

Where are we now? Mapping activity

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| **CQC key question** | **These link to the organisational audit so**  **those criteria should be utilised** | **Step/s** | **Assessment re frequency /attributes** | **Gaps identified** |
| **Is the service well led?** | Does the care home have an End of Life Care policy/ guidelines/ statement? | Step on |  |  |
| **Is the service safe?** | Are Mental Capacity Assessments completed? | 2,3 |  |  |
| Do Best Interest Discussions take place? | 2,3 |  |  |
| Are DNAR-CPR forms/decisions completed? | 2,3 |  |  |
| **Is the service effective?** | How is end of life care training provided?  How many staff have received end of life care training within the last 12 months? | 4 |  |  |
| Is there a plan to consider anticipatory medicines prescribing? | 5 |  |  |
| **Is the service caring?** | Do conversations about end of care take place?  How are these documented? | 1,2,3  2 |  |  |
| Is information given about approaching end of life provided? | 2,3 |  |  |
| Is bereavement support offered? | 6 |  |  |
| **Is the service responsive?** | Is an individualised plan for end of life care or similar completed? | 5 |  |  |
| Are Advance Care Plan discussions documented?  What format do these take? | 1,2,3  2 |  |  |
| Does the care home have a Supportive Care Record in use?  Does the care home liaise with GPs re GSF register or similar? | 1  3 |  |  |

*Continued over*

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| **Other areas to consider** | **Step/s** | **Assessment re frequency**  **/attributes** | **Gaps identified** |
| Regular Significant Event Analysis | 4 |  |  |
| Working within the wider MDT, including appropriate referrals? | 3 |  |  |
| Care after death, including physical, spiritual, social and psychological care for the deceased, relatives and other residents | 6 |  |  |
| Sensitive communications take place around all areas of end of life care | 1,3,5,6 |  |  |
| Support of relatives/relatives/friends during the final days of life | 5 |  |  |
| Appropriate environment for end of life care | 5 |  |  |
| Feedback mechanisms/processes are in place | 4 |  |  |
| Spiritual and religious needs are identified and met | 2,4,5 |  |  |
| There is a nominated end of life champion/lead | 3 |  |  |
| There is a service improvement plan for EOLC | Step off |  |  |
| **Add any additional areas below** |  |  |  |
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*Once this mapping activity has been completed, the care home and the Six Steps facilitator will need to use the Action Plan form to address any gaps and plan for the Six Steps Programme*