EoLC Functional Analysis:

Organ Failure

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 effectiveness[17]
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*

Notes:

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

Individuals on this pathway tend to have frequent acute hospital admissions and therefore many of the transitions will take place within hospital: the figures here include the cost of community in-reach to acute care, but not the cost of that acute 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	E	S
Plan assessment			
A2.1.2 Plan assessment and investigation into an individual's health status			20 (60)
Carry out assessment			
A2.2.1 Obtain information from individuals to support assessment of their health status and needs	20	20	150 (180)
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		10	10
2.3.1 Obtain specimens non-invasively	10 (30)		
A2.3.2 Obtain specimens invasively		10 (30)	
A2.5.1 Undertake routine clinical measurements	10 (30)		60
4.5 Contribute to the identification of the risk of danger to individuals and others[19]		90	5
F1.2.2 Input data and information for processing[1]	20		
Early management and pre-diagnosis of end of life			
1.3 Communicate significant news to individuals			60[26] (120)
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			
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			
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			
Receive referral			
B1.2.1 Receive and direct requests for health care assistance using protocols and guidelines		30	30
Develop care plan			
A2.8.7 Assess the needs of carers and families [23]		90 (150)	30
B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others*			
B1.1.3 Prepare individualised treatment plans for individuals			
B1.1.4 Plan activities, interventions and treatments to achieve specified health goals[2]			
F1.2.2 Input data and information for processing[1]	20		
H4.1 Identify the learning needs of patients and carers to enable management of a defined condition			

H4.3 Provide information and advice to individuals/carers on managing health care needs*			
B1.2.2 Refer individuals to specialist services for treatment and care		30	
TOTALS	**100 (140)**	**280 (360)**	**365 (495)**

Notes:

1. recording information centrally for sharing with colleagues
2. describes advance care planning
10. includes other agencies, including social care, GPs etc
19. includes arrangements for young children, older children with disabilities, frail partners, etc. In this case in terms of the patient it could include falls, skin damage, nutrition, medication, environment and the capacity of carers
23. ideally the person supporting the carer should be different to the person supporting the patient, to reduce conflict of interest and ensure the carer gets proper independent support
26. including making diagnosis

* relevant to both health and social care

Point 2: "Do Something"

This is an ongoing occurrence on the pathway. Requirement for the functions is timed in minutes per day (please note, figures were originally calculated per week, but have been sub-divided to give a daily amount in line with other points in the pathway).

	G	E	S
Implement care plan			
B2.1.6 Prepare resources for use in health care actions*	4		5
B2.7.1 Co-ordinate the implementation and delivery of treatment plans[6]		4	
B2.8.10 Administer medication to individuals ii practitioner		30	
B2.8.14 Manage stocks of medication ii.practitioner		4	
B2.7.3 Implement care plans/programmes[21]	4	9 (17)	4(6)
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	120	1	
B2.9.3 Support individuals to access and use services and facilities			
B2.9.4 Support individuals in undertaking desired activities		60	
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 change			5
B2.9.11 Support individuals to undertake and monitor their own health care			4(9)
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			
B2.10.2 Enable carers to support individuals with defined health needs*			
B2.10.3 Support carers to manage their own needs			5
D2.2.4 Set up medical devices and equipment[7]		9	
F1.2.2 Input data and information for processing[1]	3		
F2.1.10 Provide expert advice[12]			1
Monitor care plan			
B3.1.2 Monitor individuals' condition over time[23]	3	14	14
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 their care			
B3.1.7 Agree changes to interventions and treatments[6]			
B2.8.13 Manage an individual's medication to achieve optimum outcomes[13]			
F1.2.2 Input data and information for processing[1]	3		
TOTALS (per day)	**137**	**131 (139)**	**33 (40)**
TOTALS (per week)	**959**	**917 (973)**	**231 (280)**

Notes:

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

	G	E	S
Assessment			
4.5 Contribute to the identification of the risk of danger to individuals and others[19]		120 (180)	120 (180)
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			
A2.2.4 Investigate factors influencing an individual's health status			
A2.8.5 Assess an individual's needs arising from their health status			
A2.7.1 Interpret and report on the findings of investigations			
A2.8.7 Assess the needs of carers and families			
A2.3.1 Obtain specimens non-invasively	20		
A2.3.2 Obtain specimens invasively			
A2.5.1 Undertake routine clinical measurements			
F1.2.2 Input data and information for processing[1]	20		
Develop and agree care plan			
1.3 Communicate significant news to individuals	30	120	180
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]			
B1.1.3 Prepare individualised treatment plans for individuals			
B1.1.4 Plan activities, interventions and treatments to achieve specified health goals[2] *			
B2.7.3 Implement care plans/programmes			
B2.9.10 Support individuals to prepare for and manage change			
B3.1.6 Evaluate treatment plans with individuals and those involved in their care			
B3.1.7 Agree changes to interventions and treatments			
H4.3 Provide information and advice to individuals/carers on managing health care needs*			
Referral			
B1.2.1 Receive and direct requests for health care assistance using protocols and guidelines*	30	60	120
B1.2.2 Refer individuals to specialist services for treatment and care			
B2.1.9 Arrange access to resources needed to support planned health care/lifestyle programmes[6 22] *			
TOTALS	**100**	**300 (360)**	**420 (480)**

Notes:

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

Enhanced and specialist time has been doubled in this section of the pathway because several members of multi-disciplinary teams are involved, therefore multiplying time required.

Point 4: "Do something more"

This is an ongoing occurrence on the pathway. Requirement for the functions is timed in minutes per day (please note, figures were originally calculated per week, but have been sub-divided to give a daily amount in line with other points in the pathway).

	G	E	S
Receive referral			
B1.2.1 Receive and direct requests for health care assistance using protocols and guidelines*		17	
Implement the care plan			
B2.1.6 Prepare resources for use in health care actions	4		5
B2.7.1 Co-ordinate the implementation and delivery of treatment plans[6]		18	
B2.7.3 Implement care plans/programmes[21]			
B2.7.5 Deliver therapeutic activities for individuals	341		
B2.9.1 Support individuals during and after clinical/therapeutic activities			
B2.7.7 Undertake extended personal care for individuals unable to do so themselves			
B2.8.10 Administer medication to individuals [20]		34	
B2.8.14 Manage stocks of medication			
B2.9.5 Support individuals in their daily living[11]			
B2.9.6 Support individuals with their personal care needs		30	
B2.9.8 Support individuals to keep mobile[4]			
B2.9.2 Support individuals who are distressed		1	5
B2.9.3 Support individuals to access and use services and facilities			
B2.9.10 Support individuals to prepare for and manage change		60	5
B2.9.12 Support individuals to maintain their spiritual well-being			
B2.9.11 Support individuals to undertake and monitor their own health care			4(9)
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			
B2.10.2 Enable carers to support individuals with defined health needs			
B2.10.3 Support carers to manage their own needs			5
D2.2.4 Set up medical devices and equipment[7]		9	
F1.2.2 Input data and information for processing[1]	3		
F2.1.10 Provide expert advice[12]			1
Monitor the care plan			
B2.8.13 Manage an individual's medication to achieve optimum outcomes	3	4	4
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 individuals	3	4	4
B3.1.6 Evaluate treatment plans with individuals and those involved in their care			
B3.1.7 Agree changes to interventions and treatments			
F2.1.10 Provide expert advice[12]		3	3
TOTALS (per day)	**354**	**180**	**36 (41)**
TOTALS (per week)	**2478**	**1260**	**252 (287)**

Notes:

1. recording information centrally for sharing with colleagues
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

Specialist input includes

- in-reach
- early assisted discharge
- tele-health
- recognition of signs and symptoms
- acute respiratory assessment service
- national heartfailure programme

and time needed will increase if a patient is managed at home during a crisis

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.

	G	E	S
Assessment of care needs			
4.5 Contribute to the identification of the risk of danger to individuals and others[19]	60	180 (220)	30 (45)
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 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		60	60
B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others *	30	60	30
B1.1.3 Prepare individualised treatment plans for individuals			
B1.1.4 Plan activities, interventions and treatments to achieve specified health goals[2] *			
B1.2.2 Refer individuals to specialist services for treatment and care[7]			
B2.7.1 Co-ordinate the implementation and delivery of treatment plans[6]			
B2.9.6 Support individuals with their personal care needs			
B2.9.10 Support individuals to prepare for and manage change			
B2.10.1 Work in collaboration with carers in the caring role			
B2.10.2 Enable carers to support individuals with defined health needs			
F2.1.10 Provide expert advice[12]			
H4.3 Provide information and advice to individuals/carers on managing health care needs *			
Referral			
F1.2.2 Input data and information for processing[1]	20		
TOTALS	**110**	**300 (340)**	**120 (135)**

Notes:

1. recording information centrally for sharing with colleagues
2. describes advance care planning
6. could include equipment
7. includes assistive technology
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	E	S
Care within last days of life			
1.3 Communicate significant news to individuals	1440	200	5
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			
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
9. could be from one room to another within a hospital or hospice, or within a private home
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.

Point 7 – Care After Death

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

	G	E	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		60 (90)	
B2.9.12 Support individuals to maintain their spiritual well-being			
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		
TOTALS	**20**	**235 (265)**	**0**

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

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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.

	G	E	S
Plan assessment			
A2.1.2 Plan assessment and investigation into an individual's health status			20 (60)
Carry out assessment			
A2.2.1 Obtain information from individuals to support assessment of their health status and needs	20	20	240 (270)
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		10	10
2.3.1 Obtain specimens non-invasively	10 (30)		
A2.3.2 Obtain specimens invasively		10 (30)	
A2.5.1 Undertake routine clinical measurements	10 (30)		60
4.5 Contribute to the identification of the risk of danger to individuals and others[19]		90	5
F1.2.2 Input data and information for processing[1]	20		
Early management and pre-diagnosis of end of life			
1.3 Communicate significant news to individuals			150[26] (180)
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			
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			
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			
Receive referral			
B1.2.1 Receive and direct requests for health care assistance using protocols and guidelines		30	30
Develop care plan			
A2.8.7 Assess the needs of carers and families [23]		90 (150)	120
B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others*			
B1.1.3 Prepare individualised treatment plans for individuals			
B1.1.4 Plan activities, interventions and treatments to achieve specified health goals[2]			
F1.2.2 Input data and information for processing[1]	20		
H4.1 Identify the learning needs of patients and carers to enable management of a defined condition			
H4.3 Provide information and advice to individuals/carers on managing health care needs*			
B1.2.2 Refer individuals to specialist services for treatment and care		30	

TOTALS	**100**	**280 (360)**	**635 (735)**

Notes:

1. recording information centrally for sharing with colleagues
2. describes advance care planning
10. includes other agencies, including social care, GPs etc
19. includes arrangements for young children, older children with disabilities, frail partners, etc. In this case in terms of the patient it could include falls, skin damage, nutrition, medication, environment and the capacity of carers
23. ideally the person supporting the carer should be different to the person supporting the patient, to reduce conflict of interest and ensure the carer gets proper independent support
26. including making diagnosis

* 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.

	G	E	S
Plan assessment			
A2.1.2 Plan assessment and investigation into an individual's health status			20 (60)
Carry out assessment			
A2.2.1 Obtain information from individuals to support assessment of their health status and needs	20	20	240 (270)
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		10	10
2.3.1 Obtain specimens non-invasively	10 (30)		
A2.3.2 Obtain specimens invasively		10 (30)	
A2.5.1 Undertake routine clinical measurements	10 (30)		60
4.5 Contribute to the identification of the risk of danger to individuals and others[19]		90	5
F1.2.2 Input data and information for processing[1]	20		
Early management and pre-diagnosis of end of life			
1.3 Communicate significant news to individuals			150[26] (180)
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			
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			
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			
Receive referral			
B1.2.1 Receive and direct requests for health care assistance using protocols and guidelines		30	30
Develop care plan			
A2.8.7 Assess the needs of carers and families [23]		90 (150)	120
B1.1.2 Enable individuals to make health choices and decisions regarding their own health or the health of others*			
B1.1.3 Prepare individualised treatment plans for individuals			
B1.1.4 Plan activities, interventions and treatments to achieve specified health goals[2]			
F1.2.2 Input data and information for processing[1]	20		
H4.1 Identify the learning needs of patients and carers to enable management of a defined condition			
H4.3 Provide information and advice to individuals/carers on managing health care needs*			

B1.2.2 Refer individuals to specialist services for treatment and care		30	
TOTALS	**100 (140)**	**280 (360)**	**635 (735)**

Notes:

1. recording information centrally for sharing with colleagues
2. describes advance care planning
10. includes other agencies, including social care, GPs etc
19. includes arrangements for young children, older children with disabilities, frail partners, etc. In this case in terms of the patient it could include falls, skin damage, nutrition, medication, environment and the capacity of carers
23. ideally the person supporting the carer should be different to the person supporting the patient, to reduce conflict of interest and ensure the carer gets proper independent support
26. including making diagnosis

* relevant to both health and social care