Advanced Person-Centred End-of-Life Care Coordination Training Course

30 November – 4 December 2026
Addis Ababa

AGILE LEADERS
Training Center

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Advanced Person-Centred End-of-Life Care Coordination Training Course

Ref: 1447_224610 **Date:** 30 November – 4 December 2026 **Location:** Addis Ababa **Fees:** 4500 Euro

Overview

Advanced Person-Centred End-of-Life Care Coordination Training Course is a one-week advanced course for healthcare service managers, palliative-care coordinators, nursing and allied-health team leaders, social-care supervisors, and professionals coordinating non-specialist end-of-life support. Participants leave with a Person-Centred End-of-Life Care Coordination Portfolio linking goals and preferences, advance-care conversations, comfort-focused support planning, family communication, cultural and spiritual needs, multidisciplinary continuity, observation and escalation boundaries, bereavement support, documentation, ethics, safeguarding, and quality review. Agile Leaders Training Center presents end-of-life care coordination as a person-centred service responsibility rather than specialist clinical treatment.

Who Should Attend

- Healthcare service managers responsible for end-of-life pathways and continuity
- Palliative-care coordinators working across teams and settings
- Nursing and allied-health team leaders coordinating non-specialist support
- Social-care supervisors supporting people and families
- Quality, safeguarding, and workforce-support professionals

The course assumes professional experience in health or social care coordination. It does not teach diagnosis, prescribing, symptom-treatment decisions, specialist palliative medicine, or hands-on clinical procedures.

Departments and Industries

The course supports services that coordinate care, communication, family support, and continuity for people approaching the end of life.

- Hospitals and specialist clinical services
- Primary, community, and home-care organizations
- Hospices and palliative-support services
- Residential and social-care providers
- Quality, safeguarding, bereavement, and workforce-wellbeing functions

Learning Objectives

By the end of this course, participants will be able to:

- Structure person-centred conversations about goals, preferences, and what matters
- Build coordinated comfort-focused support plans with clear role boundaries
- Integrate family, cultural, spiritual, psychosocial, and practical support needs
- Use observation, documentation, and escalation pathways without crossing clinical scope
- Coordinate transitions, information sharing, bereavement support, and staff wellbeing
- Evaluate end-of-life support quality, continuity, ethics, and safeguarding

Course Agenda

Day 1: Person-Centred End-of-Life Support

- End-of-Life Goals, Preferences, and What-Matters Profile
- Dignity, Choice, Privacy, and Involvement Checklist
- Advance-Care Conversation Readiness Map
- Person, Family, Advocate, and Team Role Matrix
- End-of-Life Support Scope and Clinical-Boundary Guide

Day 2: Communication and Support Planning

- Sensitive Conversation Preparation Framework
- Shared-Decision and Understanding Check
- Comfort-Focused Support Plan Template
- Cultural, Spiritual, Psychosocial, and Practical Needs Record
- Family Communication and Contact Plan

Day 3: Multidisciplinary Coordination and Continuity

- Multidisciplinary Responsibility and Referral Map
- Transition and Information-Sharing Checklist
- Named-Lead and Out-of-Hours Contact Record
- Observation, Change, and Escalation Decision Guide
- Continuity Risk and Crisis-Prevention Review

Day 4: Bereavement, Ethics, Safeguarding, and Staff Support

- Anticipatory Grief and Bereavement Support Pathway
- Ethical Concern and Values-Conflict Review
- Safeguarding Indicator and Escalation Matrix
- Staff Reflection, Boundary, and Support Plan
- End-of-Life Documentation and Accountability Audit

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Day 5: End-of-Life Care Coordination Practice

- Exercise: Facilitate a Goals and Preferences Conversation
- Exercise: Build a Coordinated Comfort-Support Plan
- Exercise: Review a Transition and Escalation Scenario
- Exercise: Evaluate Family, Cultural, and Bereavement Support
- Capstone Exercise: Person-Centred End-of-Life Care Coordination Portfolio

Practical Exercises

The course uses coordination scenarios from hospital, community, home-care, hospice, residential-care, and social-support settings.

- Suggested activity: prepare and facilitate a conversation about what matters, involvement, and preferences.
- Suggested activity: coordinate a support plan across disciplines, settings, and contact routes.
- Suggested activity: document a change and select the correct escalation pathway without making a clinical decision.
- Suggested activity: audit continuity, family support, ethics, safeguarding, bereavement, and staff-support arrangements.

FAQs

Who suits end-of-life care coordination training, and what does it assume?

It suits managers, coordinators, team leaders, social-care supervisors, and quality professionals with experience in health or social care. It assumes coordination experience rather than specialist palliative-medicine competence.

How does this course differ from specialist palliative medicine?

The course develops coordination, communication, support planning, documentation, escalation, continuity, and quality review. It does not teach diagnosis, prescribing, symptom-treatment decisions, or clinical procedures.

How are the person and family involved in end-of-life support planning?

Participants use structured conversations to establish desired involvement, goals, preferences, cultural and spiritual needs, contact arrangements, and what matters, then document and share agreed support actions.

What happens when staff observe a change or concern?

They record the observation, check the agreed plan and role boundary, contact the named professional or appropriate service, and escalate through the defined pathway rather than making an unsupported clinical decision.

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What practical outputs do participants complete?

Outputs include a preferences profile, conversation framework, support-plan template, role and referral map, transition checklist, escalation guide, bereavement pathway, quality audit, and integrated coordination portfolio.