

Portfolio Guidance and Checklist for Facilitators

For Facilitators



Safe

Effective

Caring

Responsive

Well led









Welcome to the portfolio

This guide is to support the facilitator assessing the portfolio to ensure essential evidence is included. The portfolio of evidence can be used to showcase the implementation of the Six Steps to Success programme.

As part of the Six Steps Organisational Programme, care homes are required to develop a portfolio of evidence to demonstrate that they have met the outcomes of the programme. The portfolio is divided into FIVE SECTIONS that align to the five key questions that are asked by the Care Quality Commission (CQC) during inspections. Each of these five key questions is broken down into a further set of questions called key lines of enquiry (KLOEs). KLOE R3 specifically relates to end of life care, however, good end of life care spans across many of the KLOEs, so the prompts have been aligned more broadly. These would address also fully address the requirements of KLOE R3. The portfolio remains in the care home and can be shared with commissioners, Local Authority monitors and CQC.

Creativity is encouraged; however the facilitator would need to see that essential criteria are included. It does not prohibit the care home from including other relevant information as detailed in the care home portfolio of evidence guidance.

There are no marking criteria as the assessment should be seen more as a supportive process. The aim of the facilitator reviewing the portfolio is to identify any gaps and work with the care home to implement what is needed by compiling an action plan together with identified timelines and then support the care home to implement and produce the evidence required. **All information included within the portfolio must be anonymised and not contain any information that could make a resident identifiable**.

Once the facilitator is satisfied the care home has implemented the programme fully and the evidence is included in the portfolio the care home certificate can be presented. The certificate confirms that at that moment in time, the home has implemented the programme and supplied the evidence. The care home manager must sign the certificate to agree the programme has been implemented and that the care home will sustain the programme in the future.

This guidance supports the facilitator assessment to ensure the essential evidence is included in the portfolio based on the implementation within the care home. There is a column for you to record all other pieces of evidence the care home has provided.

You may want to keep a final completed copy of the checklist in the portfolio as a care home record to evidence what was included at that time.

Even though a care home will have ‘completed’ the programme, they will need to keep the portfolio updated as evidence of good practice. We also recommend that care homes renew their Six Steps Programme at least every 2 years, and this can be updated as part of the refresh programme ‘Stepping forward’.

Safe

People are protected from abuse and avoidable harm

| **KLOE** | **Prompts/measures** | **Possible evidence in Portfolio** | **🗸🗴** | **Comments** |
| --- | --- | --- | --- | --- |
| **S2** | DNACPR decisions are made appropriately and in line with national guidance | Anonymised example of a DNACPR discussion and decision |  |  |
| **S2** | Decisions about mental capacity are made appropriately and in line with national guidance | Example of how a mental capacity/ Best Interests Decision has been made |  |  |
| **S6** | The care home regularly uses reflective practice for learning from occurrences, such as Significant Event Analysis (SEA) | Examples of reflective learning practices |  |  |
| **OTHER COMMENTS** |

**Effective**

A person’s care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

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| --- | --- | --- | --- | --- |
| **KLOE** | **Prompts/measures** | **Possible evidence in Portfolio** | **🗸🗴** | **Comments** |
| **E1** | End of Life Care achieves the Priorities for Care of the Dying Person (as set out by the Leadership Alliance for the Care of Dying People) | Case study to highlight the Five Priorities for CareStaff have attended session  |  |  |
| **E1** | Anticipatory medications are appropriately prescribed in people identified as requiring EOLC | Copy of anonymised medication chart showing use referenced to notes |  |  |
| **E2** | Staff are supported in providing EOLC | Staff have taken part in Six Steps training programme and completed Six Steps Learning LogCare home end of life care training planList of available end of life care education |  |  |
| **E2** | The care home is working towards an independent accreditation standard | This portfolio will provide this evidence of Six Steps Programme if competed and kept up to date |  |  |
| **E2** | EOLC training/ up-skilling is provided to staff, to ensure that people receive appropriate care 24/7 | Staff have completed Six Steps to Learning Logs |  |  |
| **E2** | New staff receive training during their induction period | EOLC is identified in new staff induction programme  |  |  |
| **E2** | Staff are trained in Advance Care Planning | Staff have completed ACP training and recorded in Six Steps to Learning Logs |  |  |
| **E3** | Nutrition and hydration needs at the end of life are included in people’s individual care plans | Anonymised example from notesDiscussion with SALT or dietician |  |  |
| **E4/ E5** | People are considered for referral to specialist palliative care when appropriate | Example of when this has occurred |  |  |
| **E4/W5** | EOLC is coordinated across areas, and with external providers and services  | Examples where this has taken place or use of a local electronic recording tool such asElectronic Palliative Care Coordination System (EPaCCS) |  |  |
| **E4** | The care participates in a Palliative Care Multidisciplinary Team meeting | Record of meetings and actions |  |  |
| **E4** | There is effective communication between the EOLC team and other services | Examples where this has taken placeList of key contacts readily accessible for all staff |  |  |
| **E5** | GPs are informed that a person has been identified as requiring EOLC | Examples of when this has happened  |  |  |
| **OTHER COMMENTS** |

**Caring**

Staff involve and treat people with compassion, kindness, dignity and respect

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| **KLOE** | **Prompts/measures** | **Possible evidence in Portfolio** | **🗸🗴** | **Comments** |
| **C1** | Care after death ensures that the spiritual and cultural wishes of the deceased person and their family and carers are met whilst making sure legal obligations are met | Example or case study of a situation as to how this was achieved |  |  |
| **C1** | People receiving EOLC are supported emotionally, especially those who do not have family or friends to support them | Evidence of ongoing support with resident and/or family  |  |  |
| **C1/ C2** | Staff ensure that sensitive communication takes place between staff and the dying person, and those identified as important to them | Example of when this has occurredStaff have completed communications training and recorded in Six Steps to Learning Logs |  |  |
| **C1/ C2** | Staff are able to recognise communication barriers because of dementia, learning difficulties or other health related impairments | Appropriate strategies are in place to support communication, e.g., a picture board |  |  |
| **C1/ C2** | When a person is in the last days and hours of life, the dying person and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants | Staff are able to recognise and record when a resident’s signs and symptoms have increased or his/her condition has deteriorated |  |  |
| **C1/ C3** | Staff ensure that the needs of families and others important to a person who is dying are actively explored, respected and met as far as possible, including after the person has died | Evidence of ongoing communication with resident and/or familyRefer to relevant information, e.g. what to do after a death? (On-line at gov.uk) |  |  |
| **C3** | Privacy and dignity of the deceased person are maintained | Example or case study of a situation as to how this was achieved  |  |  |
| **OTHER COMMENTS** |

**Responsive**

Services are organised so that they meet people’s needs

| **KLOE** | **Prompts/measures** | **Possible evidence in Portfolio** | **🗸🗴** | **Comments** |
| --- | --- | --- | --- | --- |
| **R1** | The environment is made conducive for people who are dying | Evidence of how the environment provides privacy, dignity and respectPhotos (with consent if residents are portrayed) |  |  |
| **R1** | There are facilities for relatives to be able to stay with the person | As above |  |  |
| **R1** | People who are approaching the end of life identified are offered and given the opportunity to create an Advance Care Plan, including EOLC wishes and any advanced directives (including organ donation) | The care home has a Policy or guidance on how Advance Care Planning will be implemented in the homeExamples of literature usedEvidence of best interest decisions where resident lacks capacity |  |  |
| **R1** | Staff are informed of a person’s Advance Care Plan and Preferred Place of Care | Policy or guidance on how Advance Care Planning will be implemented in the home |  |  |
| **R2** | People’s views and experiences are gathered and acted on to shape and improve the services and culture | Examples of how views are sought and how changes have been made as a result of these |  |  |
| **R2** | People’s spiritual, religious, psychological and social needs are taken into account and provided for | Information available showing different religious/cultural needs at end of lifeExamples of supporting literature used, e.g. leaflets |  |  |
| **R3** | There is a nominated lead or champion/ link worker for end of life care | Home information showing nominated lead/champion for end of life care |  |  |
| **R3** | A individualised end of life care plan is in use which helps staff identify and care for people at the end of their life | Anonymised example of an individualised end of life care planEvidence of regular review of needs (updated care plan, documentation) |  |  |
| **R3** | People who are likely to be in the last 12 months of life are identified in a timely way | Use of the North West End of Life Care Model, PIG, SPICT or similarUse of a Supportive Care Record or similar |  |  |
| **OTHER COMMENTS** |

**Well led**

The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture

| **KLOE** | **Prompts/measures** | **Possible evidence in Portfolio** | **🗸🗴** | **Comments** |
| --- | --- | --- | --- | --- |
| **W1** | The care home has an end of life care policy, guidance or statement | Care home end of life policy or guideline |  |  |
| **W4** | There is a service improvement plan for EOLC | A service improvement plan is in place |  |  |
| **W4** | The care home uses an EOLC Quality Assessment Tool | Copy of a completed quality assessment tool, e.g., Six Steps Organisational Programme Audit |  |  |
| **OTHER COMMENTS** |