EoLC Functional Analysis:

Frailty

Underpinning Principles

Underpinning principles are functional aspects of providing care which do not entail discreet time requirements – they are implicit with other tasks for which timings have been included, and have been identified as follows:

- 1.2 Communicate effectively
- 1.4 Support individuals with specific communication needs ⁵
- 1.8 Relate to, and interact with, individuals
- 2.5 Ensure your own actions support the equality, diversity, rights and responsibilities of individuals
- 3.8 Ensure your own actions reduce risks to health and safety
- 4.1 Ensure compliance with legal, regulatory, ethical and social requirements ¹⁶
- 4.2 Ensure your own actions support the care, protection and wellbeing of individuals
- C2.3.4 Act with, and on behalf of individuals, to present their needs and wishes
- G1.3.3 Develop productive working relationships with contacts and stakeholders
- H2.1 Develop your knowledge and practice
- H2.2 Reflect on and evaluate your own values, priorities, interests and effectiveness¹⁷
- H3.5 Take responsibility for the continuing professional development of yourself and others
- H4.1 Identify the learning needs of patients and carers to enable management of a defined condition
- H4.2 Develop relationships with individuals which support them in addressing their health needs*
- H4.3 Provide information and advice to individuals/carers on managing health care needs*

- 5. intended for communication with individuals with specific difficulties such as an inability to speak, but could include people with dementia or learning disabilities
- 16. includes confidentiality
- 17. includes making use of supervision as a way of supporting the individual providing support
- * relevant to both health and social care



Point 1: Enter EoL Pathway – Transition to "Do Something"

This is a one-off occurrence on the pathway. Requirement for the functions is timed in minutes.

TRIGGERS: Eg diagnosis, clinical instability, pain/symptom relief needed, mobility support needed, some assistance with personal care needs, frequent use of OOH's plus frequent

admissions to hospital G Ε S Plan assessment A2.1.2 Plan assessment and investigation into an individual's health 15 status (30)Carry out assessment A2.2.1 Obtain information from individuals to support assessment of their health status and needs A2.2.2 Obtain information from indirect sources to inform assessment 60 30 of an individual's health status and needs¹⁰ A2.8.6 Assess the need for, and provision of environmental and social A2.2.3 Request investigations to provide information on an individual's health status and needs 15 2.3.1 Obtain specimens non-invasively 15 A2.3.2 Obtain specimens invasively 30 A2.5.1 Undertake routine clinical measurements 15 4.5 Contribute to the identification of the risk of danger to individuals 30 30 30 and others¹⁹ F1.2.2 Input data and information for processing¹ 20 Early management and pre-diagnosis of end of life 1.3 Communicate significant news to individuals 60 A2.8.5 Assess an individual's needs arising from their health status A2.8.8 Agree courses of action following assessment B2.9.10 Support individuals to prepare for, adapt to and manage 60 change B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others B1.2.2 Refer individuals to specialist services for treatment and care 30 F1.2.2 Input data and information for processing¹ 20 H4.3 Provide information and advice to individuals/carers on managing health care needs 30 60 Make diagnosis A2.7.1 Interpret and report on the findings of investigations A2.10.1 Determine a diagnosis and prognosis for an individual 60 F1.2.2 Input data and information for processing¹ 20 Receive referral B1.2.1 Receive and direct requests for health care assistance using 30 protocols and guidelines Develop care plan A2.8.7 Assess the needs of carers and families B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others* 60 B1.1.3 Prepare individualised treatment plans for individuals 15 B1.1.4 Plan activities, interventions and treatments to achieve specified 60 health goals² F1.2.2 Input data and information for processing¹ 20

H4.1 Identify the learning needs of patients and carers to enable



30

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management of a defined condition			
B1.2.2 Refer individuals to specialist services for treatment and care		30	
	125	465	285
TOTALS		(480)	

- 1. recording information centrally for sharing with colleagues
- describes advance care planning
 includes other agencies, including social care, GPs etc
- 19. includes arrangements for young children, older children with disabilities, frail partners, etc relevant to both health and social care



Point 2: "Do Something"

This is an ongoing occurrence on the pathway. Requirement is timed in minutes per day.

This is an ongoing occurrence on the pathway. Requirement is timed in			
	G	E	S
Implement care plan			_
B2.1.6 Prepare resources for use in health care actions*	30	10	4
B2.7.1 Co-ordinate the implementation and delivery of treatment		13	
plans ⁶			
B2.8.10 Administer medication to individuals	10		
B2.8.14 Manage stocks of medication		10	
B2.7.3 Implement care plans/programmes ²¹			
B2.7.5 Deliver therapeutic activities for individuals			
B2.9.1 Support individuals during and after clinical/therapeutic			
activities			
B2.9.2 Support individuals who are distressed			
B2.9.3 Support individuals to access and use services and facilities	80	30	
B2.9.4 Support individuals in undertaking desired activities			
B2.9.5 Support individuals in their daily living ¹¹			
B2.9.6 Support individuals with their personal care needs			
B2.9.8 Support individuals to keep mobile ⁴			
B2.9.10 Support individuals to prepare for, adapt to and manage			4
change			
B2.9.11 Support individuals to undertake and monitor their own health	1		
care		10	
B2.9.12 Support individuals to maintain their spiritual well-being	1		
B2.9.13 Support individuals and carers to cope with the emotional and			
psychological aspects of healthcare activities		15	
B2.10.1 Work in collaboration with carers in the caring role	15		
B2.10.2 Enable carers to support individuals with defined health			
needs*			
B2.10.3 Support carers to manage their own needs	15	15	
C2.3.4 Act with, and on behalf of, individuals to present their needs			
and wishes			
D2.2.4 Set up medical devices and equipment ⁷	1	30	9
F1.2.2 Input data and information for processing ¹	20		
F2.1.10 Provide expert advice ¹²			30
Monitor care plan			
B3.1.2 Monitor individuals' condition over time ²³	15	5	
B3.1.3 Monitor and evaluate individuals' progress in managing health			
conditions			
B3.1.5 Evaluate the delivery of care plans to meet the needs of			
individuals			
B3.1.6 Evaluate treatment plans with individuals and those involved in		15	
their care			4
B3.1.7 Agree changes to interventions and treatments ⁶	1		
B2.8.13 Manage an individual's medication to achieve optimum	1		
outcomes ¹³			
F1.2.2 Input data and information for processing ¹	20		
TOTALS (per day)	205	153	51
TOTALS (per week)	1435	1071	357



- 1. recording information centrally for sharing with colleagues
- 4. this is to enable people to keep mobile both within their home and outside, so could include using a wheelchair or walking stick outside, or continuing to be able to go to the bathroom on their own, or to feed themselves
- 6. could include equipment
- 7. includes assistive technology
- 11. includes information and advice around non health issues such as access to welfare benefits, housing adaptations etc
- 12. includes signposting individuals to other sources of expertise
- 13. includes reviewing medication on a regular basis
- 21. the people with specialist/enhanced skills are providing the service while the people with generic skills are acknowledging need and signposting
- 23. if this means monitoring the specific condition then it's a specialist skill but if it's the individual self-monitoring their overall health, it's a lower level skill
- * relevant to both health and social care



Point 3: Transition to "Do something more"

This is a one-off occurrence on the pathway. Requirement for the functions is timed in minutes.

TRIGGERS: Eg increasing clinical instability, pain/symptom relief needed, extended personal care

needs, increased mobility support needs

needs, increased mobility support needs	G	E	S
Assessment	u	<u> </u>	
4.5 Contribute to the identification of the risk of danger to individuals			
and others ¹⁹			
A2.2.1 Obtain information from individuals to support assessment of			
their health status and needs*		105	
A2.2.2 Obtain information from indirect sources to inform assessment			
of an individual's health status and needs*			
A2.2.3 Request investigations to provide information on an individual's			
health status and needs			
A2.2.4 Investigate factors influencing an individual's health status			
A2.8.5 Assess an individuals needs arising from their health status			60
A2.7.1 Interpret and report on the findings of investigations			
A2.8.6 Assess the need for, and provision of environmental and social		60	
support			
A2.8.7 Assess the needs of carers and families			
A2.3.1 Obtain specimens non-invasively	15		
A2.3.2 Obtain specimens invasively		30	
A2.5.1 Undertake routine clinical measurements		15	
F1.2.2 Input data and information for processing ¹	20		
Develop and agree care plan		<u> </u>	
1.3 Communicate significant news to individuals			60
B1.1.1 Prioritise treatment and care for individuals according to their			
health status and needs ⁸			
B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others ⁸		60	60
B1.1.3 Prepare individualised treatment plans for individuals			00
B1.1.4 Plan activities, interventions and treatments to achieve			
specified health goals ² *			
B2.9.10 Support individuals to prepare for and manage change			
H4.3 Provide information and advice to individuals/carers on			
managing health care needs*			
B3.1.6 Evaluate treatment plans with individuals and those involved in			
their care			30
B3.1.7 Agree changes to interventions and treatments			60
Referral			
B1.2.1 Receive and direct requests for health care assistance using	30		
protocols and guidelines*			
B1.2.2 Refer individuals to specialist services for treatment and care		30	
B2.1.9 Arrange access to resources needed to support planned health			
care/lifestyle programmes ^{6 22 *}		60	240
TOTALS	65	360	510



- 1. recording information centrally for sharing with colleagues
- 2. describes advance care planning
- 6. could include equipment
- 8. includes as assessment of the location/home, such as whether the patient is upstairs
- 19. includes arrangements for young children, older children with disabilities, frail partners, etc
- 22. at this stage in the pathway this could include arranging access to funding such as Continuing Health Care which is a specialist skill
- * relevant to both health and social care



Point 4: "Do something more"

This is an ongoing occurrence on the pathway. Requirement for the functions is timed in minutes per day

per day			
	G	<u>E</u>	S
Receive referral			
B1.2.1 Receive and direct requests for health care assistance using	30		
protocols and guidelines*			
Implement the care plan			
B2.1.6 Prepare resources for use in health care actions	30		4
B2.7.1 Co-ordinate the implementation and delivery of treatment			
plans ⁶		13	
B2.7.3 Implement care plans/programmes ²¹			
B2.7.5 Deliver therapeutic activities for individuals			
B2.9.1 Support individuals during and after clinical/therapeutic	250		
activities			
B2.7.7 Undertake extended personal care for individuals unable to do			
so themselves			
B2.8.10 Administer medication to individuals ²⁰		20	40
B2.8.14 Manage stocks of medication ²⁰			
B2.9.5 Support individuals in their daily living ¹¹			
B2.9.6 Support individuals with their personal care needs			
B2.9.8 Support individuals to keep mobile ⁴	200	60	
B2.9.2 Support individuals who are distressed			
B2.9.3 Support individuals to access and use services and facilities			
B2.9.10 Support individuals to prepare for and manage change			
B2.9.11 Support individuals to undertake and monitor their own health			
care			
B2.9.12 Support individuals to maintain their spiritual well-being			
B2.9.13 Support individuals and carers to cope with the emotional and			4
psychological aspects of healthcare activities	75		
B2.10.1 Work in collaboration with carers in the caring role	. •		
B2.10.2 Enable carers to support individuals with defined health needs			
B2.10.3 Support carers to manage their own needs			
D2.2.4 Set up medical devices and equipment ⁷		4	8
F1.2.2 Input data and information for processing ¹	20		U
F2.1.10 Provide expert advice ¹²	20		7
Monitor the care plan			1
B2.8.13 Manage an individual's medication to achieve optimum			
outcomes			
B3.1.2 Monitor individuals' condition over time ²³			
B3.1.3 Monitor and evaluate individuals' progress in managing health			
conditions			
B3.1.5 Evaluate the delivery of care plans to meet the needs of	-	15	4
individuals		13	7
B3.1.6 Evaluate treatment plans with individuals and those involved in	-		
their care			
	-		
B3.1.7 Agree changes to interventions and treatments			
TOTALS (per day)	605	112	67
TOTALO (per day)	003	114	O1
TOTALS (per week)	4235	784	469
IOIALO (pei week)	TEUU	704	703



- 1. recording information centrally for sharing with colleagues
- 2. describes advance care planning
- 4. is to enable people to keep mobile both within their home and outside, so could include using a wheelchair or walking stick outside, or continuing to be able to go to the bathroom on their own
- 6. could include equipment
- 7. includes assistive technology
- 8. includes as assessment of the location/home, such as whether the patient is upstairs
- 11. includes information and advice around non health issues such as access to welfare benefits, housing adaptations etc
- 12. includes signposting individuals to other sources of expertise
- 20. controlled drugs must be managed/removed in conjunction with a practitioner defined by the 1968 Medicine Act
- 21. the people with specialist/enhanced skills are providing the service while the people with generic skills are acknowledging need and signposting
- 23. if this means monitoring the specific condition then it's a specialist skill but if it's the individual self-monitoring their overall health, it's a lower level skill
- * relevant to both health and social care



Point 5 – Transition to Last Days of Life

This is a one-off occurrence on the pathway. Requirement for the functions is timed in minutes.

TRIGGERS: Eg advance directive, multiple organ failure, discharge from hospital for last days, prognosis indicators for LCP

prognosis indicators for LCP.				
	G	Е	S	
Assessment of care needs				
4.5 Contribute to the identification of the risk of danger to individuals and				
others ¹⁹				
A2.8.5 Assess an individual's needs arising from their health status*				
A2.8.6 Assess the need for and provision of environmental and social		180		
support				
A2.8.7 Assess the needs of carers and families				
B2.9.10 Support individuals to prepare for, adapt to and manage change				
Develop care plan and support people				
1.3 Communicate significant news to individuals				
B1.1.4 Plan activities, interventions and treatments to achieve specified				
health goals ² *			60	
B1.1.3 Prepare individualised treatment plans for individuals				
B1.1.2 Enable individuals to make health choices and decisions		120		
regarding their own health or the health of others *				
B2.7.1 Co-ordinate the implementation and delivery of treatment plans ⁶	300			
B2.9.10 Support individuals to prepare for and manage change				
F2.1.10 Provide expert advice ¹²				
B1.2.2 Refer individuals to specialist services for treatment and care ⁷				
H4.3 Provide information and advice to individuals/carers on managing				
health care needs *				
B2.10.1 Work in collaboration with carers in the caring role				
B2.10.2 Enable carers to support individuals with defined health needs				
F1.2.2 Input data and information for processing ¹				
F2.1.10 Provide expert advice ¹²				
E2.3.1 Move and transport patients within the work area ⁹				
Referral				
F1.2.2 Input data and information for processing ¹	20			
TOTALS	320	300	60	

- 1. recording information centrally for sharing with colleagues
- 2. describes advance care planning
- 6. could include equipment
- 7. includes assistive technology
- 9. could be from one room to another within a hospital or hospice, or within a private home
- 12. includes signposting individuals to other sources of expertise
- 19. includes arrangements for young children, older children with disabilities, frail partners, etc.
- * relevant to both health and social care



Point 6 – Last Days of Life/Death

This is an ongoing occurrence on the pathway. Requirement for the functions is timed in minutes per day.

This is drawn from the Liverpool Care Pathway	G	Е	S	
Care within last days of life				
1.3 Communicate significant news to individuals				
A2.8.6 Assess the need for and provision of environmental and social				
support ⁸				
B2.7.7 Undertake extended personal care for individuals unable to do so				
themselves ²⁵				
B2.8.10 Administer medication to individuals ²⁰				
B2.8.14 Manage stocks of medication ²⁰				
B2.9.2 Support individuals who are distressed				
B2.9.5 Support individuals in their daily living ^{11, 24}			_	
B2.9.10 Support individuals to prepare for and manage change	1440	200	5	
B2.9.12 Support individuals to maintain their spiritual well-being				
B2.9.13 Support individuals and carers to cope with the emotional and				
psychological aspects of healthcare activities				
B2.10.1 Work in collaboration with carers in the caring role				
B2.7.3 Implement care plans/programmes				
B2.9.14 Support individuals through the process of dying				
B2.3.3 Establish and maintain pain relief				
B3.1.3 Evaluate treatment plans with individuals and those involved in their				
care				
D2.2.4 Set up medical devices and equipment ⁷				
F1.2.2 Input data and information for processing ¹				
TOTALS (per day)	1440	200	5	

Notes:

- 1. recording information centrally for sharing with colleagues
- 7. includes assistive technology
- 8. includes as assessment of the location/home, such as whether the patient is upstairs
- 11. includes information and advice around non health issues such as access to welfare benefits, housing adaptations etc
- 20. controlled drugs must be managed/removed in conjunction with a practitioner defined by the 1968 Medicine Act
- 24. could include drinking
- 25. part of the skill lies in knowing when to provide care and when it is better (more caring) to leave the person alone.

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Point 7 – Care After Death

This is a one-off occurrence on the pathway. Requirement for the functions is timed in minutes.

	G	Е	S
Care after death			
A2.5.4 Assess system/organ function using specialised procedures ¹⁸		25	
1.3 Communicate significant news to individuals		60	
B2.8.14 Manage stocks of medication ²⁰		30	
B2.9.2 Support individuals who are distressed			
B2.9.14 Support individuals through the process of dying ³			
B2.9.10 Support individuals to prepare for and manage change		150	
B2.9.12 Support individuals to maintain their spiritual well-being		(180)	
B2.9.15 Support individuals through bereavement ²⁶			
B2.10.3 Support carers to manage their own needs			
F2.1.10 Provide expert advice ¹²			
E2.3.4 Transport the deceased		60	
F1.2.2 Input data and information for processing ¹	20		
	20	325	0
TOTALS		(355)	

Notes:

- 1. recording information centrally for sharing with colleagues
- 3. includes last offices
- 12. includes signposting individuals to other sources of expertise
- 18. includes verification of an expected death
- 20. controlled drugs must be managed/removed in conjunction with a practitioner defined by the 1968 Medicine Act
- 26. additional time is allowed to support individuals through bereavement if the bereaved individual has dementia, rather than the person who has just died

Timings for care after death are likely to be higher if the person enters the pathway later, particularly if the carer is also frail/elderly as there may be a need to provide support / place of safety for them.

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Point 8: Enter EoL Pathway – Transition to "Do Something" This is a one-off occurrence on the pathway. Requirement for the functions is timed in minutes.

Plan assessment A2.1.2 Plan assessment and investigation into an individual's health status Carry out assessment A2.2.1 Obtain information from individuals to support assessment of their health status and needs A2.2.2 Obtain information from indirect sources to inform assessment of an individual's health status and needs ¹⁰ A2.8.6 Assess the need for, and provision of environmental and social support A2.2.3 Request investigations to provide information on an individual's health status and needs 2.3.1 Obtain specimens non-invasively A2.3.2 Obtain specimens invasively A2.5.1 Undertake routine clinical measurements 4.5 Contribute to the identification of the risk of danger to individuals and others ¹⁹ F1.2.2 Input data and information for processing¹ Early management and pre-diagnosis of end of life 1.3 Communicate significant news to individuals A2.8.5 Assess an individual's needs arising from their health status A2.8.8 Agree courses of action following assessment B2.9.10 Support individuals to prepare for, adapt to and manage change	This is a one-off occurrence on the pathway. Requirement for the function			
A2.1.2 Plan assessment and investigation into an individual's health status Carry out assessment A2.2.1 Obtain information from individuals to support assessment of their health status and needs A2.2.2 Obtain information from indirect sources to inform assessment of an individual's health status and needs' A2.8.6 Assess the need for, and provision of environmental and social support A2.2.3 Request investigations to provide information on an individual's health status and needs 15 A2.3.1 Obtain specimens non-invasively A2.3.2 Obtain specimens non-invasively A2.3.2 Obtain specimens invasively A2.3.1 Obtain specimens non-invasively A2.3.1 Obtain specimens invasively A2.5.1 Undertake routine clinical measurements 4.5 Contribute to the identification of the risk of danger to individuals and others¹ F1.2.2 Input data and information for processing¹ Early management and pre-diagnosis of end of life 1.3 Communicate significant news to individuals A2.8.5 Assess an individual's needs arising from their health status A2.8.3 Agree courses of action following assessment 60 A2.9.1 Support individuals to make health choices and decisions regarding their own health or the health of others B1.2.2 Refer individuals to specialist services for treatment and care F1.2.2 Input data and information for processing¹ A2.1.1 Interpret and report on the findings of investigations A2.1.1.1 Determine a diagnosis and prognosis for an individual F1.2.2 Input data and information for processing¹ A2.8.7 Assess the needs of carers and families Develop care plan A2.8.7 Assess the needs of carers and families B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others' B1.1.1 Receive and direct requests for heath care assistance using protocols and guidelines Develop care plan A2.8.7 Assess the needs of carers and families B1.1.1 Plan activities, interventions and treatments to achieve specified health goals' F1.2.2 Input data and information for processing¹ B	Di	G	E	S
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TOTALS (480)	TOTALS	120		200



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- 1. recording information centrally for sharing with colleagues
- 2. describes advance care planning
- 10. includes other agencies, including social care, GPs etc19. includes arrangements for young children, older children with disabilities, frail partners,
- relevant to both health and social care



Point 9: Enter EoL Pathway – Transition to "Do Something" This is a one-off occurrence on the pathway. Requirement for the functions is timed in minutes.

This is a one-off occurrence on the pathway. Requirement for the function			
DI .	G	E	S
Plan assessment	T		
A2.1.2 Plan assessment and investigation into an individual's health		15	
status		(30)	
Carry out assessment	T		
A2.2.1 Obtain information from individuals to support assessment of			
their health status and needs	_		
A2.2.2 Obtain information from indirect sources to inform assessment		60	30
of an individual's health status and needs ¹⁰			
A2.8.6 Assess the need for, and provision of environmental and social			
support			
A2.2.3 Request investigations to provide information on an individual's			
health status and needs		15	
2.3.1 Obtain specimens non-invasively	15		
A2.3.2 Obtain specimens invasively		30	
A2.5.1 Undertake routine clinical measurements		15	
4.5 Contribute to the identification of the risk of danger to individuals	30	30	30
and others ¹⁹			
F1.2.2 Input data and information for processing ¹	20		
Early management and pre-diagnosis of end of li	fe		
1.3 Communicate significant news to individuals			60
A2.8.5 Assess an individual's needs arising from their health status			
A2.8.8 Agree courses of action following assessment			
B2.9.10 Support individuals to prepare for, adapt to and manage		60	
change			
B1.1.2 Enable individuals to make health choices and decisions			
regarding their own health or the health of others			
B1.2.2 Refer individuals to specialist services for treatment and care		30	
F1.2.2 Input data and information for processing ¹	20		
H4.3 Provide information and advice to individuals/carers on managing			
health care needs		60	30
Make diagnosis			
A2.7.1 Interpret and report on the findings of investigations			
A2.10.1 Determine a diagnosis and prognosis for an individual			60
F1.2.2 Input data and information for processing ¹	20		
Receive referral			
B1.2.1 Receive and direct requests for health care assistance using		30	
protocols and guidelines			
Develop care plan			
A2.8.7 Assess the needs of carers and families			
B1.1.2 Enable individuals to make health choices and decisions	_		
regarding their own health or the health of others*		60	
B1.1.3 Prepare individualised treatment plans for individuals	1		15
B1.1.4 Plan activities, interventions and treatments to achieve specified	1		10
health goals ²			60
F1.2.2 Input data and information for processing ¹	20	1	00
H4.1 Identify the learning needs of patients and carers to enable	20	30	
management of a defined condition		30	
•	1	20	
B1.2.2 Refer individuals to specialist services for treatment and care	125	30 465	205
TOTALS	125		285
TOTALS		(480)	



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