

Portfolio Guidance and Checklist for Facilitators

For Facilitators



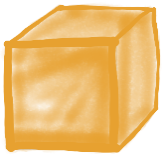
Wellbeing

Care and Support

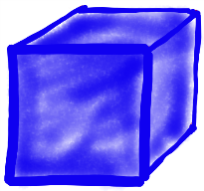
Leadership and Management

Environment









*Adapted with the kind permission of the Cheshire & Merseyside Clinical Network and the Greater Manchester, Lancs & South Cumbria Clinical Network 2020*

**Welcome to your 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, you are required to develop a portfolio of evidence to demonstrate that you have met the outcomes of the programme. The portfolio is aligned to the four assessment themes that are asked by the Care Inspectorate Wales (CIW) during inspections. Each of these four assessment themes are broken down into a further set of questions called lines of enquiry (LOEs). LOE R3 specifically relates to end of life care, however, good end of life care spans across many of the LOEs, so the prompts have been aligned more broadly. These would also fully address the requirements of LOE R3. The portfolio remains in the care home and can be shared with commissioners, Local Authority monitors and CIW.

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 an individual 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 1 to 2 years, and this can be updated as part of the refresh programme ‘Stepping forward’.

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| **What well-being means** | **National well-being Outcomes** | **Line of Enquiry** | | |
| **C & S** | **L & M** | **ENV** |
| 1. **Securing rights and entitlements**   **Also for adults: Control over day-to-day life** | **I know and understand what care, support and opportunities are available and use these to help me achieve my well-being.**  **I can access the right information, when I need it, in the way I want it and use this to manage and improve my well-being.**  **I am treated with dignity and respect and treat others the same.**  **My voice is heard and listened to.**  **My individual circumstances are considered.**  **I speak for myself and contribute to the decisions that affect my life, or have someone who can do it for me.** | 1, 2, 3, 11, 15 | 3, 4, 9, 10, 11, 14 | 21 |
| 1. **Physical and mental health and emotional  well-being**   **Also for children: Physical, intellectual, emotional, social and behavioural development** | **I am healthy and active and do things to keep myself healthy.**  **I am happy and do the things that make me happy.**  **I get the right care and support, as early as possible.** | 1, 2, 3, 7, 11, 15 | 3, 9, 10, 11, 13, 14 |  |
| 1. **Protection from abuse and neglect** | **I am safe and protected from abuse and neglect.**  **I am supported to protect the people that matter to me from abuse and neglect.**  **I am informed about how to make my concerns known.** | 1, 2, 3 | 9, 10, 11, 13, 14, 15, 18 |  |
| **4. Education, training and recreation** | **I can learn and develop to my full potential.**  **I do the things that matter to me.** | 2, 3 | 3, 9 |  |
| **5. Domestic, family and personal relationships** | **I belong.**  **I contribute to and enjoy safe and healthy relationships** | 1, 2, 3 | 9, 10, 11,  13 - 15 | 3 |
| **6. Contribution made to society** | **I engage and make a contribution to my community.**  **I feel valued in society.** | 2, 3 | 4, 14 |  |
| **7. Social and economic well-being**  **Also for adults: Participation in work** | **I contribute towards my social life and can be with the people that I choose.**  **I do not live in poverty.**  **I am supported to work.**  **I get the help I need to grow up and be independent.**  **I get care and support through the Welsh language if I want it.** | 2, 3, 7 | 9-11 13-15 |  |
| **8. Suitability of living accommodation** | **I live in a home that best supports me to achieve my well-being.** | 1, 2, 3 | 4, 9,  11, 14 | 21 |

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Environment

The physical setting in which care and support is provided.

| **LOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** | **√ X** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| **21** | The environment is made conducive for people who are dying | 4 & 5 | Evidence of how the environment provide privacy, dignity and respect. |  |  |
| **21** | Privacy and dignity of the deceased person are maintained | 6 | Last office policy, SEA, audit |  |  |
| **3** | There are facilities for relatives to stay with the deceased or dying person | 4 | Evidence of how the environment provide privacy, dignity and respect. |  |  |
| **Other comments** | | | | | |

**Care and Support**

The quality of care and support staff provide. Staff involve and treat people with compassion, kindness, dignity and respect.

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| **LOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** | **√ X** | **Comments** |
| **2, 3** | 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 | 6 | Example of a situation as to how this was achieved ( personal plan) |  |  |
| **3** | People receiving EOLC are supported emotionally, especially those who do not have family or friends to support them | 5 | Evidence of ongoing support with resident and/or family |  |  |
| **3** | Staff ensure that sensitive communication takes place between staff and the dying person, and those identified as important to them | 1,2 &5 | Example of when this has occurred  Staff have completed communications training and recorded in Six Steps to Learning Logs, care decisions, personal plan, ACP |  |  |
| **2 & 3** | Staff are able to recognise communication barriers because of dementia, learning difficulties or other health related impairments | 1&2 | Appropriate strategies are in place to support communication, e.g., a picture board, communication sheets |  |  |
| **3** | 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 | 2, 5 | Staff are able to recognise and record when a resident’s signs and symptoms have increased or his/her condition has deteriorated, supportive care register; escalate concerns & care decisions, ACP. |  |  |
| **3** | 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 | 5&6 | Evidence of ongoing communication with resident and/or family (personal plan or care decisions, LPA)  Refer to relevant information; e.g. what to do after a death? (On-line at gov.uk) |  |  |
| **3** | End of life care achieves the priorities for the care of the dying person | 5 | Care decisions document to highlight the 5 priorities of care or personal plan. Staff have attended care decisions training. |  |  |
| **7** | Anticipatory medications are appropriately prescribed to those identified as requiring end of life care. | 5 | Care decisions, medication chart, control drug register, medicine administration record, and personal plan. |  |  |
| **3** | Nutrition and hydration needs at the end of life are included in people’s individual personal plans. | 2 | Anonymised examples from notes with discussion with SALT or dietician or EoLC team. Evidence or oral care in personal plan. |  |  |
| **2, 3** | Individuals identified as approaching the end of life are offered and given the opportunity to create an advance care plan. This includes end of life care wishes and any advance directive including organ donation. Staff are aware of the personal PPC and ACP, with consent. | 1 & 2 | In the end of life care policy or statement. ACP, best interest decision. Evidence of an event or gathering to share benefits of an ACP |  |  |
| **15** | There is a nominated lead or champion / key worker for end of life | 3 | The home information showing a nominated key worker for end of life care. Information added to supportive care register, information board. |  |  |
| **3,11** | A individualised end of life care personal plan is in use which helps staff identify and care for people at the end of their life | 1 & 5 | Anonymised end of life personal plan, evidence of regular review, evidence of holistic assessment and planning |  |  |
| **1** | Individual’s spiritual, religious, psychological and social needs are taken into account and provided for. | 2,4 & 5 | Information available showing different religious and cultural needs at the end of life. Examples of literature used. |  |  |
| **11, 3** | People who are likely to be in the last 12 months of life are identified in a timely way | 1 | Use of the North West End of Life Care Model, PIG, surprise questions or similar  Use of a Supportive Care Record or similar and personal plan. |  |  |
| **3** | DNACPR decisions are made appropriately and in line with national guidance. | 2 & 3 | Anonymised DNACPR completed document |  |  |
| **Other Comments** | | | | | |

**Leadership and Management**

Organisational arrangements for the provision of care and support

| **LOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** | **√ X** | **Comments** |
| --- | --- | --- | --- | --- | --- |
| **9, 10,14** | The care home has an end of life care policy, guidance or statement | 1 | Care home end of life policy or guideline |  |  |
| **11** | There is a service improvement plan for EOLC | At end | A service improvement plan is in place |  |  |
| **11** | The care home uses an EOLC Quality Assessment Tool | 1&6 | Copy of a completed quality assessment tool, e.g., Six Steps Organisational Programme Audit |  |  |
| **13** | Providing information about incidents which happen & the outcome | 4 | Significant Event analyses |  |  |
| **14, 4** | Referrals to other agencies with clear understanding of service provisions. | 3 | Referral forms |  |  |
| **3, 14** | There is effective communication between the care setting and other services such as EOLC team, GP. | 3 | Referral forms, key contacts list, personal plans, care decision document. |  |  |
| **18** | Staff are aware of the process of notification of sudden / shorten death | 6 | Last office policy and audit. |  |  |
| **9, 15** | Staff are supported in providing end of life care, by upskilling / training to ensure people receive appropriate care 24/7. New staff receive EoLC training during their induction period. | 4 | Staff have attended the Six Steps Programme. The learning log book, training matrix |  |  |
| **9, 3** | Staff are trained in advance care planning | 2 | Attendance at ACP training and recorded in their learning log |  |  |
| **Other Comments** | | | | | |