The Marie Curie
Palliative Care Institute
LIVERPOOL

WHAT IS THE LIVERPOOL CARE PATHWAY FOR THE DYING PATIENT (LCP)?

INFORMATION FOR HEALTHCARE PROFESSIONALS

LCP CENTRAL TEAM
MCPCIL

T: +44 (0) 151 706 2274
E: lcp.enquiries@rlbuht.nhs.uk
W: www.mcpcil.org.uk

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The Royal Liverpool and Broadgreen University Hospitals NHS Trust
Marie Curie Cancer Care Devoted to Life
UNIVERSITY OF LIVERPOOL

GENERAL LCP OVERVIEW

What is a Care Pathway?

A care pathway is a complex intervention for the mutual decision making & organisation of care processes for a well defined group of patients during a well defined period.

Defining characteristics of care pathways include: 5 Key Elements

1. An explicit statement of goals / key elements of care based on evidence, best practice
2. The facilitation of the communication among team members & with patient's & families
3. The coordination of the care process by coordinating the roles & sequencing the activities of the MDT, patients & carers
4. The documentation, monitoring & evaluation of variances & outcomes
5. The identification of the appropriate resources

Dr kris Vanhaecht, secretary General of the European Pathway Association

The Liverpool Care Pathway for the Dying Patient (LCP)

Over the past few years a major drive has been underway to ensure that all dying patients, and their relatives and carers receive a high standard of care in the last hours and days of their life. The Liverpool Care pathway for the Dying Patient (LCP) within the LCP Continuous Quality Improvement Programme is one of the key programmes within the Marie Curie Palliative Care Institute Liverpool (MCPCIL) portfolio.

The LCP was recognised as a model of best practice in the NHS Beacon Programme (2001). It was then subsequently incorporated into the Cancer Services Collaborative project and the National End of Life Care Programme (2004-7). It was recommended in the NICE guidance on supportive and palliative care for patients with cancer (2004) as a mechanism for identifying and addressing the needs of dying patients. It was recommended in the Our Health, Our Care, Our Say white paper 2006 as a tool that should be rolled out across the country. It is recommended in the End of Life Care Strategy DH 2008.

The LCP Continuous Quality Improvement Programme incorporates:

1 Aim

To improve care of the dying in the last hours or days of life

2 Key Themes

To improve the knowledge related to the process of dying
To improve the quality of care in the last hours or days of life

3 Key Sections

Initial Assessment
Ongoing Assessment
Care after death

4 Key Domains of Care

Physical
Psychological
Social
Spiritual

5 Key Requirements for Organisational Governance

Clinical Decision Making
Management & Leadership
Learning & Teaching
Research & Development
Governance & Risk

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LCP generic version 12– consultation exercise

Following a 2 year consultation exercise including the latest evidence from 2 rounds of the National Care of the Dying Audit - Hospitals (NCDAH), LCP generic version 12 was presented at the 6th Annual LCP Conference on 25th November 2009, Royal Society of Medicine, London and to the National LCP Reference Group on 2nd December 2009 and subsequently the LCP core documentation was published on the Institute website. www.mcpcil.org.uk

All registered users in the UK received a copy of the LCP generic version 12 – UK in December 2009.

The LCP generic version 12 – UK is one document that supports the care of the patient in the last hours or days of life irrespective of the location of care.

THERE IS ONLY ONE DOCUMENT FOR ALL CARE SETTINGS

The assessments in Section 2 (ongoing assessment) of the LCP for the community setting (i.e. patient's own home / residential placement) will be recorded per visit rather than 4hourly timed assessments in an inpatient care setting where there is 24 hour trained nursing care

The ethos of the LCP generic document has remained unchanged - LCP generic version 12 – UK has greater clarity in key areas particularly communication, nutrition and hydration. Care of the dying patient and their relative or carer can be supported effectively by either version of the LCP. The responsibility for the use of the LCP generic document as part of a continuous quality improvement programme sits within the governance of an organisation underpinned by a robust ongoing education and training programme.

We believe as with any evolving tool or technology that those organisations who are using the LCP generic version 11 will work towards adopting version 12.

What is Organisational Governance?
There is no single, comprehensive, universally accepted definition of organisational governance.

However, certain common elements are present in most definitions of organisational governance that describe consistent management, cohesive policies, processes, and structures used by organisations to direct and control its activities, achieve its objectives, and protect the interests of its diverse stakeholder groups in a manner consistent with appropriate ethical standards.

Clinical governance is the term used to describe a systematic approach to maintaining and improving the quality of patient care within a health system that embodies three key attributes: recognisably high standards of care, transparent responsibility and accountability for those standards.

The organisation strives to continually improve the quality of their services and safeguard high standards of care by creating an environment in which excellence in clinical care will flourish.

Key Messages for the healthcare professional using the LCP generic version 12 - UK

The LCP is only as good as the teams using it and must be underpinned by a robust ongoing education and training programme. As with all clinical guidelines and pathways the LCP aims to support but does not replace clinical judgement.

10 KEY LCP Messages

1. **The LCP is only as good as the people who are using it**
2. **The LCP should not be used without the support of education & training**
3. **Good communication is pivotal to success**
4. **The LCP neither hastens nor postpones death**
5. **Diagnosis of dying should be made by the multidisciplinary team (MDT)**
6. **The LCP does not recommend the use of continuous deep sedation**
7. **The LCP does not preclude the use of artificial hydration**
8. **The LCP supports continual reassessment**
9. **Reflect, Audit, Measure & Learn**
10. **Stop, Think, Assess & Change**

The responsibility for the use of the LCP generic version 12 - UK document as part of a continuous quality improvement programme sits within the governance of an organisation and must be underpinned by a robust education and training programme

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Healthcare professional information – LCP generic version 12 – UK

As with all clinical guidelines and pathways the LCP aims to support but does not replace clinical judgement

The LCP generic version 12 - UK includes a section to highlight important information to the user before the LCP is commenced

- The LCP generic version 12 – UK document guides and enables healthcare professionals to focus on care in the last hours or days of life. This provides high quality care tailored to the patient's individual needs, when their death is expected.
- Using the LCP in any environment requires regular assessment and involves regular reflection, challenge, critical senior decision-making and clinical skill, in the best interest of the patient. A robust continuous learning and teaching programme must underpin the use of the LCP.
- The recognition and diagnosis of dying is always complex; irrespective of previous diagnosis or history. Uncertainty is an integral part of dying. There are occasions when a patient who is thought to be dying lives longer than expected and vice versa. Seek a second opinion or specialist palliative care support as needed.
- Changes in care at this complex, uncertain time are made in the best interest of the patient and relative or carer and needs to be reviewed regularly by the multidisciplinary team (MDT).
- Good comprehensive clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative or carer. The views of all concerned must be listened to and documented.
- If a goal on the LCP is not achieved this should be coded as a variance. This is not a negative process but demonstrates the individual nature of the patient's condition based on their particular needs, your clinical judgement and the needs of the relative or carer.
- The LCP does not preclude the use of clinically assisted nutrition or hydration or antibiotics. All clinical decisions must be made in the patient's best interest.
- A blanket policy of clinically assisted (artificial) nutrition or hydration or of no clinically assisted (artificial) hydration is ethically indefensible and in the case of patients lacking capacity prohibited under the Mental Capacity Act (2005).
- For the purpose of this LCP generic version 12 UK document - The term best interest includes medical, physical, emotional, social and spiritual and all other factors relevant to the patient's welfare.

The patient will be assessed regularly and a formal full MDT review must be undertaken every 3 days.

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Multidisciplinary Team (MDT) Decision Making

The individual organisation will need to determine the personnel who constitute a multidisciplinary team (MDT). As a minimum the MDT is usually a doctor and a nurse but may include other healthcare professionals / other personnel as appropriate.

The recognition and diagnosis of dying is always complex; irrespective of previous diagnosis or history. The LCP generic version 12 UK includes a helpful algorithm to support the clinical decision making process regarding the recognition and diagnosis of dying and use of the LCP to support care in the last hours or days of life.

The MDT assessment will include the following:

- Is there a potentially reversible cause for the patient's condition e.g. exclude Opioid toxicity, renal failure, hypercalcaemia, infection
- Could the patient be in the last hours or days of life?
- Is Specialist referral needed? e.g. specialist palliative care or a second opinion

If the patient is diagnosed as dying (in the last hours or days of life) then this should be communicated appropriately. Good comprehensive clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative or carer. The views of all concerned must be listened to and documented. All decisions must be documented accordingly on the LCP.

This process should reflect other elements of healthcare clinical decision making.
for example: when a decision is made to record a do not attempt cardiopulmonary resuscitation order, this decision must be made by the most senior healthcare professional immediately available in the environment, documented and witnessed according to local policy and procedure within the organisational governance framework. This decision is then endorsed by the most senior healthcare professional responsible for the patient's care at the earliest opportunity.

LCP generic version 12 calls for the same decision making process to be followed when diagnosing dying and commencing the LCP

Example documentation from LCP generic version 12 UK document (page3)

Healthcare professional documenting the MDT decision

Following a full MDT assessment and a decision to use the LCP:

Date LCP commenced:………………………………………………….

Time LCP commenced:…………………………………………………..

Name (Print):………………………………………………. Signature:………………….............

This will vary according to circumstances and local governance arrangements. In general this should be the most senior healthcare professional immediately available.

The decision must be endorsed by the most senior healthcare professional responsible for the patient's care at the earliest opportunity if different from above.

Name (Print):………………………………………………. Signature:………………….............

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We continue to believe the LCP is a means to empower healthcare professionals by winning time in the climate of "busyness" to enable best practice in the last hours or days of life. The LCP is a vehicle through which best quality of care for the dying is made measurable, explicit and visible. It is valued because of the positive impact on the patient, carer and staff and it can therefore bring about a change in the culture of an organisation.

Professor Mike Richards, Chair, End of Life Care Strategy Advisory Board commented in the foreword of the final Report of the National Audit Round 1 2008 that:
"How we care for the dying must surely be an indicator of how we care for all our sick and vulnerable patients. Care of the dying is urgent care; with only one opportunity to get it right to create a potential lasting memory for relatives and carers."

End of Life Care Strategy July 2008
"Good PCT's will want to ensure that the particular needs and wishes of all people who are dying should be identified and addressed.
The LCP provides a well-established mechanism for achieving this. PCT's are therefore strongly recommended to ensure that the LCP is adopted and its use audited in all locations where people are likely to die"

Thomas Hughes-Hallett, Chief Executive of Marie Curie Cancer Care, and Chair, End of Life Care Implementation Advisory Board commented in the foreword of the final Report of the National Audit Round 2 2009 that:
''Time is of the essence; care of the dying is everyone's business''

ORGANISATIONAL GOVERNANCE

The LCP generic document is only as good as the teams using it. Using the LCP generic document in any environment therefore requires regular assessment and involves regular reflection, challenge, critical senior decision-making and clinical skill, in the best interest of the patient. A robust continuous learning and teaching programme must underpin the implementation and dissemination of the LCP generic document. This LCP generic version 11 has been reviewed since December 2007 as part of an extensive consultation exercise and the LCP generic version 12 is now available to reflect the feedback from the consultation and latest evidence.

The ethos of the LCP generic document has remained unchanged. In response to the consultation exercise including 2 rounds of the National Care of the Dying Audit – Hospitals (NCDAH), version 12 has greater clarity in key areas particularly communication, nutrition and hydration. Care of the dying patient and their relative/carer can be supported effectively by either version of the LCP. The responsibility for the use of the LCP generic document as part of a continuous quality improvement programme sits within the governance of an organisation underpinned by a robust ongoing education and training programme.

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National Care of the Dying Audit – Hospitals – NCDAH Round 2 - September 09

The second **National Care of the Dying Audit of Hospitals (NCDAH)** published on the 14.09.09, shows that patients supported by the Liverpool Care Pathway for the Dying Patient (LCP) are receiving high quality care in the last hours and days of life.

The audit covers the use of the LCP in 155 hospitals, looking at the records of almost 4000 patients. The audit was led by the Marie Curie Palliative Care Institute Liverpool (MCPCIL) in collaboration with the Clinical Standards Department of the Royal College of Physicians (RCP) supported by Marie Curie Cancer Care & the Department of Health End of Life Care Programme.
The audit results are as impressive as those of the first audit, published in 2007. This shows that standards of patient care remain high, and underlines the value of the LCP in providing a framework in which clinical judgement can be exercised for the benefit of individual patients.

In the last 24 hours of life the vast majority of patients are reported to be comfortable. This is demonstrated by the four hourly assessments recorded on the LCP

This audit of patients whose care was supported by the LCP showed that, even in their last 24 hours, 65% of patients needed no continuous subcutaneous infusion of medication to control distress from agitation or restlessness. 31% had low doses of medication to relieve symptoms delivered by a subcutaneous infusion, the remaining 4% required higher doses. These findings indicate, that dying patients receive good clinical care, tailored to the individual and their distress, when supported by the LCP

New in this Round of the Audit are 3 Key Performance Indicators (KPI's) that managers in healthcare use to monitor and improve care:

- Spread of the LCP
- Anticipatory prescribing for the key symptoms in the last hours or days of life
- Compliance with completion of the LCP

A key recommendation in the Audit is that hospitals collate a remedial action plan in response to the audit key findings and the individual hospitals results.

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THE LCP AND SUB - SPECIALITY AREAS

There is a 4 phased approach to demonstrate transferability into a sub speciality area as outlined below;

Key Requirements for all projects:

- A specialist palliative care team who have implemented the LCP within the generic environment
- A specialist palliative care team with the resource to implement the LCP in the sub-speciality areas
- Sub-speciality areas with the capacity to engage in the LCP programme

PHASE 1 Local Induction Model - Local Pilot / Single site sub speciality area / patient cohort, a local project led by MCPCIL

PHASE 2 Local or National Dissemination Model to 4 – 6 sites (This may be a local dissemination or a national dissemination depending on the clinical arena and potential for national support)

PHASE 3 National Dissemination Model - Advertise a national consensus meeting

PHASE 4 National Evaluation Model **-** The National Meeting agreed consensus and proposes a National Benchmarking programme in line with National Audit Programme.

There are programmes within these phases for the following:

- Care in the last hours or days of life for those with advanced chronic kidney disease
- Care in the last hours or days of life for those with heart failure
- LCP - Intensive Care Units (ICU)
- LCP Children

WINNING HEARTS AND MINDS

A major cultural shift is required if the needs of dying people are to be met and the workforce are to be empowered to take a leading role in this process. Dying patients are an integral part of the population. Their death must not be considered a failure; the only failure is, if a person's death is not as restful and dignified as possible.

Since improvement depends on the actions of people, ultimately it comes down to winning hearts and minds. No matter how good you believe the LCP Continuous Quality Improvement Programme is; you cannot just expect others to do as they are told, nor can you be everywhere at once to ensure compliance. Command and control will not be successful in this process.

The LCP is only as good as the people using it. It represents a step in the right direction towards best practice for all whose death is expected. The LCP document itself will only make a real difference if it is used alongside an implementation and dissemination model firmly embedded in the organisation and supported by a continuous learning programme.

The LCP acts as a catalyst for organisational change, it can generate discussions on a local, national and international level that can only serve to improve care of the dying from bedside to policy.

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CONTACT DETAILS

If you would like further information about the LCP please contact:

Deborah Murphy
Associate Director Marie Curie Palliative Care Institute Liverpool (MCPCIL)
Lead Nurse – LCP

Professor John Ellershaw
Director Marie Curie Palliative Care Institute Liverpool (MCPCIL)
Clinical Lead – LCP

LCP Central Team
Marie Curie Palliative Care Institute Liverpool (MCPCIL)
C/o Directorate of Specialist Palliative Care
1st Floor, Linda McCartney Centre
Royal Liverpool University Hospital
Prescot Street
Liverpool
L7 8XP

Tel: **+44 (0) 151 706 2274**
Email: **lcp.enquiries@rlbuht.nhs.uk** **Website:** **www.mcpcil.org.uk**

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