

The Six Steps to Success Programme has been developed in the North West of England by the Cheshire & Merseyside Clinical Network and the Greater Manchester, Lancs & South Cumbria Clinical Network with support from the National End of Life Care Programme.

The programme aims to **enhance End of Life Care** through facilitating organisational change and supporting staff to develop their roles around End of Life Care. The programme is based on the Six Steps described in the **Route to Success**; a guide to improving End of Life Care provided by a Care Home that **encompasses the philosophy of palliative care**.

There is no charge for this programme. All that is asked is that Care Homes commit to the programme by supporting a Care Home Representative to attend the full programme and to support, embed and sustain the organisational change required, which will be demonstrated in a completed portfolio of evidence.

The six core workshops in between will each cover one of the following steps:

- Step 1** Discussions as 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

The remit:

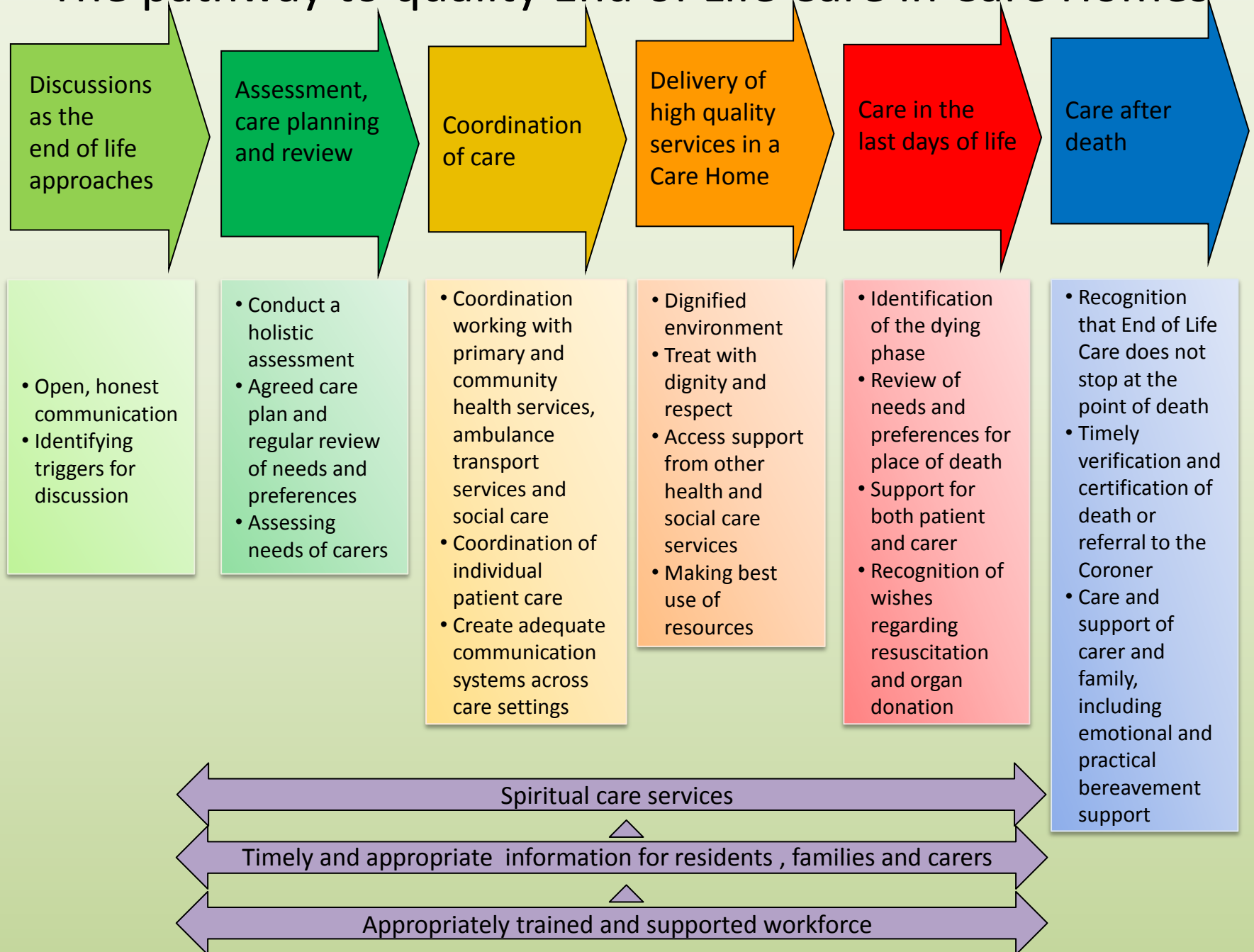
- 10 Nursing Homes
- Introduction
- 9 workshops
- Six steps
- Dementia Workshop
- Conclusion

10 month secondment period

At the core of Six Steps Programme is the nomination of a representative from the Care Home. Having a Care Home Representative for End of Life Care will ensure each Care Home has a champion who has access to current national and local information. They will be supported to develop their knowledge and skills and encouraged to empower staff within their organisation to deliver End of Life Care.

The Six Steps encourages audit throughout the programme, beginning with a pre-programme audit. On completion homes are encouraged to demonstrate the improvement in skills & knowledge, achieving preferred place of care with post death audits, and improving quality markers in End of Life Care.

The pathway to quality End of Life Care in Care Homes



Post completion

- Post death audits are continued to monitor supportive evidence to show the provision of End of Life Care in relation to nationally recommended End of Life Care tools. This includes sudden deaths and residence who have died in hospital.
- The Six Steps facilitator will analyse and compare the post-death audits with the pre-programme audits.



Six Steps to Success Quality Markers Audit: Level Descriptors

This document provides the level descriptors which are associated with the markers and measures in the Quality Markers audit. Use this document in conjunction with the Six Steps to Success Quality Markers Audit Tool to self-assess at which level your care home is at in relation to the quality markers and measures.

Summary of End of Life Care Tools

0	Care home has not implemented the specific end of life care tool
1	Care home has plans in place for the implementation of the specific end of life care tool
2	Care home is in the early phase of implementing the specific end of life care
3	Care home is able to demonstrate implementation of the specific end of life care tool
4	Care home has embedded and sustained the specific end of life care tool

Strategic Context:

Care home has a planned approach to service development

0	Care home does not have a policy for end of life care to fulfil the criteria set out in the measures
1	Care home has the intention of developing a policy for end of life care to fulfil the criteria set out in the measures
2	Care home is currently in the process of developing a policy for end of life care to fulfil the criteria set out in the measures
3	Care home has developed a policy for end of life care which fulfils the criteria set out in the measures
4	Care home has a published end of life care policy which fulfils in full the criteria set out in the measures

Advance Care Planning and Communication:

Processes are in place to enable effective identification, communication, and care planning, also to ensure that care for individuals is coordinated across organisational boundaries 24/7.

0	Care home has no processes for planning or communicating the resident or carers needs
1	Care home has plans to improve care planning and communication protocols for residents and carers
2	Care home is currently developing planning/communication protocols for residents and carers
3	Care home has implemented planning/communication protocols for both residents and carers
4	Care home has embedded and sustained effective protocols for planning the care of residents and carers also effective operational communication systems