

Nurses' perceptions of the Liverpool Care Pathway for the dying patient in the acute hospital setting

Barbara A Jack, Maureen Gambles, Deborah Murphy, John E Ellershaw

Abstract

The Liverpool Care Pathway for the dying patient (LCP) was developed to transfer the hospice model of care into other care settings. It is a multiprofessional document that provides an evidence-based framework for the dying phase. It provides guidance on the different aspects of care required including comfort measures, anticipatory prescribing of medication, and discontinuation of inappropriate interventions. Additionally, psychological and spiritual care and family support is included. This article presents the findings of a study to explore hospital nurses' perceptions of the impact of the LCP using focus group interviews. Data were analysed for emerging themes using thematic analysis. The results suggest that the nurses have generally found that the LCP had a positive impact on patients, their families and also on nurses and doctors. This article will explore these benefits, as well as potential barriers to its use.

The hospice model of care is held up as a model of excellence and has resulted in the expansion of the hospice movement and the delivery of high-quality care to dying patients (Ellershaw and Ward, 2003). However, only 12% of patients in the UK die in a hospice (Ellershaw and Murphy, 2003). A major challenge faced by specialist palliative care services has been the transfer of best practice from a hospice setting to other care settings and to non-cancer patients.

The Liverpool Care Pathway for the dying patient (LCP), developed by the Royal Liverpool University Trust and the Marie Curie Centre Liverpool, has been recognized as a model of good care and was awarded NHS Beacon Status in 2000. The NHS Beacon Programme identifies centres of excellence and supports the delivery of high-quality patient-centred care by spreading good practice across the NHS. The LCP is a multiprofessional document that provides an evidence-based framework for the dying phase of a patient (*Table 1*).

The commencement of the pathway follows the decision by the multidisciplinary team that the patient is dying. This is based

on the presence of two of the following four criteria: the patient is bed bound, semi-comatose, only able to take sips of fluid or no longer able to take fluids. The LCP provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing of medication, discontinuation of inappropriate interventions, and psychological and spiritual care. It also focuses on care of the family, including their care after death of the patient (Ellershaw et al, 2001; Ellershaw and Murphy, 2003; Ellershaw and Ward, 2003; Ellershaw and Wilkinson, 2003). Furthermore, it provides measurable outcomes of care (Ellershaw et al, 2001).

Since the development of the LCP, study days have been established to aid the dissemination of the pathway. These have been attended by over 500 health-care professionals and, to date, there are over 120 services in the UK at various stages of implementing the LCP. European use of the LCP is also taking place, with the development of a Dutch translation of the pathway in Rotterdam (Ellershaw and Murphy, 2003). Additionally, it has been adapted for local use throughout Wales, taking into account local guidelines and protocols for the care of the dying patient (Fowell et al, 2002).

Evaluation of the impact of the LCP is underway and results regarding symptom control have already been published (Ellershaw et al, 2001). As part of this evaluation the views of the doctors and nurses who use the LCP are being sought both in the hospice and acute hospital setting. This article focuses on exploring how nurses in a large university teaching hospital perceived the impact of the LCP.

Methodology

As the aim of the study was to explore the perceptions of the nurses regarding the impact of the LCP, a qualitative approach

Barbara A Jack is Senior Lecturer at Edge Hill College School of Health Studies, University Hospital Aintree, Longmore Lane, Liverpool, L9 7AL, UK and Marie Curie Senior Research Fellow at Marie Curie Centre, Liverpool, **Maureen Gambles** is Research Fellow at Marie Curie Centre, Speke Road, Woolton, Liverpool, L25 8QA, UK, **Deborah Murphy** is Palliative Care Team Directorate Manager at Royal Liverpool University Hospital, Longmore Lane, Liverpool, L9 7AL, UK, and **John E Ellershaw** is Medical Director Marie Curie Centre, Speke Road, Woolton, Liverpool, L25 8QA, UK, and Consultant in Palliative Medicine/Honorary Senior Lecturer, Royal Liverpool University Hospital, Liverpool, UK

Correspondence to:
Barbara Jack

was selected. This was considered to be the most appropriate approach, as the basic aim of qualitative research is to explore and understand people's experiences, feelings and beliefs (Holloway and Wheeler, 1996). To obtain an overview of how the nurses perceived the impact of the LCP across the hospital a focus group approach was taken.

The rationale for this method of data collection was to enable group discussion and interaction to take place (Kitzinger, 1996; Vaughn et al, 1996; Bloor et al, 2001; Hudson, 2003). Focus groups allow the participants to use their own frames of reference and to identify topics that are important to them. Additionally, the clarification of views through discussion and debate may reveal information that would not have emerged in an individual interview (Lane et al, 2001).

Sample

To meet the aim of the study the respondents needed to have both an understanding and practical experience of the LCP. Therefore, a purposive sample was selected that focused on the conscious selection of certain subjects (Patton, 1990; Polit et al,

2001; Hudson, 2003). As part of the introduction of the LCP, a network nurse programme has been developed. This programme is for generalist nurses who have an interest in palliative care and take a nursing lead for palliative care on their ward. This includes liaising with the palliative care team and attending monthly educational meetings (Murphy, 2003). The network nurses were considered to meet the criteria for the study and provided a homogeneity that is suggested by Vaughn et al (1996) to be important for a successful focus group. Network nurses who had been employed in the hospital for less than 6 months were excluded from the study.

Fifteen network nurses from across the hospital settings (medicine, surgery, care of the elderly, intensive care and the renal unit) volunteered to participate in the study. Nurses ranged from grade D to ward managers (grade G), with the majority being grade E. There is no consensus in the literature regarding the size of focus groups (Morgan, 1988), although it is suggested that the optimum number of participants should be between eight and ten respondents (Vaughn et al, 1996). Therefore, two focus groups were constructed with the nurses selecting their group depending on their availability. Additionally, one supplementary semi-structured interview was carried out with a participant who was unable to attend the focus group because of a clinical emergency.

Research ethics committee approval was granted for the study and both verbal and written consent was obtained from each participant. Because of the potential difficulty of maintaining group confidentiality, the group were asked to respect the confidentiality of the interview before the groups started (Jones, 2003).

Data collection

Two focus group interviews lasting for approximately 1 hour and a supplementary interview took place. These were conducted by one researcher, who was not part of the clinical team (BJ), and who acted as the moderator for the focus groups. The role of the moderator is argued to be vital to the success of a focus group. The moderator should create a non-threatening environment and encourage all group members to share their views (Vaughn et al, 1996). They also have a key role in controlling more vocal group members and encouraging the contribu-

Table 1. Goals of care for patients in the dying phase. Adapted from the Liverpool Care Pathway for the dying patient initial assessment

Comfort measures

- Goal 1. Current medication assessed and non essentials discontinued
- Goal 2. As required subcutaneous medication written up as per protocol (pain, agitation, respiratory tract secretions, nausea and vomiting)
- Goal 3. Discontinue inappropriate interventions (Blood tests, antibiotics, intravenous fluids/medications, not for cardiopulmonary resuscitation documented, turning regimens/vital signs)

Psychological/insight

- Goal 4. Ability to communicate in English assessed as adequate
- Goal 5. Insight into condition assessed

Religious/spiritual support

- Goal 6. Religious/spiritual needs assessed with patient/family

Communication with family/other

- Goal 7. Identify how family/other are to be informed of patient's impending death
- Goal 8. Family given relevant hospital information

Communication with primary health care team

- Goal 9. GP is aware of patient's condition

Summary

- Goal 10. Plan of care explained and discussed with patient/family
- Goal 11. Family/others express understanding of plan of care

(Ellershaw and Murphy, 2003; Ellershaw and Ward, 2003; Ellershaw and Wilkinson, 2003)

tions of more reserved participants (Lane et al, 2001).

A semi-structured interview guide was constructed to provide focus for the discussion, which included exploring care before the LCP, the impact of the LCP and potential barriers to its use. Questions were open-ended and prompts were used to elicit further discussion as necessary. A summary of the key points from the focus group interviews were identified at the end of each meeting by the moderator and presented back to the respondents. This enabled clarification of the main points of the interview and to allow additional comments to be made by the participants

(Jones, 2003). Audiotape recording of the interviews was selected to ensure that a record of the entire interview was available.

Data analysis

The interpretation of data gathered from focus groups is recognized as having inherent problems because of the difficulties in transcribing the data (Jones, 2003). Furthermore, there are no specific approaches to focus group analysis (Vaughn et al, 1996). Therefore, a hybrid approach was selected for the data analysis process that drew on various approaches suggested in the literature (Collaizzi, 1978; Patton, 1990; May, 1998). A summary of this is given in *Figure 1*. This approach consisted of the four stages of organization, familiarization, reduction and analysis. The reduction stage introduced coding to the data, categories under each question were identified and subsequently numerically coded (May, 1998). This process was also followed for the individual interview and the findings compared to those obtained for the focus groups. This analysis was also undertaken by an additional researcher who had not been involved with the data collection phase and agreement was reached as to a valid interpretation of the data. The final coding of the data that was agreed is summarized in *Table 2*. Finally, the main themes that were identified were returned to the respondents for checking (May, 1998).

Results

Several themes relating to the impact of the LCP emerged from the data analysis. These included: the care of the dying patients before the introduction of the pathway; the impact on patients and relatives, and doctors and nurses; and potential barriers to its use.

Impact of the LCP on patients and relatives

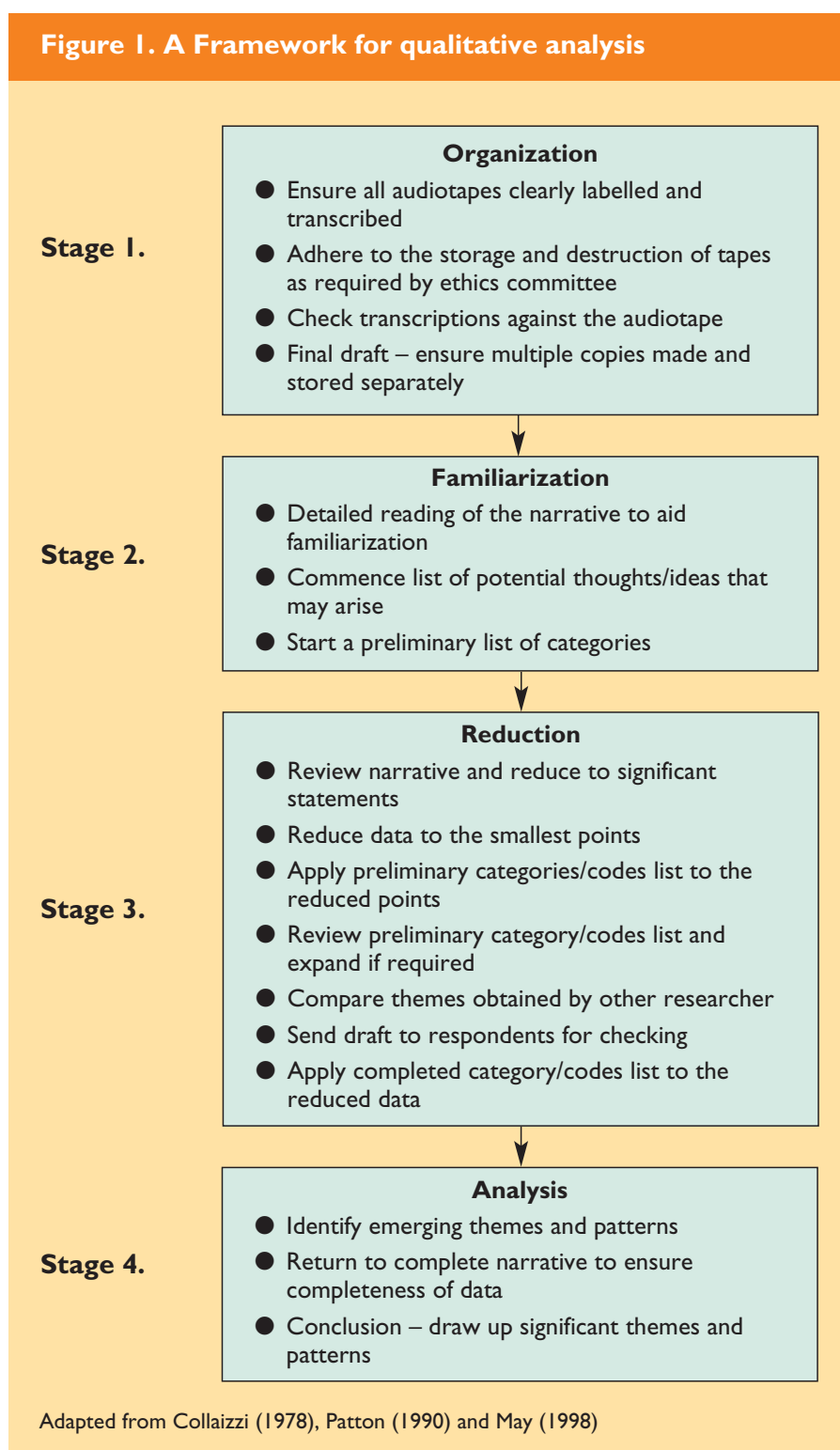
Symptom control

The impact of the LCP on symptom control was discussed with much reference to the confusion and lack of guidance that existed before its introduction.

‘there was no guidelines, everyone was doing something but nothing was actually happening for the patients’

‘we had junior doctors coming in and picking out figures and there was no measure to assess the pain for the patient’

Figure 1. A Framework for qualitative analysis



'... However, there was a consensus of opinion between the nurses that there had been a general improvement in symptom control since the introduction of the pathway.'

'when the patient was nauseous no-one knew how to handle it, what to give, everyone was given different injections'

The symptoms of increased chest secretions and terminal agitation, which are very common in dying patients, were highlighted. The management of these symptoms was often poor and there was an acceptance that these symptoms were unavoidable in dying patients.

However, there was a consensus of opinion between the nurses that there had been a general improvement in symptom control since the introduction of the pathway. One respondent referred to how junior doctors had become more confident in prescribing drugs.

Routine care

Reference was also made to routine care, i.e. care related to routine observations, turning the patients to prevent pressure area care, and intravenous fluids. Nurses discussed how routine care had previously been performed on dying patients and one respondent referred to how this unnecessarily disturbed the patients:

'I think we were still going through the motions doing things like observations and so on, which were never going to be acted upon and disturbing the patients unnecessarily because people could not see there was actually an end product.'

Furthermore, this performance of routine care was also considered to have a negative effect on the relatives, resulting in a false hope of the patient surviving:

'I think before the pathway you seemed to be doing active treatments, the obs [observations] and everything and I think then relatives probably thought maybe the patient was still in with a chance of surviving'

However, there was agreement that the pathway had resulted in the discontinuation of inappropriate routine care. One respondent commented on the issue of pressure area care and how the pathway had been of benefit in changing this practice:

'you used to feel guilty if it wasn't done, you felt as though your colleagues were looking and saying "she hasn't done this and she has not done that". You knew why you weren't doing it and very often the family would say to you "oh leave

her, she looks so comfortable" and you'd be thinking "oh she should be turned, she's on a turn chart and there's going to be a space missed"'

The discontinuation of intravenous fluids was also identified as having occurred since the introduction of the pathway. Interestingly, this discussion centred on the knowledge that nurses had gained from using the pathway. Previously, people had thought that intravenous fluids were necessary for dying patients. One respondent stated:

'The thought of leaving somebody to die without fluid input has always seemed barbaric, torturous, negligent and we had the view without really understanding why we had that view'

Table 2. The coding framework

1. Care before pathway

- 1.1 Patients
 - Symptom relief
 - Routine care

- 1.2 Relatives
 - Practical
 - Psychological

- 1.3 Nurses/doctors
 - Poor direction
 - Poor documentation

2. Impact on patients/relatives

- 2.1 Patients
 - Symptom relief
 - Reducing interventions

- 2.2 Psychological
 - Death

- 2.3 Communication
 - Regarding information
 - Regarding care

3. Impact on staff

- 3.1 Guidance

- 3.2 Confidence
 - Care
 - Death

- 3.3 Documentation

- 3.4 Continuity of care

4. Barriers

- 4.1 Litigation

- 4.2 Fear

5 Miscellaneous

- 5.1 Differences from other pathways

'It was agreed that there was a general reduction in paperwork following the introduction of the pathway.'

Care of relatives

The care of relatives before the introduction of the pathway was discussed. One respondent referred to the practical care of the relatives, for example:

'you did not think about the relatives, where they were, did they know where the toilets were on the ward, did we tell them they could use them?'

Communication with the relatives was also discussed, with a general consensus that there was a lack of openness in discussing the impending death.

'I don't think that the family got considered before. Yes we spoke to them but I don't think it was flagged up... People knew they were there but we didn't consider the family... yes we gave them a cup of tea and things like that, but we never discussed anything. It seemed like a big secret before the pathway'

Respondents agreed that since the introduction of the pathway communicating with the relatives had been given a higher priority:

'I think it brings the relatives into the care of the patient more than previously because you are discussing a lot.'

'Gives you the opportunity to talk about death and dying'

'I think it brings about a great deal of honesty between everyone, between all members of staff, nurses, relatives, patients. It gives you the right to say "yes she is going to die" and it gives you time to talk to your colleagues about how you feel about the situation and it does give the relatives time with that patients and I think ultimately it gives the patients the care that they need.'

One respondent compared the LCP with other care pathways that she was using, stating that the LCP was:

'More constructive, it is guidance, knowledge and it's an education for the relatives as well, it's a shared way of saying for the relatives this is what we expect and what we are going to achieve for your relative.'

Impact of the LCP on nurses

The impact of the LCP on the nurses was the most discussed theme in the study. This impact focused on the benefit that the

pathway had given to their provision of care for the dying patients. Reference was made to continuity of care, guidance for junior nurses and an increased confidence:

'I'm far more confident since the pathway came in'

'The confidence to care for that dying patient appropriately'

'We are carrying out the best care that we can do but we have the knowledge behind what we are doing'

'It gives you confidence to argue your corner'

Documentation

It was agreed that there was a general reduction in paperwork following the introduction of the pathway. The documentation of information in the pathway was also seen as an advantage in the care of relatives. For example, it contains the up-to-date contact details of the next of kin, including who to contact during the night. This is information that often changes while a patient is in hospital. The pathway also contains a spiritual assessment of whether the patient, or the relatives, want a priest. This information can be invaluable for the dying patient and their families.

'You can just look at the pathway and you have got the next of kin details, you have got who wants to be contacted, you have got if they want the priest to come in or whatever and that makes things much easier'

The value of the pathway documentation was also identified for the care of relatives after the patient's death, acting as a guide to ensure all information is given to them.

'It does give you instructions on the back about when the patient has died, about what to do with the relatives like giving them the bereavement book and then giving them details about visiting the patient in the mortuary.'

Barriers to the use of the LCP

Respondents identified initial resistance to the LCP from nursing and medical staff. However, it was generally felt that this resistance was starting to diminish, particularly with the junior medical staff using the LCP, although there was agreement that some of the more senior consultants were still reluctant to use the pathway.

'The impact of the LCP on nurses was generally found to be extremely positive with an increased confidence and knowledge to care for dying patients.'

'They would be very rigid in their views, not just about dying patients... but I think by a process of education. As the junior doctors who I think are tuned in, understand, accept and see the value of the pathway, as they progress up the ladder and the education is continuous, we will get it right eventually'

One respondent identified concern regarding the withdrawal of the pathway when a patient's condition had improved. This related to potential negligence, as during a patient's time on the LCP certain routine care would be discontinued.

'If you recover or if your episode of recovery persists, legally where am I, I haven't been attending to your dressings for that period because I thought you were dying and I didn't want to put you through it. Have I in fact been negligent?'

This promoted some discussion in the group, which included the finding that none of the group had actually seen major problems when the LCP had been withdrawn. Furthermore, a consensus was reached within the group that the LCP was in fact a legal document.

Discussion

The results from the interviews suggest that the nurses using the LCP perceived it to have a positive impact on the care of dying patients, their relatives and medical and nursing staff. The respondents highlighted the improvement in symptom control, with examples of a confused picture in drug selection and dosage before the LCP. Additionally, a lack of interventions for symptoms such as terminal agitation and increased respiratory secretions was noted, with a general acceptance of their persistence as being part of the dying process. The LCP has been shown to promote anticipatory prescribing of medication, and has symptom control guidelines attached that are based on the incidence of symptoms and their effective control in the last 48 hours of life (Ellershaw et al, 2001). There is an ongoing 4-hourly assessment in the LCP of all symptoms that can contribute to optimal care (Ellershaw and Murphy, 2003; Kinder and Ellershaw, 2003).

The care of the relatives was a key theme that emerged in the study, examples were given of the practical issues for relatives when visiting hospital. The importance of

communication with relatives was stressed, with the pathway helping to foster effective communication with the families. This included care after death, with the pathway acting as a checklist to ensure all information is given (Ellershaw and Murphy, 2003).

The impact of the LCP on nurses was generally found to be extremely positive with an increased confidence and knowledge to care for dying patients. This is similar to the finding by Peters et al (2002) in a study evaluating a care pathway for myocardial infarction, where staff reported being more aware of the care given to patients, ensuring nothing was missed. The nurses perceived the reduction in documentation associated with the introduction of the LCP as positive. This reduction in documentation was also referred to by Bond et al (2001) who's multi-centred study on orthopaedic care pathways, reported that staff perceived pathways as being a useful aid to memory. Bond et al (2001) also discussed the legal implications surrounding the sole use of a care pathway for documentation purposes. However, there was also a view that it improved documentation and led to fewer complaints.

A perceived barrier to the use of the LCP was resistance to change by some medical staff. This is in keeping with other studies on care pathways (Bond et al, 2001). However, the rapid expansion of the use of the LCP, including its use for non-cancer patients, indicates that this resistance may be diminishing.

Limitations


There are certain limitations of the study design that need to be considered when looking at the generalizability of the findings. Issues relevant to much qualitative research are small sample size and the selection of a sample suitable to inform the research topic (Polit et al, 2001). In this study palliative care network nurses formed the sample. It could be suggested that they have more in-depth understanding of the LCP than other nurses do. Additionally, they had a relationship with the members of the palliative care team, which could have influenced their comments. Furthermore, the study was undertaken in one acute hospital setting, where the LCP had been developed and had received national recognition. Organizational support may differ in other hospitals. Bond et al (2001) identifies such support as crucial to the success of care pathways. Thus the

Key words

- Palliative care
- Care pathway
- Symptom control
- Care of relatives
- Focus groups

perceptions of the nurses in this study may not be the same as for other hospitals, that may be at an earlier stage of pathway development. However, some of the results are similar to other studies exploring staff perceptions of care pathways, thus giving support to the findings (Bond et al, 2001; Peters et al, 2002). Research that involves a wider sample and in other locations would undoubtedly be of value and is currently being planned.

Conclusion

This study has shown that nurses who are using the LCP in the hospital setting generally perceive the pathway to have a positive impact on patients and relatives, as well as on doctors and nurses. Although there are limitations with regard to the study design, it nevertheless provides insight from nurses who use the pathway and have first-hand experience of it. The pathway is arguably beneficial and necessary, as it can help to improve the care of the dying patient and their families. 

Bloor M, Frankland J, Thomas M, Robson K (2001) *Focus Groups in Social Research*. Sage Publications, London

Bond S, Balogh R, McKeever M (2001) Care pathways: integrated clinical record or management information tool? *Journal of Integrated Care Pathways* 5: 54–63

Colaizzi P (1978) Psychological research as a phenomenologist views it. In Valle R, King M, eds. *Existential Phenomenological Alternatives For Psychology*. Oxford University Press, New York

Ellershaw JE, Smith C, Overill S, Walker S, Aldridge J (2001) Care of the dying: setting standards for symptom control in the last 48 hours of life. *J Pain Symptom Manage* 21(1): 12–7

Ellershaw JE, Murphy D (2003) The national pathway network of palliative care pathways. *Journal*

of Integrated Care Pathways 7: 11–3

Ellershaw JE, Ward C (2003) Care of the dying patient: the last hours or days of life. *BMJ* 326: 30–4

Ellershaw JE, Wilkinson S, eds (2003) *A Pathway to Excellence*. Oxford University Press, Oxford

Fowell A, Finlay I, Johnstone R, Minto L (2002) An integrated care pathway for the last two days of life: Wales-wide benchmarking in palliative care. *Int J Palliat Nurs* 8(12): 566–73

Holloway I, Wheeler S (1996) *Qualitative Research for Nurses*. Blackwell Science, London

Hudson P (2003) Focus group interviews: a guide for palliative care researchers and clinicians. *Int J Palliat Nurs* 9(5): 202–7

Jones AM (2003) Changes in practice at the nurse-doctor interface. Using focus groups to explore the perceptions of first level nurses working in an acute care setting. *J Clin Nurs* 12: 124–31

Kinder C, Ellershaw JE (2003) How to use the Liverpool Care Pathway for the Dying Patient. In: Ellershaw JE, Wilkinson S, eds. *A Pathway to Excellence*. Oxford University Press, Oxford: 11–41

Kitzinger J (1996) Introducing focus groups. In: Mays N, Pope C, eds. *Qualitative Research in Health Care*. BMJ Publishing Group, London: 36–45

Lane P, McKenna H, Ryan A, Torrance C (2001) Focus group methodology. *Nurse Researcher* 8(3): 45–59

May C (1998) The preparation and analysis of qualitative interview data. In: Roe B, Webb C eds. *Research and Development in Clinical Nursing Practice*. Whurr Publishers Ltd, London

Morgan (1988) *Focus Groups as Qualitative Research*. Sage, California

Murphy D (2003) The education strategy to implement the Liverpool Care Pathway for the Dying Patient (LCP). In: Ellershaw JE, Wilkinson S, eds. *A Pathway to Excellence*. Oxford University Press, Oxford: 106–20

Patton MQ (1990) *Qualitative Evaluation and Research Methods* 2nd edn. Sage Publications, California

Peters J, Baxter T, Pollard S (2002) Evaluation of the development and implementation of a care pathway for myocardial infarction. *Journal of Integrated Care Pathways* 6: 63–8

Polit D, Beck C, Hungler B (2001) *Essentials of Nursing Research Methods, Appraisal and Utilisation* 5th edn. Lippincott, Philadelphia

Vaughn S, Schumm J, Sinagub J (1996) *Focus Group Interviews In Education and Psychology*. Sage Publications, London

Correspondence

IJPN welcomes correspondence regarding any issues relating to palliative nursing. If you would like to comment on an article in the journal, or any issues relevant to our readers, please write in no more than 250 words to:

Ruth Laughton
 Editor, *IJPN*
 Mark Allen Publishing Limited
 St Jude's Church
 Herne Hill
 London SE24 0PB
 or email ruth@markallengroup.com