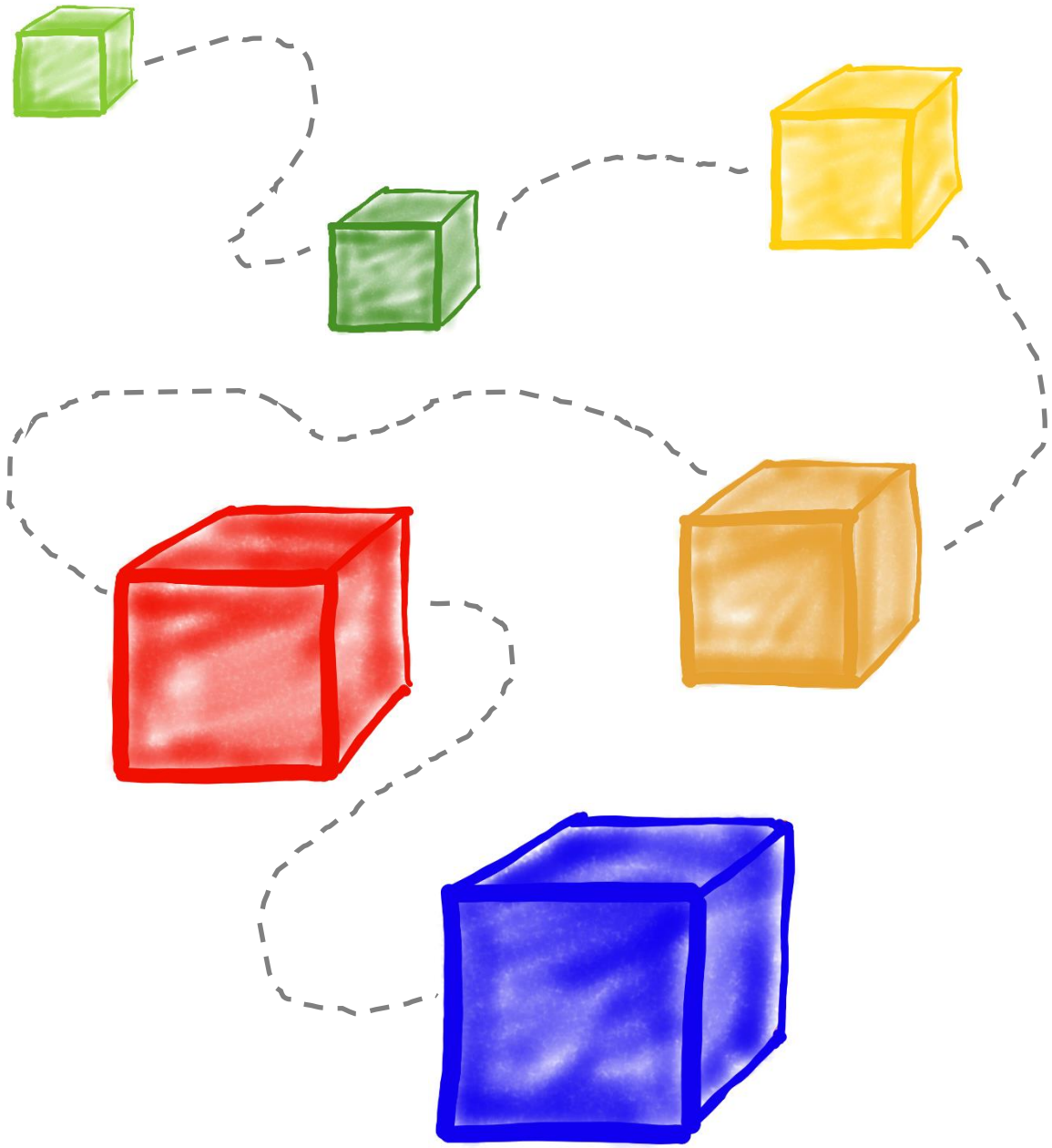
Six Steps
to success
The North West End of Life Care
Programme for Care Homes

Full Facilitators Guide



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Contents

Introduction

Many care homes have the enthusiasm to deliver good end of life care but may need support to identify what is their best practice and what additional systems might enhance their service delivery.

The programme is a collaborative project between Merseyside and Cheshire Cancer Network, Greater Manchester and Cheshire Cancer Network and Cumbria and Lancashire End of Life Network and has received support and advice from the National End of Life Care Programme.

The National End of Life Care Programme document, The Route to Success in End of Life Care - achieving quality in care homes (2010) was developed as a resource to help care homes identify the processes involved in the provision of high quality end of life care.

The Route to Success follows the six steps laid out in the national strategy and includes questions for staff and managers to ask themselves about the end of life care provision in their care home.

Many care homes have embraced the document and its approach, using it as a tool to analyse the levels of service delivery within their settings.

In 2010, the end of life care home coordinators in the North West of England took this process one step further and developed a workshop style training programme. In 2017, the programme was moved to a new website and had a content refresh. In 2018, following extensive consultation with end of life care facilitators from across the UK, the revised programme within this guide was developed. It takes the original programme back to its' roots and offers a specific organisational programme, but now also offers an integrated staff education programme. Both parts of the programme can be delivered in a traditional workshop style or can be supported more flexibly.

This guide is intended to provide an overview of the programme, however, all resources to support the delivery of the programmes are available to access at www.sixsteps.net

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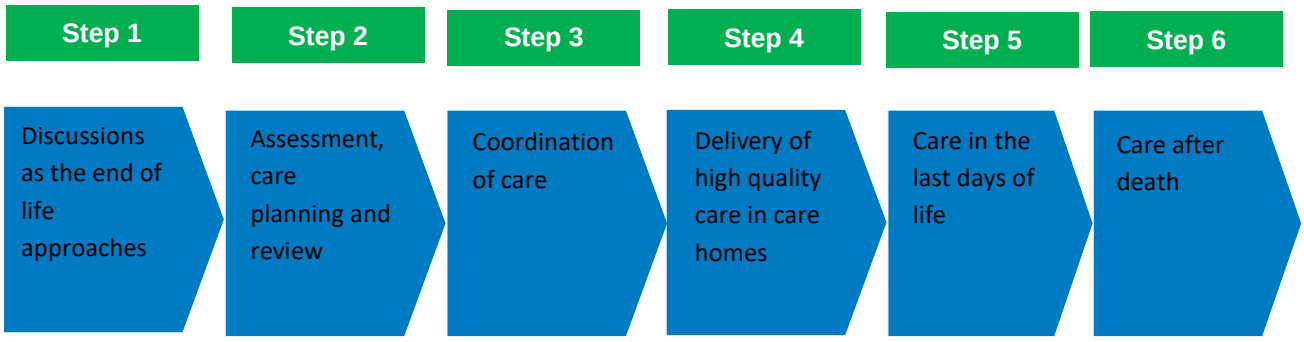
The Programme Overview

The Six Steps for Care Homes follows the six steps laid out in the national strategy, 'The route to success in end of life care - achieving quality in care home'. Initial discussion about death and future care, on to assessment and the provision of high quality co-ordinated care and support through to the final days and end of life.

The Route to Success Six Steps



Open, honest communication Identifying triggers for discussion	Conduct a holistic assessment Agreed care plan and regular review of needs and preferences Assessing needs of carers	Coordination working with primary and community health services, ambulance transport services and social care Coordination of individual patient care Create adequate communication systems across care settings	Dignified environment Treat with dignity and respect Access support from other health and social care services Making best use of resources	Identification of the dying phase Review of needs and preferences for place of death Support for both patient and carer Recognition of wishes regarding resuscitation and organ donation	Recognition that end of life care does not stop at the point of death Timely verification and certification of death or referral to the Coroner Care and support of carer and family, including emotional and practical bereavement support

There are two interlinked programmes within the overarching programme: the **Organisational Programme** and the **Six Steps to learning** (a staff education programme).

Each part adopts the process of Six Steps and they are designed to be complementary to each other, however, while the organisational programme utilises care home representative/s to implement the structured organisational change, the Six Steps to Learning supports staff development and learning across the whole organisation in small flexible chunks.

Flexible delivery, flexible implementation and flexible learning

Both programmes are designed to be delivered flexibly to meet the needs of individual care homes and individual staff within those care homes.

The programme can be delivered in a number of different ways to support and empower the care home representatives to implement and embed the Six Steps to Success within their care home.

As with the original programme, it can be delivered within a workshop format which will comprise of six workshops, however, depending on the need of a care home, it can also be delivered to individually to match their current needs. This can be useful when care homes have already got a high level of understanding of end of life care or have previously completed the programme or have undertaken other forms of development around end of life.

The programme starts with a process called '**Stepping on**', and will be completed by '**Stepping off**'.

The entire programme is based over 8 phases:

Stepping on: A pre programme implementation stage
Step 1: Discussions as the end of life approaches
Step 2: Assessment, care planning and review
Step 3: Coordination of care
Step 4: Delivery of high quality care in care homes
Step 5: Care in the last days of life
Step 6: Care after death
Stepping off: Completing the programme

In addition, there is a refresh programme for care homes that have previously undertaken Six Steps **Stepping forward.** It is advised that homes undertake this at least every 1 to 2 years.

The Organisational Programme

The programme utilises a care home representative/s from each care home to implement the structured organisational change to deliver the best end of life care based on the National End of Life Care Programme guidance (2010) – The Route to Success in end of life care - achieving quality in care homes.

This can be delivered in cohorts or to individual care homes. Prior to starting the Six Steps organisational programme, all care homes must undertake '**Where are you now'**. This is a mapping exercise that enables the care home and their facilitator to work out an individual programme for the care home. For some homes, they may need to complete the whole programme while others may require to complete certain aspects of the programme. All care homes, regardless of their

starting point will need to complete a portfolio in order to successfully 'complete' the Six Steps programme and gain a certificate of completion.

Staff Education Programme

The programme contains a set of learning outcomes which comprise a number of core aspects necessary for staff to support high quality end of life care. In addition, there are a number of suggestions for additional learning, and staff can add their own as well. These are identified in the **Six Steps to Learning Logs**, however, areas may already have learning records (many areas call these 'passports' or similar) that might be utilised instead.

These learning outcomes are intended to offer a flexible approach to the programme. Learning can take place in a variety of different ways and this guide offers suggestions as to how they can be met as well as a number of lesson plans and worksheets for delivery of the core outcomes.

There are two versions of the **Six Steps to Learning Logs**. One is aimed at the Six Steps Champions (i.e., those staff who are nominated to lead and support the programme) and the other is aimed at other care home staff, who will not have been directly involved with the Organisational Programme. This has been a major change to the revised Six Steps programme to ensure that it is not only the Champions that increase their end of life care knowledge.

The Welsh Language Standards

Following on from the Welsh Language (Wales) Measure 2011, we need to ensure we are making an 'Active Offer' in relation to the training we are delivering and how staff completing the programme are sharing the information with residents, patients and families. An active offer means we provide the service in Welsh without someone having to ask for it.

- It means creating a change in culture that takes the responsibility off the patient / resident to ask for a service through the medium of Welsh.
- Making an 'Active Offer' means not making assumptions that all Welsh speakers speak English
- A proactive approach is needed to ensure language need is identified as part of safe, high-quality care
- It is also about creating the right environment

This should be considered during any of the steps.

This guide is intended to provide an overview of the programme, however, all resources to support delivery of the programmes are available to access at www.sixsteps.net

Implementation of the Six Steps to Success Programme

The programme has been developed to be inclusive of all care homes. Further guidance around the process of recruitment, implementation and all resources and templates (highlighted in italics on the programme plans) contained in the programmes can be found at **www.sixsteps.net**. The pre programme implementation plan '**Stepping on**' should always consider sustainability.

Points to consider:

- Ensure the nominated representative/s has the authority to implement change within the organisation
- There is engagement and agreement from local authorities and Health Boards
- Raise awareness with health and social care organisations
- Consider what integrated working looks like in practice within the locality
- On-going support and dissemination of information to the organisations post programme e.g. End of Life Care Forums
- Post programme collection and analysis of post programme audits to monitor and support those homes who may require further support

The length of time it takes to deliver the organisational programme is flexible and dependent on each local area, for example, one half day workshop per month over six months.

It is suggested the education for all staff, to support this programme, is delivered over the same period as the organisational programme considering the following points:

- Use of **Six Steps to Learning Log** or equivalent
- Agreed proportion of staff who will undergo the key learning outcomes identified within the log
- The facilitator will support staff to achieve key learning outcomes and either support optional learning or signpost to opportunities for staff to achieve the learning outcomes externally
- The key learning outcomes can be delivered in a number of ways. Within each of the following steps are ideas and resources to how these can be done.

Delivery of each step always starts with an overview from the Route to Success guide to ensure representatives understand their role in delivering high quality end of life care. They conclude with a **'To Do' list** for the representative to action before the next step. Facilitators will be able to identify at the earliest opportunity organisations that require extra support from reviewing the '**To Do List**'.

It is suggested the organisations are given an agreed timeframe to embed the programme and complete the portfolio of evidence e.g. 3 months.

The Facilitator has licence to use their professional judgment in the content and delivery of the workshops, ensuring the measures from the programme are achieved at all times. The Facilitator should try and integrate local policies and guidance into the programme as much as possible.

This guide is intended to provide an overview of the programme, however, all resources to support delivery of the programmes are available to access at www.sixsteps.net
There is a specific tab for Six Steps Wales resources WHERE THEY DIFFER FROM THE ORIGINAL PROGRAMME.

Recruitment

The programme has been primarily developed for care homes. However, to be inclusive of all care homes, the programme can be adapted to suit the individual care setting; ensuring all the set outcomes are met. Discussions with the local multidisciplinary team should take place prior to the programme commencing to ensure care homes have support to meet the programme outcomes.

It is suggested you hold an awareness event to introduce the Six Steps to Success Programme. The aim is to invite all interested care homes, giving consideration on how to manage numbers.

Participation criteria has been developed not to limit recruitment but to affirm commitment to the Six Steps to Success Programme.

There are a number of resources on the website that will support the recruitment phase:

- Recruitment Leaflet
- Letter of Invite to Care Homes
- Registration Form
- Communication Letter for Care Homes to Distribute
- Participation Criteria
- Roles and Responsibilities
- Attendance Register
- Recruitment PowerPoint Presentation (if appropriate)

Stepping on

Aim
To commence the Six Steps to Success Programme
Objectives
For the facilitator and the care home to have an understanding of the current position of the care home in relation to the Six Steps Programme
For all parties to feel prepared to undertake the programme
An agreed action plan to undertake the programme

At a glance

ORGANISATIONAL PROGRAMME		OUTCOME	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Complete pre-programme audit	Pre-programme audit	**Have an understanding of current position**	KSC self-assessment	KSC audit
Cross-reference to 'where are we now' document to understand 'gaps'	Where are we now? Mapping Activity	**Feel prepared to undertake programme**		
Assess gaps to plan programme Evidencing care provision	Action Plan Identify staff education need Portfolio mapped to CIW standards	**A completed action plan**	Complete Learning log (Note Key and Optional learning outcomes)	Six Steps to Learning log (or equivalent)

Audits

There are two audits within the Six Steps Programme: the **Organisational Programme Audit** and the **Knowledge, Skills and Confidence Audit**.

The **Organisational Programme Audit** will help to develop the Six Steps to Success Programme and it is important to capture data to demonstrate the effectiveness of the programme and identify the provision of end of life care in relation. The Organisational Programme Audit should be carried out prior to the commencement of the programme and again at the end of life programme.

The **Knowledge, Skills and Confidence Audit** has been designed so that data can be collected from care home staff across sixteen key areas of End of Life Care. This audit should assist in preparing feedback and in developing reports to evaluate the implementation of the Six Steps to Success Programme. The Knowledge, Skills and Confidence Audit should be carried out prior to the commencement of the programme and again at the end of life programme.

There are several audit tools that will support collation and analysis of the information and they are available on the website along with full guidance documents.

'Where are we now?' Mapping Activity and Action Planning

The '**Where are we now?**' activity is one of the key areas that promote a flexible approach to the Six Steps Programme. For all care homes starting on the Six Steps Programme, regardless of whether they have previously completed an end of life care programme should begin with mapping their current level of end of life care practice and delivery. This will help both the care home and the facilitator to gain an understanding of the current position of the care home and their strengths and areas for development (gaps). The areas to be considered are linked to the CIW themes and lines of enquires (and the Six Steps Portfolio).

Once the mapping activity has been completed, the care home and the Six Steps facilitator will then need to complete the **Action Plan** form to address any gaps and make a plan for the Six Steps Programme. For areas that **both** the care home and facilitator agree are currently being well met, they do not have to be unnecessarily repeated. However, the facilitator as the expert in end of life care needs to agree this, and if there are any areas of doubt then that topic or aspect should be included in the subsequent programme.

Six Steps to Learning – Logs for Champions and for Care Home Staff

The programme contains a set of learning outcomes which comprise a number of core aspects necessary for staff to support high quality end of life care. In addition, there are a number of suggestions for additional learning, and staff can add their own as well.

These learning outcomes are intended to offer a flexible approach to the programme. Learning can take place in a variety of different ways and this guide offers suggestions as to how they can be met as well as a number of lesson plans and worksheets for delivery of the core outcomes. Facilitators can agree which are the key learning outcomes to be achieved depending on the nature of end of life care, the type of care home and the role of individual staff.

It is suggested the education for all staff, to support this programme, is delivered over the same period as the organisational programme considering the following points:

- Use of **Six Steps to Learning Log** or equivalent
- Agreed which staff will complete the **Six Steps Learning Log for Six Steps champions**
- Agreed proportion of other staff who will undergo the key learning outcomes identified within the **Six Steps Learning Log for care home staff**
- The facilitator will support staff to achieve key learning outcomes and either support optional learning or signpost to opportunities for staff to achieve the learning outcomes externally
- The key learning outcomes can be delivered in a number of ways so could be delivered directly with case studies, discussions etc. However, given the challenges of staff being able to attend sessions, there are on-line resources, individual activities and reflection sheets. Within each of the following steps are ideas and resources to how these can be done. Many of these link to the resources within each step on the website

The learning logs have space for recording when and how each outcome has been achieved, and a place for a signature. The facilitator is not responsible for signing every log (especially if several care home staff are completing them), however, it is important to be consistent in the level required, so it would be helpful for the facilitator to support senior staff to cascade this to others.

The Portfolio

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.

An easy portfolio can be created using the dividers and a front insert file cover that is available on the website on the STEPPING ON page.

The portfolio is divided into THREE SECTIONS that align to the three themes with the Wellbeing Framework running through all three themes that are asked by the Care Inspectorate Wales (CIW) during inspections. Each of these three themes are then broken down into a further set of questions called lines of enquiry (LOEs). LOE 3 – Regulation 21 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 address the requirements of LOE 3. The portfolio remains in the care home and can be shared with commissioners, Local Authority monitors and CIW.

The Organisational Programme links closely to the portfolio, but the portfolio is intended to show changes in practice in the care homes not attendance at the sessions. It is worth recapping at the end of each session how the content links to the portfolio but it requires **the content to be translated into changes in the care home**, either culturally, organisationally or practically.

Creativity in developing the portfolio 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

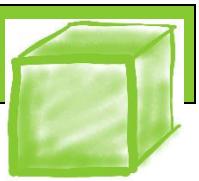
to implement what is needed by compiling an action plan together with identified timelines and then support the care home to implement and produce the evidence required. All information included within the portfolio must be anonymised and not contain any information that could make a resident identifiable.

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 the facilitator to record all other pieces of evidence the care home has provided.

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'.

Step 1 - Discussions as the end of life approaches



Overview

Aim
The care home will be able to identify individuals who are entering the last year of life so discussions on end of life care can take place at the appropriate time
Objectives
The care home will have an end of life care statement if they do not already have a statement/policy or guideline in place
Be able to identify how the North West Model for Life Limiting Conditions supports a Supportive Care Record leading to the recognition of individuals who may be in the final year of life
Be able to identify **when** to undertake Advance Care Planning discussions

At a glance

ORGANISATIONAL PROGRAMME		**OUTCOME**	**STAFF EDUCATION PROGRAMME**	
Content	**Resources**		**Content**	**Resources**
Policy or action plan for use within care home	Statement template if care home do not currently have one	**To have an organisation statement for EOLC**	n/a	n/a
A system in place for identifying individuals who may be in the last year of life Identifying individuals at the end of life	North West Model Supportive Care Record	**Identify how the North West Model for Life Limiting Conditions supports a Supportive Care Record**	Understanding the systems in place	North West Model Supportive Care Record
	Supportive Care Record	**How to identify residents who may be in the final year of life**	Recognising the different stages of end of life and consider reversibility Use of the double surprise question	Proactive Identification Guidance Double surprise question Case studies
Individualised discussions around end of life care.	Sample documents	**Identify when to undertake end of life care**	Communications - supporting end of life	Session/ resources for communications, e.g., Simple

(Consider making an Active Offer).		**discussions**	discussions	Secret Skills, CLEARER, Sage and Thyme Video case studies

ORGANISATIONAL PROGRAMME

As with the original programme, the organisational programme can be delivered within a workshop format with a cohort of homes together, however, depending on the need of a care home, it can be delivered to individually to match their current need. This can be useful when care homes have already got a high level of understanding of end of life care, have previously completed the programme or have undertaken other forms of development around end of life care. If the Action Plan has been linked to the 'Where are we now?' document, it may be that only certain elements of each step are undertaken.

The following programme provides a brief 'example' of how a half day workshop might be structured. Sample PowerPoint presentations will be shared on the website. The resources identified in the staff education programme could also be incorporated into these sessions depending on the needs of the groups.

Time	Session	Activity
1pm	Welcome and introductions	Use ice breaker
1.20pm	Developing a care home end of life statement	Complete end of life statement template
2.00pm	What is end of life care/ palliative care? Identifying individuals in the final year of life	Review North West End Model for Life Limiting Conditions Practice use of the surprise question/ double surprise question with known residents How to complete a Supportive Care Register Use of case studies
3.00pm	Recognise when to start/ undertake ACP discussions	Group discussion about current practice Use of case study
3.45pm	Six Steps programme planning	Map today's session to portfolio To do list for next session
4.00pm	Evaluation	Evaluation form

STAFF EDUCATION PROGRAMME

Please read the section on page 11 regarding the use of the Learning Logs. The following tables provide some examples on how the outcomes can be achieved. Several can be achieved through e-learning, such as the e-elca (e-lfh) website (Information on how to access this is on the Six Steps website on the STEPPING ON tab.

For Six Steps champions

Learning outcomes	**Suggested ways to achieve outcomes**
Be able to complete an end of life care statement for the care home	- Present an existing policy/ guideline/ statement for end of life care, and understand the rationale for it - Completed the end of life care statement template in workshop/ session
Implement the use of a Supportive Care Record (SCR)	- Demonstrate the use of the SCR in session/meeting with current residents (included in sample session plan) - Give examples of the use with residents with different diagnoses/at different prognostic points (included in sample session plan) - Describe how the SCR will be implemented in the care home
Identify the different stages of end of life, and how to use the '(double) surprise' question	- Familiarity with the North West Model for Life Limiting Conditions (or equivalent) - Demonstrate the knowledge and use of the Proactive Identification Guidance - Be able to use the surprise question or double surprise question (included in sample session plan) plus article in downloads
Be able to identify **when** to undertake Advance Care Planning discussions relevant to role	- Complete 'How to get started and get the timing right' (e-elca session 01_12) - Attendance at the North West 'Advance Care Planning and Difficult Communications' day (or equivalent)
Optional learning outcomes	**Suggested ways to achieve outcomes**
Understand the complexity of identifying individuals at the end of life	- Complete the Long Term Conditions Case Study (in downloads) - Complete the Cancer Case Study (in downloads)

For care home staff

Key learning outcomes	**Suggested ways to achieve outcomes**
Understand what is Palliative/End of Life Care and what is Advance Care Planning (ACP)	- Watch IAPC "What is Palliative Care?" video at http://www.adultpalliativehub.com/resources/videos/iapc-what-palliative-care - Complete 'Introduction to e-learning for End of Life Care' (e-elca session 00_01) - Attendance at the North West 'Advance Care Planning and Difficult Communications' day (or equivalent)
Demonstrate an understanding of a Supportive Care Record (SCR)	- Complete Worksheet ST1.1 (in downloads)

Recognise the different stages of end of life, and why the '(double) surprise' question is used	- Complete Worksheet ST1.2 (in downloads)
Identify how to undertake ACP discussions relevant to role	- Complete 'How to get started and get the timing right' (e-elca session 01_12)
Optional learning outcomes	**Suggested ways to achieve outcomes**
Appreciate the complexity of identifying individuals at the end of life	- Demonstrate the knowledge and use of the Proactive Identification Guidance - Be able to use the surprise question or double surprise question (included in sample session plan) plus article in downloads - Complete the Long Term Conditions Case Study (in downloads) - Complete the Cancer Case Study (in downloads)

There may be resources within Wales you wish to access

https://www.nice.org.uk/search?q=palliative%20care%20guideline

https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/palliative-and-end-of-life-care-toolkit.aspx

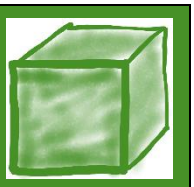
https://wales.pallcare.info/

https://socialcare.wales/research-and-data/research-on-care-finder/palliative-and-end-of-life-care-delivery-plan

https://gov.wales/palliative-and-end-life-care-delivery-plan-2017

http://ncpc.org.uk/ National Council for palliative care

Step 2 - Assessment, care planning and review



Aim
The care home will understand holistic assessment and its relevance to advance care planning. They will explore systems to discuss, record, review and share assessments appropriately
Objectives
Recognise the importance of the assessment, planning and review of holistic care
Be able to provide individualised Advance Care Planning to support individuals wishes
Understand the implications of the Mental Capacity Act, Best Interest Decision Making and Lasting Power of Attorney

At a glance

ORGANISATIONAL PROGRAMME		OUTCOME	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Consider care home holistic assessment measures	Sample holistic measures	**Recognise the importance of holistic care planning**	How to complete an holistic assessment	Sample holistic measures
ACP processes in place. (make active offer)	Sample ACP tools and guidance	**Be able to provide individualised ACP**	Advance Care Planning including Advance Clinical Planning, ADRT, DNACPR	Overview session Case studies Handouts
MCA, BID, decision making for those lacking capacity	MCA guide, Capacity care planning, Best Interests	**Understand the implications of the MCA and BID**	MCA, BID, LPA	What is ACP, how to assess Case studies, Handouts

ORGANISATIONAL PROGRAMME

The following programme provides a brief 'example' of how a half day workshop might be structured. Sample PowerPoint presentations will be shared on the website.

Time	Session	Activity
1pm	Welcome and recap on STEP 1	Group discussion. Review to-do lists from STEP 1
1.20pm	Holistic assessment –What is it?	Case study – use care plan template or care

	How is it done? Which assessment tools can be used?	homes own care plan
2.00pm	Advance Care Planning – What is currently done to assess, record and communicate resident's wishes	Different documents and processes Methods of recording and sharing information Use case study 'Betty' (bespoke video for Six Steps)
3.00pm	Decision making for those who lack capacity	Relate discussion to those with dementia/ lacking capacity Case study
3.45pm	Six Steps programme planning	Map today's session to portfolio To do list for next session
4.00pm	Evaluation	Evaluation form

STAFF EDUCATION PROGRAMME

Please read the section on page 11 regarding the use of the Learning Logs. The following tables provide some examples on how the outcomes can be achieved.

Six steps champions

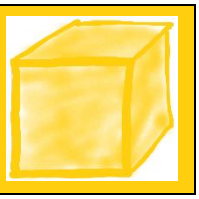
Learning outcomes	Suggested ways to achieve outcomes
Recognise different holistic assessments relevant to end of life and how to complete them	- Read and reflect upon the Support Sheet 'Holistic Assessment' (in downloads) - Take part in a discussion of the case study around a person who has had a stroke (in downloads) - Complete 'Introduction to principles of assessment in end of life care: Part 1' (e-elca session 02_01) - Complete 'Introduction to principles of assessment in end of life care: Part 2' (e-elca session 02_02) - Complete 'Uses and limitations of assessment tools (e-elca session 02_19)
Be able to provide individualised Advance Care Planning to support residents wishes	- Read and reflect upon the Support Sheets 'ACP', 'PPC' and 'ADRT' (in downloads) - Take part in a facilitated discussion using the set of videos 'Betty' (in downloads) - Complete 'Introduction to conducting conversations about advance care planning' (e-elca session 01_11) - Complete 'How to Document Conversations About Advance Care Planning' (e-elca session 01_14) - Take part in a discussion of the case study around Advance Care Planning with a person who has dementia (in downloads)
Understand implications of Mental Capacity Act, Best Interests Decision and Lasting Power of Attorney	- Read and reflect upon the Support Sheets 'MCA' and 'BID' (in downloads) - Complete 'Assessing through proxies' (e-elca session 02_11) - Complete 'Assessing those with fluctuating mental capacity' (e-elca session 02_12)

Optional learning outcomes	Suggested ways to achieve outcomes
Gain additional knowledge of Advance Care Planning	- Complete 'Writing an advance decision to refuse treatment' (e-elca session 01_06b) - Attendance at the North West 'Advance Care Planning and Difficult Communications' day (or equivalent)

Care home staff

Key learning outcomes	Suggested ways to achieve outcomes
Recognise the different holistic assessments in use at end of life	- Read and reflect upon the Support Sheet 'Holistic Assessment' (in downloads) - Take part in a discussion of the case study around a person who has had a stroke (in downloads) - Complete 'Introduction to principles of assessment in end of life care: Part 1' (e-elca session 02_01) - Complete 'Introduction to principles of assessment in end of life care: Part 2' (e-elca session 02_02)
Understand what an Advance Care Plan is, and how to support a residents wishes	- Read and reflect upon the Support Sheets 'ACP', 'PPC' and 'ADRT' (in downloads) - Take part in a facilitated discussion using the video 'Betty' (in downloads) - Take part in a discussion of the case study around Advance Care Planning with a person who has dementia (in downloads)
Understand implications of Mental Capacity Act, Best Interests Decision and Lasting Power of Attorney	- Read and reflect upon the Support Sheets 'MCA' and 'BID', (in downloads)
Optional learning outcomes	**Suggested ways to achieve outcomes**
Gain additional knowledge of Advance Care Planning	- Complete 'Introduction to conducting conversations about advance care planning' (e-elca session 01_11) - Complete 'How to Document Conversations About Advance Care Planning' (e-elca session 01_14) - Complete 'Assessing through proxies' (e-elca session 02_11) - Complete 'Assessing those with fluctuating mental capacity' (e-elca session 02_12) - Attendance at the North West 'Advance Care Planning and Difficult Communications' day (or equivalent)

Step 3 - Co-ordination of care



Aim
The care home is able to ensure that coordinated care takes place
Objectives
Be proactive in the promotion of collaborative working
Recognise the importance of sharing information with the wider multidisciplinary team
Staff are able to deal with situations with challenging communication issues
Define and implement the role of the end of life care champion
To have a system in place to reflect on any significant events that have occurred

At a glance

ORGANISATIONAL PROGRAMME		OUTCOME	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Recognise role in co-ordinating care with other services, professionals	Awareness of other services Key contacts sheet	**Promotion of collaborative working**	The roles of other professionals	Key contacts sheet
Challenging communications		**Able to deal with situations with challenging communication issues**	Challenging communications	
Communication systems, internal and external. (Make active offer)	Session Sample documents	**Recognise the importance of sharing information with the wider multidisciplinary team**	Communicating with others, e.g. electronic systems, OOH,	Systems to share resources, Know who to contact and when
The role of the end of life care champion	Outline role and responsibilities	**Define the role of the end of life care champion**	How to be an end of life care champion	Outline role and responsibilities
		Have a system in place to reflect on any significant events		

ORGANISATIONAL PROGRAMME

The following programme provides a brief 'example' of how a half day workshop might be structured. Sample PowerPoint presentations will be shared on the website.

Time	Session	Activity
1pm	Welcome and recap on STEP 2	Group discussion. Review to-do lists from STEP 2
1.10pm	Collaborative working and sharing information	Consider who is involved/ should be involved/ how to involve them? Key contacts sheet
1.40pm	Challenging communication issues	Use case study 'Liz' (bespoke video for Six Steps)
2.50pm	Developing the role of the Six Steps Champion	What does it take to deliver high quality EoLC? Group discussion of the role of the Champion
3.05pm	How to carry out a Significant Event Analysis (SEA)	Quick guide document Practice a SEA using an example from the group
3.50pm	Six Steps programme planning	Map today's session to portfolio To do list for next session
4.00pm	Evaluation	Evaluation form

STAFF EDUCATION PROGRAMME

Please read the section on page 11 regarding the use of the Learning Logs. The following tables provide some examples on how the outcomes can be achieved. Several can be achieved through e-learning, such as the e-elca (e-lfh) website (Information on how to access this is on the Six Steps website under the STEPPING ON tab.

Six Steps champions

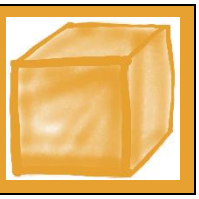
Learning outcomes	**Suggested ways to achieve outcomes**
A knowledge of other roles within wider multi-professional teams	- Complete and discuss Support Sheet 'Key Contacts' - Complete 'Documentation, communication and coordination' (e-elca session 02_17)
Be able to deal with challenging communication issues	- Take part in a facilitated discussion using the set of videos 'Liz' (in downloads) - Complete 'How to handle patients' questions and concerns' (e-elca session 01_13) - Complete 'How to Negotiate Decisions Which May be Difficult to Implement' (e-elca session 01_15) - For senior staff consider Advanced Communication Skills Training course places

Understand the role of an end of life champion and what you need to do	- Discuss the key points from the Marie Curie website 'What does it take to deliver high quality end of life care' (in downloads) - Complete Worksheet ST3.1 (in downloads)
Be able to lead/support a reflection on a significant event	- Read and discuss the document 'Quick guide to conducting a Significant Event Analysis' (in downloads) - Carry out an SEA using the SEA template (in downloads)
Optional learning outcomes	**Suggested ways to achieve outcomes**
Recognise the requirements to lead and manage change in an organisation	- Complete 'The Principles of Change Management' (e-LfH session 12_05_001)

Care home staff

Key learning outcomes	**Suggested ways to achieve outcomes**
A knowledge of other roles within wider multi-professional teams	- Discuss what the completed Support Sheet 'Key Contacts' means to the team and how other professionals may be engaged with
Be able to deal with challenging communication issues	- Take part in a facilitated discussion using the set of videos 'Liz' (in downloads)
Know who your end of life champion is and how to support them	- Be able to name the end of life champion/s for the care home - Discuss the key points from the Marie Curie website 'What does it take to deliver high quality end of life care' (in downloads)
Be able to carry out a reflection on a significant event	- Complete Worksheet ST3.2 (in downloads)

Step 4 - Delivery of high quality care in care homes



Aim
To achieve high quality end of life care in the care home
Objectives
Able to recognise environmental factors required for high quality end of life care
Staff are able to support individual needs at the end of life with dignity and compassion
Staff are able to recognise and support individual spiritual and religious needs
Staff are prepared and supported to provide end of life care
Identify a training plan for all staff in end of life care

At a glance

ORGANISATIONAL PROGRAMME		OUTCOME	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Promoting suitable environment. Promoting dignity and compassion. Supporting individual spiritual and religious needs	Assessing own environment (incl dementia) Dignity Champions	**Able to recognise environment/ factors required for high quality EOLC**	Best use of environment Promoting dignity	Handouts Dignity Champion information
Identify a training plan for all staff in EOLC Percentage of staff undergo training *as agreed in Action Plan*	KSC audit for staff Learning log	**Staff development thorough support and training**	Identifying own needs Complete Six Steps to Learning log (or equivalent)	Referring back to KSC Six Steps to Learning log (or equivalent)

ORGANISATIONAL PROGRAMME

The following programme provides a brief 'example' of how a half day workshop might be structured. Sample PowerPoint presentations will be shared on the website.

Time	Session	Activity
1pm	Welcome and recap on STEP 3	Group discussion. Review to-do lists from STEP 3
1.15pm	Recognise environment/ factors required for high quality EOLC and EOL dementia care Environment Dignity and compassion Spiritual and religious needs	Review end of life statement template from STEP 1 Group work to discuss things that help and things that don't Group discussion around 6 C's See if care homes have a dignity Champion – discuss this role Use case study to discuss Visit website – 'Religious Needs Resource'
2.45pm	Preparing and supporting staff to deliver quality end of life care	Discuss EOLC training, i.e., is it included in induction Review uptake of Learning Logs Reflect back on SEA from STEP 3 and consider its role
3.45pm	Six Steps programme planning	Map today's session to portfolio To do list for next session
4.00pm	Evaluation	Evaluation form

STAFF EDUCATION PROGRAMME

Please read the section on page 11 regarding the use of the Learning Logs. The following tables provide some examples on how the outcomes can be achieved.

Six Steps champions

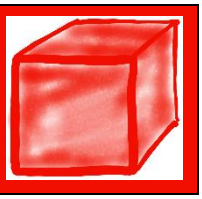
Learning outcomes	Suggested ways to achieve outcomes
Understand the impact of the environment at end of life	- Read and reflect upon the Support Sheet 'Healing Environment' (in downloads) - Visit the SCIE Dementia Gateway to consider what makes a Dementia Friendly Environment
Be able to identify and meet the spiritual needs of the individual	- Watch the IHF "Introduction to Spirituality" video at https://www.youtube.com/watch?time_continue=5&v=zIhxGvC5Ux8 - Complete Worksheet ST4.1 (in downloads)
Identify any specific needs that a person with dementia may have at the end of life	- Complete 'End of Life Care for People with Dementia' (e-elca session 05_09a) - Case study: dementia (e-elca session 05_09b)
Know how to support a resident's needs with dignity and compassion	- Read and reflect upon the Support Sheet 'Dignity' (in downloads)

Optional learning outcomes	Suggested ways to achieve outcomes
Further understanding of the needs of a resident with dementia	- Complete 'Initiating Conversations about End of Life Care: Dementia' (e-elca session 05_03)
Be able to identify and meet the spiritual needs of individuals	- Undertake Spirituality training/ education (such as the North West 'Opening the Spiritual Gate' one day session)

Care home staff

Key learning outcomes	Suggested ways to achieve outcomes
Understand the impact of the environment at end of life	- Read and reflect upon the Support Sheet 'Healing Environment' (in downloads) - Visit the SCIE Dementia Gateway to consider what makes a Dementia Friendly Environment
Understand how spirituality is relevant in end of life care	- Watch IAPC "Rev Daniel Nazum" video (What spirituality is and its role within palliative care) at http://www.adultpalliativehub.com/resources/videos/rev-daniel-nuzum
Recognise any specific needs that a person with dementia may have at the end of life	- Complete 'End of Life Care for People with Dementia' (e-elca session 05_09a)
Know how to support individual needs with dignity and compassion	- Read and reflect upon the Support Sheet 'Dignity' (in downloads)
Optional learning outcomes	**Suggested ways to achieve outcomes**
Further knowledge of the needs of a resident with dementia	- Undertake 'Dementia Friends' training (or equivalent)
Be able to identify and meet the spiritual needs of the individual	- Undertake Spirituality training/ education (such as the North West 'Opening the Spiritual Gate' one day session)

Step 5 - Care in the last days of life



Aim
It is recognised the individual is entering the last days of life and best practice is provided
Objectives
Identify the five priorities for care of the dying person
Recognise the point where the individual enters the dying phase
Be able to care for the individual in the final days
Recognise appropriate and inappropriate care
Know how to care for the people important to them, staff and other residents with dignity when a resident enters the dying phase

At a glance

ORGANISATIONAL PROGRAMME		OUTCOME	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Five Priorities for EOLC	One chance to get it right Individual Plan of Care	**Identify the 5 priorities (for care of the dying person)**	Five Priorities for EOLC	One chance to get it right Individual Plan of Care
Recognising dying	Duties and responsibilities of health and care staff	**Recognise the point where the individual enters the dying phase**	**Recognising** dying and **Communicating** with others	Changes at very end of life Case studies
Plan and Do high quality EOLC	Appropriate documentation in place	**Care of the individual in the final days**	**Plan and Do** - Care of: Physical (incl. symptoms) Spiritual Emotional Cultural	What to do after death Sessions Religious needs
Appropriate and inappropriate hospital admissions	Criteria and support, i.e. NWAS guide	**Recognise appropriate and inappropriate care pathways**	Appropriate and inappropriate hospital admissions	Criteria and support, i.e. NWAS guide
Involve, **Support** and **Communicate** with others	The duties and responsibilities of health and care staff	**Know how to care for the people important to them, staff and other residents with dignity**	**Involve**, **Support** and **Communicate** with others	Recognise grief responses

		when a resident enters the dying phase		

ORGANISATIONAL PROGRAMME

The following programme provides a brief 'example' of how a half day workshop might be structured. Sample PowerPoint presentations will be shared on the website.

Time	Session	Activity
1pm	Welcome and recap on STEP 4	Group discussion. Review to-do lists from STEP 4
2.00pm	Identifying the individual at the very end of life Care of the individual (and significant others) in final days of life	Review the North West Model for Life Limiting Conditions from STEP 1 Signs and symptoms of residents at the very end of life Focus on aspects of care: physical, psychological and spiritual. Include use of medication (qualified staff may need more about drug doses, administration etc.)
3.00pm	Recognising appropriate and inappropriate care	Consider when a hospital admission may or may not be appropriate (Link to STEP 2 ACP and respecting residents wishes) Use of case studies
3.40pm	List the Five Priorities for EOLC	CRISP – Draw using 'Palm' image
3.45pm	Six Steps programme planning	Map today's session to portfolio To do list for next session
4.00pm	Evaluation	Evaluation form

STAFF EDUCATION PROGRAMME

Please read the section on page 11 regarding the use of the Learning Logs. The following tables provide some examples on how the outcomes can be achieved.

Six steps champions

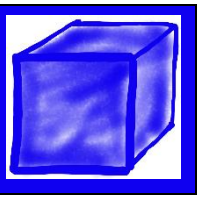
Learning outcomes	Suggested ways to achieve outcomes
Be able to recognise what happens when a resident enters dying phase	- Complete 'Assessment of dying phase and after-death care' (e-elca session 02_14) - Read and reflect upon the 'Care after death' document, pages 10 - 14 (in downloads)

Know how to care for an individual in their final days of life	- Read and reflect upon the 'What to expect when someone important to you is dying', 'Identifying dying' or 'Identifying dying in a person with dementia' (in downloads) - Complete 'Symptom Management for the Dying Adult' (e-elca session 04_23b)
Understand the process of anticipatory prescribing (Registered Nurses only)	- Refer to local policy or guidelines (An example of a document used in Cheshire is provided in the downloads)
Know how to support significant others when an individual is dying	- Complete 'Understanding and Using Empathy' (e-elca session 03_08)
Optional learning outcomes	**Suggested ways to achieve outcomes**
Be competent using a syringe pump (Registered Nurses only)	- Complete 'Using syringe drivers' (e-elca session 04_27) - Undertake specific syringe pump training (in line with local policy or guidelines)
Be able to care for an individual with a syringe pump (Support staff)	- Complete 'Using syringe drivers' (e-elca session 04_27)

Care home staff

Key learning outcomes	**Suggested ways to achieve outcomes**
Be able to recognise what happens when an individual enters dying phase	- Read and reflect upon the 'Care after death' document, pages 10 - 14 (in downloads)
Know how to care for an individual in their final days of life	- Read and reflect upon the 'What to expect when someone important to you is dying', 'Identifying dying' or 'Identifying dying in a person with dementia' (in downloads)
How to support significant others when an individual is dying	- Complete 'Understanding and Using Empathy' (e-elca session 03_08)
Optional learning outcomes	**Suggested ways to achieve outcomes**
Be competent using a syringe pump (Registered Nurses only)	- Complete 'Using syringe drivers' (e-elca session 04_27)
Be able to care for an individual with a syringe pump (Support staff)	- As above

Step 6 - Care after death



Aim
Provide excellent support and care after death
Objectives
Identify good practice for care of the deceased individual
Respect individual faiths and beliefs to address an individual's wishes
Be able to provide information to families, significant others, staff and other individuals
Recognise the importance of, and offer, bereavement support to families, significant others, staff and other individuals

At a glance

ORGANISATIONAL PROGRAMME		OUTCOME	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Policies and processes in place	What to do after death in England and Wales Tell us once	**Identify good practice for care of the deceased individual (Last Offices)**	Nurse Verification of Expected Death Notifications How to carry out last offices	Additional training Information NHS NEoLCP guidance
How to support individual faiths and beliefs Develop network and contacts	Religious needs resource	**Respect individual faiths and beliefs to address an individual's wishes**	Draw on previous session and develop	Specific religious and spiritual requirements
Access resources and information to support others	Localised knowledge to provide	**Information to families, significant others, staff and other individuals**	Know where to signpost people	Use local knowledge from care home
Consider bereavement policy	Levels of bereavement support	**Bereavement support to families, significant others, staff and other individuals**	Have an understanding of the theories of grief	Levels of bereavement support

ORGANISATIONAL PROGRAMME

The following programme provides a brief 'example' of how a half day workshop might be structured. Sample PowerPoint presentations will be shared on the website.

Time	Session	Activity
1pm	Welcome and recap on STEP 5	Group discussion. Review to-do lists from STEP 5
1.20pm	**Care of residents following death** Good practice for personal care Provide information to others	 Group discussion as to what constitutes best practice and how the care homes provide that Numbers of staff that carry out Nurse Verification of Expected Death Respect of individual beliefs and their impact Understand, discuss and know where to access generic after death information if the care home does not offer any in-house information
2.30pm	Recognise the importance, and be able to provide appropriate bereavement support	Watch The Irish Hospice Foundation video "Understanding grief" (as below) Using the Bereavement Care Standards, reflect on how the care home can address any needs Consider the impact of loss on other residents and staff members
3.30pm	Six Steps programme planning	Consider requirements for portfolio completion Develop an individual plan with each care home
4.00pm	Evaluation	Evaluation form

STAFF EDUCATION PROGRAMME

Please read the section on page 11 regarding the use of the Learning Logs. The following tables provide some examples on how the outcomes can be achieved.

Six steps champions

Learning outcomes	Suggested ways to achieve outcomes
Understand how to care for a deceased individual	- Read and reflect upon the 'Care after death' document, pages 15 - 20 (in downloads)

Recognise how to respect individual faiths and beliefs	- Visit the website 'Religious Needs' at https://www.openingthespiritualgate.net/all-faiths/ and review at least three religions that you are not familiar with that you may meet with residents
Know how to support families, significant others, staff and other individuals in bereavement	- Watch The Irish Hospice Foundation video "Understanding grief" https://youtu.be/6sA4Yyq2f3w?list=UU6XJSBWEBYir2fzV1RGaMfA - Complete Emotional Support and Signposting (e-elca session 07_05)
Be able to verify expected death (Registered Nurses only)	- Undertaking of Nurse Verification of Expected Death training (this will need to be in line with local policy or guidelines)
Optional learning outcomes	**Suggested ways to achieve outcomes**

Care home staff

Key learning outcomes	**Suggested ways to achieve outcomes**
Know how to care for a deceased individual	- Read and reflect upon the 'Care after death' document, pages 15 - 20 (in downloads)
Know how to respect individual faiths and beliefs	- Visit the website 'Religious Needs' at https://www.openingthespiritualgate.net/all-faiths/ and review at least three religions that you are not familiar with that you may meet with residents
Know how to support families, significant others, staff and other individuals in bereavement	- Watch The Irish Hospice Foundation video "Understanding grief" https://youtu.be/6sA4Yyq2f3w?list=UU6XJSBWEBYir2fzV1RGaMfA
Be able to verify expected death (Registered Nurses only)	- Undertaking of Nurse Verification of Expected Death training (this will need to be in line with local policy or guidelines)
Optional learning outcomes	**Suggested ways to achieve outcomes**

Stepping off

Aim
To evaluate if the Six Steps to Success Programme has been implemented in practice
Objectives
Describe the End of Life Care Policy implemented within the individual care home
Analyse audit figures
Understand the importance of a completed portfolio and demonstrate its' contents
Demonstrate, through the completed portfolio, that they have fulfilled their roles and responsibilities
Understand the principles and process for future updating of Six Steps within the organisation

Overview

ORGANISATIONAL PROGRAMME		OUTCOME	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Portfolio	Portfolio guide	**Complete portfolio to required standard**		
Post Organisational Programme audit	Audit guide	**Pre and post programme audit comparison**	Post Knowledge, Skills and Confidence audit	Audit guide
Future support		**Identify mechanisms of support**	Future support	

The STEPPING OFF step does not have a formal set of requirements for delivery, but functions as an end point to complete the programme.

Once a care home has successfully completed their portfolio and the post programme audits, they are able to be provided with a certificate of completion. Certificates can be provided to the care home and to the Six Steps Champions, although the completion of the Six Steps to Learning Log actually serves as the evidence for individuals. The certificates should be dated when they are distributed. If workshops have been delivered, this could be used as an opportunity to bring the care homes together for a final celebration

The Six Steps Programme for Care Homes is not an accredited programme, unless the organisation providing it wishes to offer this as a separate entity. There is (coming shortly) a section for facilitators and organisations who wish to consider this. We will offer ideas based on other practice areas that have used this approach, but it remains the responsibility of the provider organisation.

Future support for successful Six Steps care homes should be considered. Some areas have implemented care home forums and others have provided care homes with intermittent follow up support. This can include additional training for new staff or providing updates around new developments. Care homes can log this in their portfolios as ongoing evidence.

Care homes should be reminded that it is their responsibility to maintain their portfolios and to re-audit care on a regular basis. It is in their own interests to maintain an updated portfolio for inspections and visits etc.

Stepping Forward

Aim
To be able to review, update and refresh the programme for care homes that have previously completed the Six Steps Programme
Key indicators
Have a current end of life care statement
Have maintained regular (i.e., up to 6 months old) audits
Have maintained a completed portfolio and the contents meet the criteria
Have staff with completed Learning Logs (or equivalent) or staff undergoing completion of these

Overview

ORGANISATIONAL PROGRAMME		REQUIREMENT	STAFF EDUCATION PROGRAMME	
Content	**Resources**		**Content**	**Resources**
Up to date end of life care statement	End of life care statement	**Have a current end of life care statement**		
Ongoing (use Post) Organisational Programme audit	Audit guide	**Have maintained regular (i.e., up to 6 months old) audits**	Post Knowledge, Skills and Confidence audit	Audit guide
Portfolio	Portfolio guidance	**Have maintained a completed portfolio and the contents meet the criteria**		
		Have staff with completed Learning Logs (or equivalent) or staff undergoing completion of these	Six Steps to Learning Log	Learning Log

The facilitator will need to attend an informal meeting with the care home and check the above documents/content working through these with the care home representative. There are three main outcomes to this process, although, like the previous programme, the facilitator can use their own judgement if a care home falls between two boundaries. However, it would be good practice to work to the lower boundary that was achieved.

Main outcome	Action
The care home is fully up to date with all of the requirements	No further action needed – certificate can be re-issued
There are some areas identified where further work/development is required (this should be no less than 40% of the programme)	The 'Where are we now? document is completed with the care home, and the gaps identified and an action plan completed. The facilitator works with the care homes using the action plan as a gap analysis
There are multiple areas where the care home is no longer meeting the requirements (this will be less than 40% of the programme or there are significant areas of need	The care home will be required to complete the entire programme (i.e. working through each of the Six Steps) after the 'Where are we now? document and action plans are completed