

The Marie Curie
Palliative Care Institute

LIVERPOOL

WHAT IS THE LCP?

Patient & Carer Overview

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CONTENTS PAGE

General LCP Overview	Page 3
How does the LCP Improve Care for a Dying Patient and their Relative / Carer?	4 - 6
How is the LCP Introduced & Used in the Clinical Setting?	7
What is the National / International Influence of the LCP?	8
Contact Details	9

GENERAL LCP OVERVIEW

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 Specialist Palliative Care Team at the Royal Liverpool and Broadgreen University Hospitals NHS Trust and the Marie Curie Hospice, Liverpool developed the Liverpool Care Pathway for the Dying Patient (LCP). The Framework is one of the key programmes within the Marie Curie Palliative Care Institute Liverpool University (MCPCIL).

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 as a tool that should be rolled out across the country in the Our Health, Our Care, Our Say white paper 2006 and again in the DH End of Life Care Strategy in 2008.

Best practice in care of the dying should be seen as the norm, not the exception in our society driven by patient and carer expectations with generalists and specialists working together to inform and respond to the national agenda.

The LCP Framework incorporates:

1 Aim

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

3 Key Sections

Initial Assessment
Ongoing Assessment
Care after death

4 Key Domains of Care

Physical
Psychological
Social
Spiritual

The LCP therefore provides a useful template to guide the delivery of care for the dying to complement the skill and expertise of the practitioner using it. Once commenced the goals of care prompts staff to consider the continued need for invasive procedures and whether current medications really are conferring benefit. The clinician has the opportunity to follow the LCP guidance or to record the reason for decisions to determine a plan of care that deviates from this pathway. Using the LCP in any environment requires regular assessment and involves continuous reflection, challenge, critical decision-making and clinical skill.

We continue to believe the LCP is a means to empower health professionals by winning time in the climate of "busyness" to enable best practice in the last hours / 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.

HOW DOES THE LCP IMPROVE CARE FOR A DYING PATIENT AND THEIR RELATIVE / CARER?

The LCP is a continuous quality improvement programme for care in the last hours / days of life to transfer the best practice model of care of the dying from the hospice into other care settings. The LCP is not the answer to all the complex elements of this area of healthcare but we believe it is a step in the right direction.

The introduction of the LCP into a clinical environment often requires a change in behaviour, attitude, culture, knowledge, skill and clinical practice not just of the individual health care professional but indeed an organisational change.

This change management process will take time; the document itself is part of a continual process of learning as an organisation strives to give the best care according to the best models of practice for all those in the last days of life. Excellent care of the dying needs to become the norm and not the exception in our society. The LCP is one of the tools that can make a significant difference if implemented following the recommendations of the Institute.

Death must not in itself be seen as a failure; the only failure is when someone dies in distress without the dignity and respect. This is a basic human right that should be expected for every dying patient irrespective of diagnosis or location of care setting.

The LCP can be used to guide best practice care for the majority of expected deaths. The document enables individualised care according to individual needs. Health care professionals are encouraged to exercise their own professional judgement regarding clinical decision making for the individual patient.

Specialist Palliative Care Services will not always be required for every dying patient. It is the responsibility of every healthcare professional to provide palliative care, and to call in specialist colleagues if the need arises, as an integral component to good clinical practice.

The LCP is now used in hospices, acute hospitals, community hospitals, care homes and for patients dying at home with the support of community services. Not all patients who are being cared for with the support of the LCP will require specialist palliative care services.

A decision that a patient may be dying is a complex one and we would recommend therefore that it is not undertaken by one person or one discipline. Consideration should be given when possible to the views and concerns of the patient / relative / carer and the members of the health care team who coordinate, provide or manage the needs of the patient and carer. All possible reversible causes for the current condition need to have been considered.

This should raise a wider discussion and an appropriate plan which now is focused on care of the dying be put in place. If a decision is made that this patient may be dying then due consideration should be given on the use of the LCP or a similar tool.

When the LCP is used it is important for the health care professionals to:

Stop, Think Assess and Change

care according to the patients individual needs and discuss any proposed changes to the plan of care with the patient where appropriate and the relatives / carers.

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."

Professor Mike Richards, Chair, End of Life Care Strategy Advisory Board

The LCP provides guidance on key aspects of care including:

Wherever possible the patient and or relative / carer should be included in the discussion regarding the plan of care and fully understand the reasons why decisions have been made.

Symptom Control

It is important to recognise and manage pain and any other distressing symptoms.

Comfort measures

It is important to consider all aspects of physical comfort for example use of a special mattress / bed.

When there is a diminished need for food and drink, this can be a very distressing for carers as food and drink are closely associated with nurturing, never the less caring can be continued in other important ways such as spending time together, or sharing memories and news of family and friends.

Often a dry mouth or symptoms of thirst may develop. This is not always due to dehydration or a correctable problem. It may be due to medication or the disease itself, or a change in breathing pattern. Often a drip / artificial fluids do not help in this case but regular assessments and excellent delivery of mouth care is important. It is often helpful for relatives and carers to be shown by the health carer how to support the patient and achieve good mouth care.

Medication

Medication needs to be prescribed and be available usually as an injection so that there is no delay in responding to a symptom if it develops.

Appropriate & Inappropriate Interventions

Consideration should now be given to any aspect of care and for this moment in time a decision needs to be made as to whether a specific element of care or treatment should be stopped, continued or started.

Clinical decisions need to be made that consider how appropriate it is to use artificial fluids, give antibiotics in a drip, take blood samples, taking temperature / blood pressure, attempt resuscitation.

Not all interventions will be stopped, for example in some cases it will be appropriate to continue with artificial fluids or reduce the amount of fluids that are needed. It may be appropriate for example to continue to give antibiotics but all these decisions need to be reviewed regularly as the situation changes.

Psychological / Religious/ Spiritual Care

The LCP includes the need for staff to determine the wishes of the patient and the relative / carer as regards religious and or spiritual needs.

The LCP guides staff to discuss the needs of the relative / carer, for example: their family situation, young children, support, finances, and health worries.

The patient/ relative / carer should be asked if they have a religious tradition or belief and they may want to seek specific support from a chaplain / religious advisor regarding special needs now or at the time of death or after death.

Not everyone has a formal religious tradition; the staff should explore any other values, beliefs, wishes or desires that the patient or relative / carer have.

Care of the family (both before and after death of the patient)

We would recommend that if the LCP is used in care in the last hours and days of life then a discussion of this plan of care should take place with the relatives / carer. We believe it is the responsibility of the health care professional to ensure that the relative / carer has fully understood the plan of care and expressed their understanding of this and their opinion or concerns.

If you as the relative / carer are unhappy about any element of care in the last days of life or you need advice or support we would recommend that you do not hesitate to speak with the nurses or doctors regarding any worries or concerns that you may have with the plan of care in place.

The LCP should guide staff to discuss with relatives / carers, the facilities available to them such as: where they can sit, get a drink, visiting times, bathroom facilities, car parking.

The nurses and doctors and other staff are there to help you work through your worries and concerns and offer you care and support at this sad and challenging time.

HOW IS THE LCP INTRODUCED AND USED IN THE CLINICAL SETTING?

The LCP document itself is part of a continual process of learning as an organisation strives to give the best care according to the best models of practice for all those in the last days of life. The LCP is one of the tools that can make a significant difference if implemented following the recommendations of the Institute.

The LCP is only as good as the person using it. It needs to be supported by an education and training programme which will review all aspects of the LCP, to ensure that the LCP achieves its goal that is, to improve care in the last hours and days of life to the level of the best.

Introduction of the LCP into a clinical area requires a team approach, review of current practices, and reflection on complaints. It includes a review of patient and carer information, facilitates available. It supports the development of better communication systems where there is room for improvement. In areas that already care well for dying patients and their relatives / carers the LCP is a means to clearly demonstrate this best care.

The introduction of the LCP into a large clinical area for example a large hospital, takes time. The Team at the Institute recommends that the LCP should be introduced in a phased approach, in a small area at first then learning and reflecting before it is used more widely. Although the LCP is used across care settings in the UK and internationally, some areas use it across their organisation, new implementers are still only using it in specific areas with a plan for wider used.

What do people say about the LCP?

“Although I was not with her when she died I am confident that she had a peaceful death and my father was looked after also. I loved my mum very much and will always remember that the LCP made it possible for all of us to live with her until she died and cope afterwards, I am truly grateful”

Patient's Daughter

“I did not think I could do it – nothing in my pre registration training had prepared me for this – but the LCP guided me and gave me confidence to use my basic nursing skill and a bit of “me” to stay strong and be with my patient and her family – mostly saying nothing – I did not know what to say but I realised they did not expect me to say anything – I was just there – for the first time I realised that being a nurse does not always mean I have to be doing something – sometimes just being there is not just enough, but it is everything”

Nurse

WHAT IS THE NATIONAL / INTERNATIONAL INFLUENCE OF THE LCP?

The recently published End of Life Care Strategy recommends the LCP or similar framework is used in all expected deaths wherever people die. **(Department of Health (2008) End of Life Care Strategy – promoting high quality care for all adults at the end of life. DH. London)**

“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”

End of Life Care Strategy July 2008

Key Facts about the LCP:

- The LCP now covers all care settings
- It is used widely across England, and within areas of Scotland and Northern Ireland. A document based on the LCP is in use in Wales
- The LCP has been adopted across 17 other countries worldwide
- The first audit of care of the dying nationally was undertaken in 2006 / 2007 and a second audit will be commenced in 2008.
- 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.

CONTACT DETAILS

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

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