Review of Step 3 Workshop Identify any Domiciliary Care Organisations that have not completed their ‘To Do’ list | Attendance Register  
Ground rules from the Induction Workshop  
Flip Chart/pens  
Completed Step 3 ‘To Do’ list (held by each Domiciliary Care Organisation Representative) | Listen  
Complete attendance register  
Listen  
Listen  
Feedback on actions from Step 3 ‘To Do’ List |
|     | Introduction to Step 4 | Ensure all Domiciliary Care Organisation Representatives have own copy of _The Route to Success in End of Life Care-achieving quality in domiciliary care_ (NEoLCP, 2011)  
Walk through Step 4 | The Route to Success in End of Life Care-achieving quality in domiciliary care (NEoLCP 2011) | Read Listen  
Questions and answers |
### Step 4 – Work plan

#### Delivery of high quality care in domiciliary care

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>Complex combination of services</td>
<td>Facilitate a group discussion on their experiences of various end of life scenarios which have occurred out of hours</td>
<td>PowerPoint Presentation Laptop Projector</td>
<td>Discuss Feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Record on flip chart the frequent challenges raised</td>
<td>Flip chart/pens</td>
<td></td>
</tr>
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<td></td>
<td></td>
<td>Using the feedback ask the group how organisations could respond to changing needs at end of life?</td>
<td></td>
<td>Discuss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitator to source local information i.e., local advice/support phone lines, availability of out of hours pharmacies, and how help may be obtained</td>
<td>Information regarding what local services are available and contacts</td>
<td></td>
</tr>
</tbody>
</table>

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In coordination with planning, consider the following points:

- **Feasibility**: Ensure that the proposed care plans are feasible within the available resources.
- **Responsive**: Align the care plans with the evolving needs and feedback from the caregivers.
- **Communication**: Maintain clear communication channels between care providers and the patient.
- **Support**: Offer psychological and emotional support to caregivers and patients.

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Photo: Two individuals engaged in a conversation, symbolizing the importance of communication and support in care planning.
### Step 4 – Work plan

**Delivery of high quality care in domiciliary care**

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</table>
| Education and training of staff | Facilitate a discussion on the following question: *How can all Domiciliary Care staff access relevant end of life care training?* (internal/external) | Facilitator to explore the variety of local and national 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  
Skills for Care  
E-learning i.e. SCIE/e-ELCA  
Macmillan Cancer Support | Information on all training available  
(Source locally)  
Listen  
Question and answers |

**Ask the group to consider their own training needs**

**Ask the group how they are going to identify training needs of all staff**

**Distribute Knowledge, Skills and Confidence Audit**

**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**

**Points to consider:**

- Ensure end of life care training is included in the mandatory training programme and policy.
- Ensure end of life care training is included in the organisations induction programme

**Knowledge, Skills and Confidence Audit for the Workforce**

**Flip chart/pens**

**Discuss**

**Feedback**
### Delivery of high quality care in domiciliary care

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<tbody>
<tr>
<td>Significant event analysis</td>
<td>Dignity</td>
<td>Introduce group to ‘Significant Event Analysis’ (SEA) both as a reflective tool and an aid to development /Education. Discuss use in practice following each death</td>
<td><strong>Significant Event Analysis Template</strong></td>
<td>Discuss</td>
</tr>
<tr>
<td></td>
<td>Dignity</td>
<td>Utilise appropriate audio visual resource e.g. RCN Dignity Pack</td>
<td><strong>Locally sourced</strong></td>
<td><strong>RCN Definition of Dignity</strong></td>
</tr>
<tr>
<td></td>
<td>Dignity</td>
<td>Distribute ‘What do you see nurse’ Poem</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Dignity</td>
<td>Promote discussion about relevance of resource in promoting dignity</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dignity</td>
<td>Facilitate a discussion on the implementation of dignity champions within the organisation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment</td>
<td>Environment</td>
<td>Divide group into two and ask one group to capture what promotes a good environment and the other group to consider what may hinder a good environment. Facilitate a discussion on what can be done, on the part of the organisation, to support a suitable environment?</td>
<td>Flipchart and pens</td>
<td><strong>Support sheet 15</strong></td>
</tr>
<tr>
<td></td>
<td>Environment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domiciliary Care Organisation End of Life Care Policy</td>
<td>Domiciliary Care Organisation to look at the Domiciliary Care Organisation End of Life Care Policy Template addressing Step 4 Points to include: Services across settings 24/7 Education and training needs Inclusion of end of life care in mandatory training Dignity Environment</td>
<td>Domiciliary Care Organisation End of Life Care Policy Template (Brought back from each Workshop)</td>
<td></td>
<td>Record on the Domiciliary Care Organisation End of Life Care Policy Template</td>
</tr>
</tbody>
</table>
### Step 4 – Work plan

#### Delivery of high quality care in domiciliary care

<table>
<thead>
<tr>
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</table>
|      | 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 Steps to Success Portfolio  
Advise Domiciliary Care Organisation Representatives to store the ‘To Do’ List in the Six Steps to Success Portfolio and bring the Six Steps to Success Portfolio and the End of Life Care Policy to each Workshop  
Ask the group to bring any literature they use to support families, friends, significant others or staff to the next Workshop | Step 4 ‘To Do’ List | Complete Step 4 ‘To Do’ List Implement before next workshop |
| Revisit objectives, evaluation and close | Check with the group the objectives have been met  
Distribute evaluation forms  
Collect in completed evaluation forms. Review, reflect and debrief on the session  
Confirm date, time and venue of next meeting  
Close | Objectives as displayed at beginning of Workshop  
Evaluation Form | Step 4 ‘To Do’ List | Review objectives  
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 recognised the individual is entering the last days of life, and best practice is provided
**Objectives:** By the end of the session, the End of Life Domiciliary Care Organisation Representative will be able to -
- Recognise the point when the individual enters the dying phase
- Have an awareness of the use of advance care planning documents when the service user is in the last days of life
- Recognise the difference between a planned and unplanned hospital admission at end of life
- Have an understanding of the use of the 5 Priorities for Care of the Dying Person
- Have an awareness of the use of syringe pumps
- Know how to ensure the person’s spiritual, religious and cultural needs are met.
- Develop further the Domiciliary Care Organisation’s End of Life Care policy

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

<table>
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<tr>
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<th>Group activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Introduction, welcome and review</td>
<td>Welcome the group and inform them of housekeeping arrangements</td>
<td></td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduce self</td>
<td><strong>Attendance Register</strong></td>
<td>Complete attendance register</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take a register of attendance</td>
<td>Ground rules from the Induction Workshop</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Display ground rules from Induction Workshop</td>
<td>Flip Chart/pens</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Display and share objectives of the day</td>
<td></td>
<td>Feedback on actions from Step 4 ‘To Do’ List</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review of Step 4 Workshop</td>
<td>Completed Step 4 ‘To Do’ list (held by each Domiciliary Care Organisation Representative)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduction to Step 5</td>
<td>Ensure all Domiciliary Care Organisation Representatives’ have own copy of <em>Route to Success in End of Life Care-achieving quality in domiciliary care</em> (NEoLCP, 2011)</td>
<td><strong>The Route to Success in End of Life Care-achieving quality in domiciliary care (NEoLCP 2011)</strong></td>
<td>Read Listen Questions and answers</td>
</tr>
</tbody>
</table>
### Step 5 – Work plan

#### Care in the last days of life

<table>
<thead>
<tr>
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</table>
| 5 Priorities for Care of the Dying Person | Lecture on the 5 priorities for care of the dying person. Ensure topics below are cross referenced with the 5 priorities  
 Address signs and symptoms of the dying individual and consider the impact of different diseases. Knowledge of where to report changes  
 What is an End of Life Care Plan? Facilitator to lead discussion about the End of Life Care Plan and its use  
 What is a syringe driver? Facilitator to lead discussion about its use  
 Facilitate a discussion on the appropriate action to take when recognising dying and how this relates to the Domiciliary Care End of Life Care Key Worker Guide  
 Record feedback on flip chart  
 Points to consider: Advance Care Plan  
 Mental Capacity Act  
 Nutrition/hydration  
 Syringe driver  
 Communication with family and professionals | One Chance To Get It Right (facilitator reference)  
 PowerPoint Presentation  
 Laptop  
 Projector  
 Facilitator to have copies of local End of Life Care Plan for demonstration and discussion  
 Facilitator to have a syringe driver for demonstration and discussion  
 Domiciliary Care End of Life Care Keyworker Guide  
 Flip Chart/pens  
 Unified DNA-CPR Policy (local copy) | Listen and discuss  
 Listen  
 Question and answer  
 Discuss  
 Discuss  
 Discuss |
### Step 5 – Work plan

#### Care in the last days of life

<table>
<thead>
<tr>
<th>Time</th>
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</table>
|      | Decision making on hospital admissions (choices/wishes/best interest) | Divide group  
Ask the groups to share recent examples of service users admitted to hospital  
Facilitate a discussion around the scenario based on the North West Model Points to consider: 
*Did the individual 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?*  
During feedback, pull out what would support decision making at the end of life:  
*Advance Care Planning*  
*Out of Hours information*  
*GP or District Nurse review*  
*Holistic assessment*  
*Communication with acute sector*  
*Prompt Poster for display in office*  
*Prompt cards for workforce*  
Distribute Significant Event Analysis Template as introduced in Step 4 and ask the group to reflect on the discussion and record on the Significant Event Analysis Template.  
Facilitate feedback on use of Significant Event Analysis in practice | North West End of Life Care Model  
Domiciliary Organisation Prompt Poster  
Domiciliary Care Workers Prompt Card | Share examples  
Group discussion | Completion of significant event analysis template  
Discuss Feedback |
### Step 5 – Work plan

#### Care in the last days of life

<table>
<thead>
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<th>Group activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care of families, friends and significant others</td>
<td>Facilitate a discussion on how the Domiciliary Care Organisation currently care for families, friends and significant others at this time Points to consider: Practical help Physical needs Emotional support Involvement in care Source local literature to support families, friends and significant others</td>
<td>Support sheet 8  Support sheet 9</td>
<td>Discuss Feedback Review local literature and Domiciliary Care Organisation literature</td>
</tr>
<tr>
<td></td>
<td>Religious, Cultural and Spiritual Care</td>
<td>Lecture Points to consider: Different faiths, beliefs and spiritual needs pre and post death Distribute Customs and Religious Protocols handout Forward religious resource link for organisation to consider putting on own desktop</td>
<td>PowerPoint Presentation Laptop Projector Customs and Religious Protocols Handout Religious Needs Resource <a href="http://queenscourt.org.uk/spirit/">http://queenscourt.org.uk/spirit/</a></td>
<td>Listen Question and answers</td>
</tr>
<tr>
<td>Time</td>
<td>Topic</td>
<td>Facilitator Activities</td>
<td>Resources</td>
<td>Group activity</td>
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<td>------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Domiciliary</td>
<td>Domiciliary Care Organisation</td>
<td>Ask each Domiciliary Care Organisation to look at the Domiciliary Care Organisation  End of Life Care Policy Template addressing Step 5 Points to include: Recognising end of life Decision making on hospital admissions (choices/wishes/best interest) Religious, Cultural and Spiritual needs</td>
<td>Domiciliary Care Organisation End of Life Care Policy Template (Brought back from each Workshop)</td>
<td>Record on the Domiciliary Care Organisation End of Life Care Policy Template</td>
</tr>
<tr>
<td>Organisation</td>
<td>End of Life Policy</td>
<td></td>
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</tr>
<tr>
<td>Way forward</td>
<td></td>
<td>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 Steps to Success Portfolio Advise Domiciliary Care Organisation Representatives to store the ‘To Do’ List in the Six Steps to Success Portfolio and bring the Six Steps to Success Portfolio and the Domiciliary Care Organisation End of Life Care Policy to each Workshop</td>
<td>Step 5 ‘To Do’ List</td>
<td>Complete Step 5 ‘To Do’ List Implement before next workshop</td>
</tr>
<tr>
<td>Revisit</td>
<td></td>
<td>Check with the group the objectives have been met Distribute evaluation forms Collect in completed evaluation forms. Review, reflect and debrief on the session Confirm date, time and venue of next meeting Close</td>
<td>Objectives as displayed at the beginning of the Workshop Evaluation Form Step 5 ‘To Do’ List</td>
<td>Review objectives Complete Evaluation Form To be recorded on Step 5 ‘To Do’ List</td>
</tr>
<tr>
<td>objectives,</td>
<td></td>
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<tr>
<td>evaluation</td>
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<tr>
<td>and close</td>
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</table>
### 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 End of Life Domiciliary Care Organisation Representative will be able to -  
- Identify good practice regarding the care of the deceased individual  
- Give practical support and information to families, significant others, staff and other individuals  
- Respect individual faiths and beliefs to address individual wishes  
- Have an understanding of the theories of grief  
- Develop further the Domiciliary Care Organisation End of Life Care Policy

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

<table>
<thead>
<tr>
<th>Time</th>
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<th>Group activity</th>
</tr>
</thead>
</table>
| 09.00 - 10.00 | 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  
Display and share objectives of the day  
Review of Step 5 Workshop. Identify any Domiciliary Care Organisations that have not completed their ‘To Do’ list | **Attendance Register**  
Ground rules from the Induction Workshop  
Flip Chart/pens  
Completed Step 5 ‘To Do’ list (held by each Domiciliary Care Organisation Representative) | Listen  
Complete attendance register  
Listen  
Listen  
Feedback on actions from Step 3 ‘To Do’ List |
| 10.00 - 10.15 | Introduction to Step 6              | Ensure all Domiciliary Care Organisation Representatives’ have own copy of *Route to Success in End of Life Care-achieving quality in domiciliary care* (NEoLCP, 2011)  
Walk through Step 4 | **The Route to Success in End of Life Care-achieving quality in domiciliary care** (NEoLCP 2011) | Read  
Listen  
Questions and answers |
## Step 6 – Work plan
### Care after death

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Facilitator Activities</th>
<th>Resources</th>
<th>Group activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care after death for the deceased individual, families, significant others, and staff</td>
<td>Welcome the group Divide into three groups: 1. Deceased service user 2. Families and significant others 3. Staff Ask each group to discuss care after death in relation to their group heading include practical, cultural and spiritual needs, and final care needs Points to consider: Deceased service users wishes. Have the families been provided with appropriate support material? Do mechanisms exist to support non-family members, such as staff and friends, who may also be affected by death? Facilitate Feedback</td>
<td>Flip chart/pens Support sheet 9 Booklet ‘What ‘To Do’ after a death in England and Wales’ DWP 011 Support after a death DWP 004 (or other local information)</td>
<td>Discuss Feedback to the whole group</td>
</tr>
<tr>
<td></td>
<td>Requirements and actions following death</td>
<td>Source information on local bereavement support services Lecture to identify the actions that need to be taken if present at time of death Consider including: Final care-local policy on Last Offices Verification and certification of death (explain the processes) Funeral Directors Registering a death (advice/supporting families)</td>
<td>PowerPoint Presentation Laptop Projector Guidance for staff responsible for care after death Handout on local bereavement support services with contact details (Source Locally) Suggestion to invite local funeral director</td>
<td>Listen Questions and answers Read</td>
</tr>
</tbody>
</table>
### Step 6 – Work plan

#### Care after death

<table>
<thead>
<tr>
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<th>Resources</th>
<th>Group activity</th>
</tr>
</thead>
</table>
|      | Grieving Process | Lecture on theory(s) of grief  
Normal Grief  
Abnormal grief  
When to refer to other appropriate services | PowerPoint Presentation  
Laptop  
Projector | Listen  
Question and Answers |
|      | Domiciliary Care Organisation End of Life Care Policy | Ask each Domiciliary Care Organisation to look at the Domiciliary Care Organisation End of Life Care Policy Template addressing Step 6 Points to include:  
Final care after death  
Required processes following death  
Care after death for the deceased individual, family, significant others and staff  
Support to relatives and staff post bereavement  
Ask Domiciliary Care Organisation Representatives to produce their completed Six Steps Policy in the established Domiciliary Care Organisation policy format and bring to the Conclusion Workshop  
Distribute Post Programme Quality Marker Audit and Post Programme Knowledge, Skills and Confidence Audit. Ask representatives to complete. (Audits can also be completed electronically/posted or faxed and returned prior to conclusion workshop for facilitator to analyse pre and post programme audits) Results to be distributed in conclusion workshop. | Domiciliary Care Organisation End of Life Care Policy Template (Brought back from each Workshop) | Record on the Domiciliary Care Organisation End of Life Care Policy Template  
Complete Post Programme Quality Marker Audit  
Complete Post Programme Knowledge, Skills and Confidence Audit |
### Step 6 – Work plan

#### Care after death

<table>
<thead>
<tr>
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<th>Group activity</th>
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</thead>
<tbody>
<tr>
<td>Domiciliary</td>
<td>Care</td>
<td>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</td>
<td>Step 6 ‘To Do’ List</td>
<td>Complete Step 6 ‘To Do’ List Implement before next workshop</td>
</tr>
<tr>
<td>Organisation</td>
<td>End of Life Care Policy</td>
<td>Advise Domiciliary Care Organisation Representatives to store the ‘To Do’ List in the Six Steps to Success Portfolio and bring the Six Steps to Success Portfolio and the End of Life Care Policy to each workshop</td>
<td></td>
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<tr>
<td>Way forward</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Revisit</td>
<td>objectives, evaluation</td>
<td>Check with the group the objectives have been met</td>
<td>Objectives as displayed at the beginning of the Workshop</td>
<td>Review objectives</td>
</tr>
<tr>
<td>Revisit</td>
<td>evaluation and close</td>
<td></td>
<td>Evaluation Form</td>
<td>Complete Evaluation form</td>
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<tr>
<td></td>
<td></td>
<td>Distribute evaluation forms</td>
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<td></td>
<td></td>
<td>Collect in completed evaluation forms. Review, reflect and debrief on the session</td>
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<tr>
<td></td>
<td></td>
<td>Confirm date, time and venue of next meeting</td>
<td>Step 6 ‘To Do’ List</td>
<td>To be recorded on Step 6 ‘To Do’ List</td>
</tr>
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<td></td>
<td></td>
<td>Close</td>
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</tbody>
</table>
Step 6 – Work plan

Care after death
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 End of Life Domiciliary Care Organisation Representative will be able to -
- Describe the End of Life Care Policy implemented within the individual Domiciliary Care Organisation Agencies
- Analyse audit figures
- Understand the importance of a completed portfolio and demonstrate its contents
- Review portfolio, identifying gaps in practice and outcomes still to be achieved (if any) via an action plan

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

<table>
<thead>
<tr>
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<tr>
<td></td>
<td></td>
<td>Welcome the group and inform them of housekeeping arrangements</td>
<td>Attendance Register</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Introduce self</td>
<td></td>
<td>Complete attendance register</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Take a register of attendance</td>
<td></td>
<td>Listen</td>
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<tr>
<td></td>
<td></td>
<td>Display ground rules from Induction Workshop</td>
<td>Ground rules from the Induction Workshop</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Display and share objectives of the day</td>
<td>Flip Chart/pens</td>
<td>Listen</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review of Step 6 Workshop Identify Domiciliary Care Organisations that have not completed their ‘To Do’ list</td>
<td>Completed Step 6 ‘To Do’ list (held by each Domiciliary Care Organisation Representative)</td>
<td>Feedback on actions from Step 6 ‘To Do’ List</td>
</tr>
</tbody>
</table>
## Conclusion Work plan

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<tbody>
<tr>
<td>Audit</td>
<td></td>
<td>Ensure that the Interim Post Death Information Audit, as requested in Workshop 1, has been completed and returned.</td>
<td>Interim Post Death Information Audit</td>
<td>Submit Interim Post Death Information Audit completed since Workshop 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distribute and explain to the group to continue completing the Post Programme Post Death Information Audit for future deaths, to be collected or submitted electronically (make local arrangements for ongoing auditing).</td>
<td>Post Programme - Post Death Information Audit</td>
<td>Read</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distribute analysed Pre and Post Programme Six Steps Quality Marker Audit.</td>
<td>Post Programme Six Step Quality Marker Audit analysis (facilitator to provide)</td>
<td>Read. Identify gaps to be addressed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Distribute analysed Pre and Post Programme Knowledge, Skills and Confidence Audit</td>
<td>Knowledge, Skills and Confidence Audit analysis (facilitator to provide)</td>
<td>Read. Identify deficits in knowledge requiring further education and training.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advise the group the Post Death Information Audits analysis will be provided after their six deaths post programme audit forms have been submitted.</td>
<td>Individual Domiciliary Care Organisation Post Death Information Report (to be prepared locally)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
<td>Role and Responsibilities of the Domiciliary Care Organisation Representative</td>
<td></td>
</tr>
</tbody>
</table>
# Conclusion Work plan

<table>
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<th>Group activity</th>
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<tbody>
<tr>
<td></td>
<td>Portfolio of evidence review</td>
<td>Walk through each step in the Six Step to Success Portfolio of evidence; discuss the examples of evidence to be included and achievement against all of the Quality Markers and Measures. See Organisation Portfolio Guidance</td>
<td>The Six Step to Success Portfolio of Evidence (Domiciliary Care Organisation Copy)</td>
<td>Each individual Domiciliary Care Organisation to bring their Six Step to Success Portfolio of evidence Discuss Review portfolio identifying gaps. Agree action plan if required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss action plans where gaps have been identified in the portfolios and agree how these will be achieved within a set timeframe.</td>
<td>Domiciliary Care Organisation Portfolio Guidance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advise group of submission date for portfolio of evidence.</td>
<td>Action Plan Template</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domiciliary Care Organisation End of Life Care Policy</td>
<td>Ask each Domiciliary Care Organisation to present their Domiciliary Care Organisation End of Life Care Policy Identify Domiciliary Care Organisations that require further support to implement the programme and provide evidence in the Six Steps Portfolio of Evidence</td>
<td>Domiciliary Care Organisation End of Life Care Policy (Brought back from each Workshop)</td>
<td>Present Domiciliary Care Organisation End of Life Care Policy</td>
</tr>
<tr>
<td></td>
<td>Way forward</td>
<td>Give out template Conclusion ‘To Do’ List and ask individuals to complete how they will achieve the printed actions and add any further actions</td>
<td>Conclusion ‘To Do’ List</td>
<td>Complete Conclusion ‘To Do’ List</td>
</tr>
</tbody>
</table>
## Conclusion Work plan

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<tbody>
<tr>
<td>Revisit objectives, evaluation and close</td>
<td>Check with the group the objectives have been met</td>
<td>Objectives as displayed at the beginning of the Workshop</td>
<td>Review objectives</td>
<td>Complete Evaluation form</td>
</tr>
<tr>
<td></td>
<td>Distribute full programme evaluation form</td>
<td><strong>Full Programme Evaluation Form</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Collect in completed evaluation forms. Review, reflect and debrief on the session</td>
<td>Conclusion 'To Do' List</td>
<td>To be recorded on Conclusion Workshop 'To Do' List</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Confirm any plans for date, time and venue of future meetings</td>
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<tr>
<td></td>
<td>Consider using this opportunity to discuss how the programme will be sustained and what support they can receive in the future to ensure they continue to keep up to date with initiatives in end of life care, both locally and nationally, E.g. future dates of forums</td>
<td></td>
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<tr>
<td></td>
<td>Discuss how they will support their workforce to be able to access EoLC training. Consider asking a Further Education College to attend and discuss access to QCF courses.</td>
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<tr>
<td></td>
<td>Celebration event to be agreed to disseminate certificates to the delegates. On completion of the portfolio and evidence shown in practice the organisations Six Steps certificate of completion can be given.</td>
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<td></td>
<td>Close</td>
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</tbody>
</table>
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.
<table>
<thead>
<tr>
<th>Level / Award / Unit</th>
<th>Mapped to learning outcome (LO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 2 Award: Awareness of End of Life Care</strong></td>
<td>All outcomes may be met</td>
</tr>
<tr>
<td>Unit EOL 201: Understand how to work in end of life care</td>
<td>LO1 – AC 1.1, 1.2, 1.3, 1.4</td>
</tr>
<tr>
<td></td>
<td>LO2 – AC 2.1, 2.2, 2.3, 2.4, 2.5, 2.6</td>
</tr>
<tr>
<td><strong>Level 3 Award: Awareness of End of Life Care</strong></td>
<td>All outcomes may be met</td>
</tr>
<tr>
<td>Unit EOL 201: Understand how to work in end of life care</td>
<td>LO1 – AC 1.1, 1.2, 1.3, 1.4</td>
</tr>
<tr>
<td></td>
<td>LO2 – AC 2.1, 2.2, 2.3, 2.4, 2.5, 2.6</td>
</tr>
<tr>
<td><strong>Level 3 Certificate: Working in End of Life Care</strong></td>
<td>All outcomes may be met</td>
</tr>
<tr>
<td>Unit EOL 301: Understand how to provide support when working in end of life care</td>
<td>LO1 – AC 1.1, 1.2, 1.3, 1.4</td>
</tr>
<tr>
<td></td>
<td>LO2 – AC 2.1, 2.2, 2.3, 2.4</td>
</tr>
<tr>
<td></td>
<td>LO3 – AC 3.1, 3.2, 3.3, 3.4</td>
</tr>
<tr>
<td>Unit EOL 307: Understand how to support individuals during last days of life</td>
<td>LO1 – AC 1.1, 1.2, 1.3, 1.4</td>
</tr>
<tr>
<td></td>
<td>LO2 – AC 2.1, 2.2, 2.3</td>
</tr>
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<td></td>
<td>LO3 – AC 3.1, 3.2, 3.3, 3.4</td>
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<tr>
<td><strong>Level 3 Certificate: Working in End of Life Care</strong></td>
<td>All outcomes may be met</td>
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<td>Unit EOL 301: Understand how to provide support when working in end of life care</td>
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<tr>
<td></td>
<td>LO2 – AC 2.1, 2.2, 2.3, 2.4</td>
</tr>
<tr>
<td></td>
<td>LO3 – AC 3.1, 3.2, 3.3, 3.4</td>
</tr>
<tr>
<td>Unit EOL 302: Managing symptoms in end of life care (competence unit)</td>
<td>LO1 – AC 1.1, 1.2, 1.3, 1.4</td>
</tr>
<tr>
<td></td>
<td>LO2 – N/A competency AC</td>
</tr>
<tr>
<td>Unit EOL 305: Support individuals with loss and grief before death (competence unit)</td>
<td>LO1 – AC 1.1, 1.2, 1.3, 1.4</td>
</tr>
<tr>
<td></td>
<td>LO – N/A competency AC</td>
</tr>
<tr>
<td>Level / Award / Unit</td>
<td>Mapped to learning outcome</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
</tr>
</tbody>
</table>
| 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 AC        |
|                                                                                     | 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, 1.7, 1.8, 1.9 |
|                                                                                     | LO2 – AC 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9 |
|                                                                                     | LO3 – AC 3.1, 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, 2.1, 2.2, 2.3 |
|                                                                                     | 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 |
|                                                                                     | LO5 - not covered AC        |
|                                                                                     | LO6 – N/A competency AC     |
References


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

The North West End of Life Care Model

Supporting the people of the North West to live well before dying with peace and dignity in the place of their choice

End of life care

- Is about the individual and those important to them
- Is about meeting the supportive and palliative care needs for all those with an advanced progressive incurable illness or frailty, to live as well as possible until they die.
- Support may be needed in the last years, months or days of life.

It should include:

- A person centered approach to care – involving the person, and those closest to them in all aspects of their care including
- the decision making process around treatment and care
- Open, honest and sensitive communication with the patient and those important to them
- Care which is coordinated and delivered with kindness and compassion
- The needs of those identified as important to the person to be actively explored, respected and met as far as possible
- All discussions to follow guidance set within the Mental Capacity Act (MCA 2005)

Key recommended Training for health and care staff:

- Communication skills
- Holistic assessment to include: physical, psychological, spiritual and social care
- Symptom control
- Advance care planning
- Caring for carers
- Priorities for care of the dying person
- Bereavement support
- Mental Capacity Act

The model supports the assessment and planning process for patients from the diagnosis of a life limiting illness or those who may be frail.