

Portfolio Guidance Template
for Care Homes

For Care Homes



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**

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 following 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 1 to 2 years, and you can update 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 | 9-1113-15 |  |
| **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 |

Environment

The physical setting in which care and support is provided.

| **LOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** |
| --- | --- | --- | --- |
| **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. |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE** |

**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** |
| **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 occurredStaff 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 similarUse 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 |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE** |

**Leadership and Management**

Organisational arrangements for the provision of care and support

| **LOE** | **Prompts/measures** | **Step** | **Possible evidence in Six Steps Portfolio** |
| --- | --- | --- | --- |
| **9, 10,14** | The care home has an end of life care policy, guidance or statement | 1 | Care home end of life care 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 |
| **PLEASE FEEL FREE TO ADD FURTHER EVIDENCE HERE** |