GSF in Care Homes Programme – Mapped with EOL 501 – lead and manage end of life care services.

GSF Programme Learning outcome	Content of session & activities	Core Units	Core Qualification Learning outcome	Assessment Criteria
Session 1 **Introduction, Dignity in care** **How can we make the best of the final few years – Living well for the rest of your life**	**Session Content** 1. Context of EoLC in care homes a. National policy & guidance 2. Overview of GSF Care Homes Programme– Preparing yourselves 3. Role of the co-ordinator 4. Reflective practice Quality of life issues & Dignity in care 5. How can we help people to live well for the rest of their lives **Activities:** 1. Reflect - how many of your residents died in the last 6/12 – where did they die (SEA) 2. Complete confidence & team assessments 3. What are the key challenges for you? 4. What does best care look like? 5. What can go wrong 6. Review last session/Action plan SEA – episode of care – what do you need to modify if it happens again	501	1. Be able to apply current legislation and policy in end of life care in order to develop end of life services. 3. Be able to manage and lead effective end of life care services. 5. Be able to support staff and others in the delivery of excellence in the end of life care service	**1.1** Summarise current legislation relating to the provision of best practice **end of life care services.** **1.2** Apply local and national policy guidance for end of life care to the setting in which you work. **3.8** Use a wide range of tools for end of life care to measure standards through audit and after death analysis. **5.1** Describe how a shared vision for excellent end of life care services can be supported. **5.2** Implement strategies to empower staff involved in the delivery of end of life care to ensure positive outcomes for individuals and others. **5.4** Support staff and others to comply with legislation, policies and procedures.

	7. Words associated with dignity Consider key principles of dignified life & death **Action Planning** **1. Complete ADA for last 5 deaths, and other baseline evaluations** **2. Raise awareness** **a. Leaflets** **b. Letters** **c. Posters** **d. Meetings** **i. Staff** **ii. Residents & relatives** **iii. Other professionals** **3. Consider dignity in care in your care home – SWOT analysis of dignity in your home** • **What 3 things will you change?**			
Session 2 **Identify** **Identity - Needs based coding** **2 Supportive Care Register & proactive planning** **3 Review and cascade**	**Content** **1. Needs Based Coding** **2. Documenting** **3. Proactive planning meetings** **4. Communicating & collaborating with others** **Activities:** **1. Reflect on last session & your action planning** **2. Where are you now – target exercise** **3. Indicators of different stages** **4. Coding your residents** **Action Planning** **1. As a team code residents**		2. Understand current theory and practice underpinning end of life care. 3. Be able to lead and manage effective end of life care services. 4. Be able to establish and maintain key relationships to lead and manage end of life care. 5. Be able to support staff and others in the delivery of excellence in the end of life care service	**2.3** Analyse how a range of tools for end of life care can support the individual and others (NBC). **3.3** Use effective communication to support individuals at the end of life and others. **4.1** Identify key relationships essential to effective end of life care (team working). **4.2** Analyse the features of effective partnership working within your work setting. **4.5** Initiate and contribute to multi-disciplinary assessments. **5.2** Implement strategies to empower staff involved in the delivery of end of life care to ensure positive outcomes for individuals and others.

	2. Start proactive planning meetings/documentation **3. Discuss with GPs/others how you will collaborate and share the coding.**			
SESSION 3: Assess Clinical – Dementia 1 Use of assessment tools 2 Control of symptoms - and Goals of care 3 Pain & Distress in People with dementia	**Content:** 1. Value and use of Assessment tools 1. Multiple -morbidity Goals of Care 2. Depression 3. Behavioural assessment & management 4. Reflective practice – SEA 5. Demonstrate use of assessment tools in Care Homes **Activities:** 1. Reflect on last session & Action Plans. What have you changed as a result of the session? 2. Discuss - What tools do you use which could you use, how useful might they be 3. Scenario – case study multiple morbidities, continued symptoms - what can you do? 4. Case history related to changes in behaviour in a person with dementia. What can you do to help? 5. Reflect on one of your residents 6. Appropriate referral to multi-disciplinary members for assessment and assistance in managing complex situations.		1. Be able to apply current legislation and policy in end of life care in order to develop end of life services. 2. Understand current theory and practice underpinning end of life care. 3. Be able to lead and manage effective end of life care services. 4. Be able to establish and maintain key relationships to lead and manage end of life care 5. Be able to support staff and others in the delivery of excellence in the end of life care service. 6. Be able to continuously improve the quality of	**1.3** Analyse legal and ethical issues relating to decision making at end of life. **1.4** Explain how issues of mental capacity could affect end of life care. **2.3** Analyse how a range of tools for end of life care can support the individual and others (assessment tools). **3.3** Use effective communication to support individuals at the end of life. **3.5** Ensure there are sufficient and appropriate resources to support the delivery of end of life care services (assessment tools). **3.6** Describe the possible role(s) of advocates in end of life care. **4.3** Implement shared decision making strategies in working with individuals at the end of life and others. **4.7** Access specialist multi-disciplinary advice to manage complex situations. **5.5** Support staff and others to recognise when mental capacity has reduced to the extent that others will determine care and treatment for the person at the end of life.

			the end of life care service.	**6.1** Analyse how reflective practice approaches can improve the quality of end of life care services.
SESSION 4: Assess Personal – ACP, DNACPR – Client & Carers **Learning Outcomes:** 1 Communication skills 2 Understanding of advance care planning, DNACPR, ADRT, LPOA. 3 Advance care planning with people with dementia	**Content:** This session focuses on – Assess – personal, communication and advance care planning including ACP implementation with people with dementia. Communication Grieving Team working Use of words Angry relatives Breaking bad news Difficult conversations ACP, DNACPR, LPOA, ADRT, ACP with people with dementia, their families, advocates and other professionals. **Activities:** 1. Reflect on an experience of communicating with a resident and or relative a. What went well b. What didn't go so well c. What could you do differently in the future 2. Role play having an ACP conversation in threes– take turns one person observe and give constructive feedback 3. Scenario/case history		1. Be able to apply current legislation and policy in end of life care in order to develop end of life care services. 2. Understand current theory and practice underpinning end of life care. 3. Be able to lead and manage effective end of life care services. 4. Be able to establish and maintain key relationships to lead and manage end of life care. 5. Be able to support staff and others in the delivery of excellence in the end of life care service. 6. Be able to continuously improve the quality of the end of life care service.	**1.2** Apply local and national policy guidance for end of life care to the setting in which you work. (DNACPR) **1.3** Analyse legal and ethical issues relating to decision making at the end of life. (ACP, LOPA, ADRT) **1.4** Explain how issues of mental capacity could affect end of life care. (ACP with PWD) **2.1** Describe the theoretical models of grief, loss and bereavement. **2.2** Explain how grief and loss manifest in the emotions of the **individuals** who are dying and others**.** **2.3** Analyse how a range of **tools for end of life care** can support the individual and others. **3.3** Use effective communication to support individuals at end of life and others **3.4** Use effective mediation and negotiation skills on behalf of the individual who is dying. **3.6** Describe the possible role(s) of advocates in end of life care. **4.6** Explain how to overcome barriers to partnership working. **5.4** Support staff and others to comply with legislation, policies and procedures.

	Action plan: 1. Have an ACP discussion with someone, have a colleague observe and give constructive feedback **2.** Get your own house in order, make your own bucket list (make sure that when your time comes all you have left to do is dying). **3.** Have a go at having an ACP/best interests discussion for a person with dementia.			**5.5** Support staff and others to recognise when mental capacity has reduced to the extent that others will determine care and treatment for the person at the end of life. **6.1** Analyse how reflective practice approaches can improve the quality of life care services. **6.3** Use outcomes of reflective practice to improve aspects of the end of life care service.
SESSION 5 Plan – Cross Boundary Care - Coordinate – GP & Out of Hours **Learning Outcomes:** 1 Effective collaboration with GP Practices 2 Continuity –out of hours, collaboration with others 3 Planning care to reduce inappropriate hospitalisation	**Content:** 1. Collaboration with GP - Better together 2. Local policy with regard to OOH. 3. Handover forms @ Code C /EPAACS/locality register – prompting GP 4. Cross boundary communication 5. How it makes a difference 6. Continuity OOHs Handover form Night staff Induction of all staff Spread in whole care home 7. XBC Reduced hospitalisation Why NAO 8. People with dementia – the impact of hospitalisation – availability of national research to inform. 9. Reflective practice and audit		1. Be able to apply current legislation and policy in end of life care in order to develop end of life care services. 2. Understand current theory and practice underpinning end of life care. 3. Be able to lead and manage effective end of life care services. 4. Be able to establish and maintain key relationships to lead and manage end of life care. 5. Be able to support staff and others in the delivery	**1.1** Summarise current legislation relating to the provision of best practice in **end of life care services.** **1.2** Apply local and national policy guidance for end of life care to the setting in which you work. (DNACPR, OOH). **2.4** **Explain** the pathway used by your current local health authority. **2.5** Critically reflect on how the outcomes of national research can affect your workplace practices. **3.4** Use effective mediation and negotiation skills on behalf of the individual who is dying. **3.5** Ensure there are sufficient and appropriate resources to support the delivery of end of life care services. **3.7** Manage palliative care emergencies according to the wishes and preferences of the individual. **4.1** Identify key relationships essential to effective end of life care (GP).

	Activities: 1. Reflect on how you communicate with your GPs ○ Do you have regular reviews/visits ○ What information do you give when requesting a visit ○ Could it be better 2. Reflect on the scenario Was it an appropriate admission What could have been done differently Have you experienced a similar situation How could you plan for a different outcome 3. What is the admission rate in your home, what are the gaps, what are the learning needs **Action plan:** 1. As a team reflect on your communication with your GPs, OOHs providers and others 2. Review hospital admissions over last 6 months were they all appropriate, could any have been avoided? 3. Review training matrices and induction processes		of excellence in the end of life care service. 6. Be able to continuously improve the quality of the end of life care service.	**4.2** Analyse the features of effective partnership working within your work setting. Implement shared decision making strategies in working with individuals at end of life and others. **4.3** Implement shared decision making strategies in working with individuals at end of life and others. **4.4** Analyse how partnership working delivers positive outcomes for individuals and others **4.5** Initiate and contribute to multi-disciplinary assessment **4.6** Explain how to overcome barriers to partnership working. **4.7** Access specialist multi-disciplinary advice to manage complex situations. **5.1** Describe how a shared vision for excellent end of life care services can be supported. **5.2** Implement strategies to empower staff involved in the delivery of end of life care to ensure positive outcomes for individuals and others. **5.5** Support staff and others to recognise when mental capacity has reduced to the extent that others will determine care and treatment for the person at the end of life. **5.8** Provide feedback to staff on their practices in relation to end of life. **6.2** Critically reflect on methods for measuring the end of life care service against national indicators of quality.

				6.3 Use outcomes of reflective practice to improve aspects of the end of life care service.
SESSION 6: Plan – Care of Dying – **Learning Outcomes:** 1 Anticipatory prescribing 2 Care in the final days 3 Care of the dying person with dementia.	**Content:** 1. When should you obtain anticipatory drugs and any logistical difficulties? Anticipatory drugs at C 2. Other needs – Needs based coding. 3. Diagnosing dying. 4. Minimum care protocol for the dying phase – what tools are used? 5. Other anticipatory care for co-morbidities, e.g., chest crisis Fits Infections Large and sudden bleeds. 6. Be prepared – why we should be. 7. Ensuring all staff are aware and prepared. Supportive environment for staff. 8. Care events that can be managed i. In the home ii. In the home with additional support iii. Hospital/other **Activities:** 1. Reflect on last session/Action plan. What have you learned? 2. Significant Event Analysis - case study		1. Be able to apply current legislation and policy in end of life care in order to develop end of life care services. 2. Understand current theory and practice underpinning end of life care. 3. Be able to lead and manage effective end of life care services. 4. Be able to establish and maintain key relationships to lead and manage end of life care. 5. Be able to support staff and others in the delivery of excellence in the end of life care service.	**1.2** Apply local and national policy guidance for end of life care to the setting in which you work. **1.3** Analyse legal and ethical issues relating to decision making at the end of life. **1.4** Explain how issues of mental capacity could affect end of life care. **2.2** Explain how grief and loss manifest itself in the emotions of **individuals** who are dying and **others.** **2.3** Analyse how a range of **tools for end of life care** can support the individual and others. **2.4** **Explain** the pathway used by your current local health authority. **3.3** Analyse how a range of tools for end of life care can support the individual and others **3.4** Use effective mediation and negotiation skills on behalf of the individual who is dying. **3.5** Ensure there are sufficient and appropriate resources to support the delivery of end of life care services **3.6** Describe the possible role(s) of advocates in end of life care. **3.7** Manage palliative care emergencies according to the wishes and preferences of the individual.

	3. The need to anticipate in the absence of a tool– how do you ensure that best care is delivered? 4. How would you plan the care before the person reaches their final days – NSM @ weeks 5. Dying with dementia activity from dementia dvd **Action plan** 1. What else do you need to do around anticipatory care and prescribing, so that everything can happen in a timely manner 2. Review what you do in your home, do you have an EoLC plan for each person, do you have a policy/protocol for care of the dying? 3. Review the last 5 deaths of your residents, regardless of where they died – what could/should have been done differently?			**4.3** Implement shared decision making strategies in working with individuals at end of life and others. **4.4** Analyse how partnership working delivers positive outcomes for individuals and others **4.5** Initiate and contribute to multi-disciplinary assessment **5.1** Describe how a shared vision for excellent end of life care services can be supported **5.5** Support staff and others to recognise when mental capacity has reduced to the extent that others will determine care and treatment for the person at the end of life.
SESSION 7: Spiritual Care – Bereavement & Environment **Learning Outcomes:** 1 Bereavement support 2 Spirituality & cultural differences 3 Supporting carers, residents and staff	**Content:** 1. Grief – stages, effects for all involved. 2. Relationships in the care environment. 3. Spirituality and inner being. 4. Differing religions, rituals and sacraments. 5. Nurturing inner life. 6. HOPE Carers assessment 7. Quality of life for carers 8. Carers support		1. Be able to apply current legislation and policy in end of life care in order to develop end of life care services. 2. Understand current theory and practice underpinning end of life care.	**1.3** Analyse legal and ethical issues relating to decision making at end of life. **2.1** Describe the theoretical models of grief, loss and bereavement **2.2** Explain how grief and loss manifest in the emotions of **individuals** who are dying and **others.**

	Activities: 1. Reflect on last session – action plans. Reflect on areas worked on since last session. 2. What do you do to support relatives in bereavement? a. What else can you do? 3. What does spirituality mean to you? Is there more you can do to meet the spiritual needs of your residents? 4. How do you support residents and staff during difficult times? What else can you do? **Action plan:** 1. What written information/leaflets do you have for relatives? 2. Review and reflect on the level of spiritual care and its meaning in your home. 3. What resources are there locally for you to access? Who can be involved in ensuring the home meets the spiritual and human needs of people at the end of life?		3. Be able to lead and manage effective end of life care services. 4. Be able to establish and maintain key relationships to lead and manage end of life care. 5. Be able to support staff and others in the delivery of excellence in the end of life care service. 6. Be able to continuously improve the quality of the end of life care service.	**3.2** Manage own feelings and emotions in relation to end of life care, using a **range of resources** as appropriate. **3.3** Use effective communication to support individuals and end of life and others. **3.4** Use effective mediation and negotiation skills on behalf of the individual who is dying. **4.1** Identify key relationships essential to effective end of life care. **4.2** Analyse the features of effective partnership working within your work setting. **4.3** Implement shared decision making strategies in working with individuals at end of life and others. **4.4** Analyse how partnership working delivers positive outcomes for individuals and others. **5.3** Support others to use a range of resources as appropriate to manage own feelings when working in end of life care **5.6** **Access** appropriate learning and development opportunities to equip staff and others for whom you are responsible. **5.7** Explain the importance of formal and informal supervision practice to support the staff and volunteers in end of life care. **6.1** Analyse how reflective practice approaches can improve the quality of life care services. **6.3** Use outcomes of reflective practice to improve aspects of the end of life care service.

SESSION 8: Embed the Ethos - Accreditation. **Learning Outcomes:** Bringing it all together – challenges, gaps & actions. Consolidation, Sustainability and Accreditation. Understanding the Accreditation Process and identifying if you are ready for Accreditation.	**Content:** 1. Review activity through sharing ideas, reflection and good practice. 2. Goals of GSF Reflective Practice & Continued Learning (audit). 3. Understand the challenges, understand the importance of embedding sustainability. 4. Benefits of Accreditation - Process & Next steps. **Activities:** 1. Review last session/Action plan – reflect on areas worked on since last session. 2. Target exercise 3. What are your challenges now? 4. Confidence questionnaire 5. Checklist - are you ready? **Action plan**: 1. Complete ADA. 2. Go through checklist with the team – are you ready? 3. Get staff to complete follow up competence assessments.		2. Understand current theory and practice underpinning end of life care. 3. Be able to lead and manage effective end of life care services 4. Be able to establish and maintain key relationships to lead and manage end of life care 5. Be able to support staff and others in the delivery of excellence in the end of life care service 6. Be able to continuously improve the quality of the end of life care service	**2.5** Critically reflect on how the outcomes of national research can affect your workplace practices **3.1** Explain the qualities of an effective leader in end of life care. **3.3** Use effective communication to support individuals at end of life and others. **3.8** Use a range of tools for end of life care to measure standards through audit and after death analysis. **4.1** Identify key relationships essential to effective end of life care. **4.2** Analyse the features of effective partnership working within your work setting. **4.3** Implement shared decision making strategies in working with individuals at end of life and others. **4.4** Analyse how partnership working delivers positive outcomes for individuals and others. **5.1** Describe how a shared vision for excellent end of life care services can be supported. **5.2** Implement strategies to empower staff involved in the delivery of end of life care to ensure positive outcomes for individuals and others. **5.6** Access appropriate learning and development opportunities to equip staff and others for whom you are responsible. **5.7** Explain the importance of formal and informal supervision practice to support the staff and volunteers in end of life care 5.9 Provide feedback to staff on their practices in relation to end of life care.

				6.1 Analyse how reflective practice approaches can improve the quality of end of life care services. **6.2** Critically reflect on methods for measuring the end of life care service against national indicators of quality. **6.3** Use outcomes of reflective practice to improve aspects of the end of life care service.

Unable to map 2.1 – Describe theoretical models of grief, loss and bereavement.

Rationale for my including all areas available should this be required.