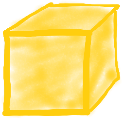


Portfolio Guidance Template for Care Homes

For Care Homes



Safe

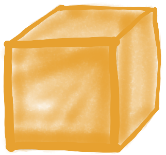
Effective

Caring

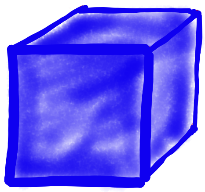
Responsive

Well led









Welcome to your portfolio

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 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 following five sections will help you put together a portfolio. This can be a simple file and your facilitator can provide you with dividers if you need them.

The aim of completing a portfolio is for you to be able to think about the key areas of end of life care and use the portfolio to reflect on your practice as well as gather evidence. The sections give you examples of things that you could use for evidence, but you can be as creative as you wish as long as you are able to show how these are achieved. You may wish to use examples, case studies or links to areas of work in the care home. You can cross-reference certain sections, so one piece of evidence may relate to more than one measure.

Don’t forget that all examples of information in the portfolio that includes resident information must be anonymised and there must be no identifiable details on show.

You will work with your facilitator, who will be able to guide you on completion. Once you are ready, your facilitator will review your portfolio and if they are satisfied you have demonstrated through your portfolio, that you have met the outcomes for the programme through the evidence identified within the five sections, you will be presented with a certificate that confirms, that at that moment in time, the care 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.

Even though you may have ‘completed’ the programme, you will need to keep the portfolio updated as you will be able to use this with inspections and share with local commissioners etc. as evidence of good practice. We also recommend that the Six Steps Programme is renewed at least every 2 years, and you can update as part of the refresh programme ‘Stepping forward’.

Aim for the sky, but move slowly, enjoying every step along the way. It is all those little steps that make the journey complete.

*Chanda Kochhar*

Safe

People are protected from abuse and avoidable harm

| **KLOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** |
| --- | --- | --- | --- |
| **S2** | DNACPR decisions are made appropriately and in line with national guidance | 2&3 | Anonymised example of a DNACPR discussion and decision |
| **S2** | Decisions about mental capacity are made appropriately and in line with national guidance | 2&3 | 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) | 4 | Examples of reflective learning practices |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE** | | | |

**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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **KLOE** | **Prompts/measures** | **Step** | | **Possible evidence in Six Steps Portfolio** |
| **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) | 5 | Case study to highlight the Five Priorities for Care  Staff have attended session | |
| **E1** | Anticipatory medications are appropriately prescribed in people identified as requiring EOLC | 5 | Copy of anonymised medication chart showing use referenced to notes | |
| **E2** | Staff are supported in providing EOLC | 4 | Staff have taken part in Six Steps training programme and completed Six Steps Learning Log  Care home end of life care training plan  List of available end of life care education | |
| **E2** | The care home is working towards an independent accreditation standard | All | 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 | 4 | Staff have completed Six Steps to Learning Logs | |
| **E2** | New staff receive training during their induction period | 4 | EOLC is identified in new staff induction programme | |
| **E2** | Staff are trained in Advance Care Planning | 2 | 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 | 5 | Anonymised example from notes  Discussion with SALT or dietician | |
| **E4/ E5** | People are considered for referral to specialist palliative care when appropriate | 3 | Example of when this has occurred | |
| **E4/W5** | EOLC is coordinated across areas, and with external providers and services | 3 | Examples where this has taken place or use of a local electronic recording tool such as  Electronic Palliative Care Coordination System (EPaCCS) | |
| **E4** | The care participates in a Palliative Care Multidisciplinary Team meeting | 3 | Record of meetings and actions | |
| **E4** | There is effective communication between the EOLC team and other services | 3 | Examples where this has taken place  List of key contacts readily accessible for all staff | |
| **E5** | GPs are informed that a person has been identified as requiring EOLC | 3 | Examples of when this has happened | |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE AND OVERLEAF** | | | | |

**Caring**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **KLOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** |
| **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 | 6 | 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 | 5 | 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 | 1&5 | Example of when this has occurred  Staff 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 | 1&2 | 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 | 5 | 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 | 5&6 | Evidence of ongoing communication with resident and/or family  Refer 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 | 6 | Example or case study of a situation as to how this was achieved |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE** | | | |

**Responsive**

Services are organised so that they meet people’s needs

| **KLOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** |
| --- | --- | --- | --- |
| **R1** | The environment is made conducive for people who are dying | 5 | Evidence of how the environment provides privacy, dignity and respect  Photos (with consent if residents are portrayed) |
| **R1** | There are facilities for relatives to be able to stay with the person | 5&6 | 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) | 1&2 | The care home has a Policy or guidance on how Advance Care Planning will be implemented in the home  Examples of literature used  Evidence of best interest decisions where resident lacks capacity |
| **R1** | Staff are informed of a person’s Advance Care Plan and Preferred Place of Care | All | 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 | 4 | 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 | 2,4&5 | Information available showing different religious/cultural needs at end of life  Examples of supporting literature used, e.g. leaflets |
| **R3** | There is a nominated lead or champion/ link worker for end of life care | 3 | 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 | 1&5 | Anonymised example of an individualised end of life care plan  Evidence 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 | 1 | Use of the North West End of Life Care Model, PIG, SPICT or similar  Use of a Supportive Care Record or similar |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE** | | | |

**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** | **Step** | **Possible evidence in Six Steps Portfolio** |
| --- | --- | --- | --- |
| **W1** | The care home has an end of life care policy, guidance or statement | 1 | Care home end of life policy or guideline |
| **W4** | There is a service improvement plan for EOLC | At end | A service improvement plan is in place |
| **W4** | 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 |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE** | | | |