

The Marie Curie
Palliative Care Institute

LIVERPOOL

LCP CENTRAL TEAM

Liverpool Care Pathway for the Dying Patient (LCP) -
ICU Version 12

**10 Step Continuous Quality Improvement
Programme (CQIP) supporting care in the last
hours or days of life**

Within a 4 phased Service Improvement model

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May 2011

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INTRODUCTION

Background to LCP Continuous Quality Improvement Programme (CQIP)

The aim of the LCP continuous quality improvement programme is to transfer the excellent model of hospice care for the dying into other health care settings and to develop outcome measures using an integrated care pathway (ICP) for the last hours or days of life.

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

The implementation of the programme will create a change in the organisation. Recognition of the fundamental aspects of a change management programme is pivotal to success. The Service Improvement Model used at the Marie Curie Palliative Care Institute Liverpool (MCPCIL) is a 4-phased approach incorporating a 10-step continuous quality improvement process for the LCP Programme.

The LCP ICU document is only as good as the teams using it. Using the LCP ICU document 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 ICU document.

The ethos of the LCP ICU document has remained unchanged. Since the launch of the LCP generic version 12 in December 2009, the local pilot ICU Action Research group at RLBUHT, working with the LCP Central Team, LCP ICU Facilitator and other ICU colleagues have created the LCP ICU Version 12. LCP ICU Version 12 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 ICU 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 ICU version 11 will work towards adopting LCP ICU version 12.

What is a Care Pathway?

A care pathway is a complex intervention for the mutual decision making and 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 and best practice
2. The facilitation of the communication among team members, with patient's and families
3. The coordination of the care process by coordinating the roles and sequencing the activities of the MDT, patients and carers
4. The documentation, monitoring and evaluation of variances and outcomes
5. The identification of the appropriate resources

Dr Kris Vanhaecht, Secretary General of the European Pathway Association

What is meant by the term "Variance"?

Variance (exception reporting) on an integrated care pathway is a mechanism by which a seemingly process driven approach to care can be tempered in line with individual patient need. The potential to use clinical skill and judgement to deviate from the suggested plan of care in response to individual patients makes the LCP a more flexible and practical document.

Variance provides other clinicians in the environment with a clear picture regarding the choices made and the care delivered. Focusing specifically on the variance sheets allows clinicians to see at a glance what the major issues have been for the patient (and relative or carer) over a given period of time.

When variance recording is studied over a cross section of patients, it can also highlight organisational or educational issues that may be impacting on the delivery of care in a given environment. Taking care to document carefully on the variance sheet can, therefore, provide a wealth of important information for clinicians and managers alike.

Failing to document variance appropriately tells us nothing!

Variance recording tells the true story of the patient's journey / condition. If the variance is not completed then we do not have documented evidence of the care that was delivered, nor care that requires action.

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 ICU version 12

The LCP ICU 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 ICU aims to support but does not replace clinical judgement.

10 KEY LCP ICU Messages

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

The responsibility for the use of the LCP ICU 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

LCP 10 Step Continuous Quality Improvement Programme (CQIP)

To support the implementation, dissemination and sustainability of the Liverpool Care Pathway for the Dying Patient (LCP)

Supporting care in the last hours or days of life in ICU

Phase 1 Induction	STEP 1	Establishing the project – preparing the environment
Phase 2 Implementation	STEP 2	Develop the Documentation
	STEP 3	Review / audit / scoping exercise of current documentation / process / practice
	STEP 4	Induction / Education Programme
	STEP 5	Clinical Implementation of the LCP ICU
Phase 3 Dissemination	STEP 6	Maintaining and improving competencies using reflective practice and post pathway analysis
	STEP 7	Evaluation and further Training
	STEP 8	Continuous development of competencies in order to embed the LCP Model within the clinical environment
Phase 4 Sustainability	STEP 9	Organisational recognition that all staff across ICU are properly trained to look after dying patients and their carers within an agreed organisational / educational strategy
	STEP 10	To establish the LCP ICU within the governance / performance agenda

PHASE 1: INDUCTION
STEP 1 – Establishing the Project – Preparing the environment

Preparing the environment – preparation & scoping

- Determine Project Steering Group - Project Group design, developed, met – core equitable representation
- Work up Project plan - agree project management tools and monitoring processes using MCPCIL 4 Phase Change Management programme and the 10 Step LCP Continuous Quality Improvement Programme
- Review the CQC / QIPP / Network(s) agenda to include appropriate evidence as the project progresses
- Agree Gantt Chart
- Secure an LCP ICU Facilitator with the knowledge, skills, attitude and experience to drive this project agenda from the clinical interface
- Agree Governance & Risk and Communication Strategy
- Agree core documentation based on the 2 year learning at RLBUHT post LCP consultation exercise
- ICUs to negotiate within their Trust regarding appropriate permissions for taking part (eg registering with audit department for collection of audit information)
- Develop draft symptom control guidelines
- Agree availability of key policies / guidance and supportive literature & agree what is locally driven and what is centrally driven and associated costings / printing ordering at local level
- Agree that LCP ICU version 12 is the core document in its entirety
- Each ICU to nominate a local project team including a nominated LCP ICU Facilitator
- LCP ICU Facilitator core role and responsibilities agreed with project team
- Each ICU to liaise locally to link with ongoing End of Life Care Strategy work streams & QIPP agenda

Management and Leadership

- The nomination of a Lead Nurse (LCP ICU Facilitator)
- The nomination of a Lead Doctor
- To promote care of the dying as a quality indicator at governance and risk / performance management level within the ICU

Learning and Teaching

This programme will only be successful if fully supported by robust and continuous education and training. There are some materials and support available but much depends on the needs of the environment and must be driven locally. This is without doubt resource intensive at the outset and will need a sustainable programme installed. The role of the LCP ICU Facilitator is pivotal to success.

The LCP Central Team also provides a programme in the form of LCP workshops and an annual conference. This programme aims to support key staff in implementing and sustaining the use of the LCP within the clinical environment.

Research and Development

Success is not always measured by the number of LCP documents to support care used in the environment – when preparing the environment for organisational change there may be many examples of changes in practice that drives up quality an innovation in unexpected ways – these should not be underestimated as significant measures of success.

Governance and Risk

The LCP ICU Project Group within each participating ICU will need to take ownership of the governance and risk agenda for this implementation. The LCP is only as good as the team using it and the group will need to take responsibility for the ongoing future development of this programme locally and ensure it reflects best governance both in clinical, business and quality assurance.

This phase is the most intensive one to complete. It is pivotal to ensure that this infrastructure is in place if long term goals and sustainability is going to be achieved.

PHASE 2: IMPLEMENTATION

STEP 2 – Development of Documentation

STEP 3 – Review / audit / scoping exercise of current documentation / process practice

STEP 4 – Induction / Education Programme

STEP 5 – Clinical Implementation of the LCP ICU into ICU

Remember the 5 key areas need to be considered as always:

- ❖ Clinical Decision Making
- ❖ Management and Leadership
- ❖ Learning and Teaching
- ❖ Research and Development
- ❖ Governance and Risk

Key Actions during this phase:

- LCP ICU Facilitators should undertake a core learning programme to facilitate/ensure:
 - A full understanding of the LCP ICU
 - Layout of the document – importance of goals and outcomes
 - The importance of the recognition and diagnosis of dying
 - National LCP agenda
 - Agreed process of the LCP audit programme for LCP ICU and care of the dying
- the three sections of the LCP ICU
 - Section 1 - Initial assessment and care
 - Section 2 – Ongoing assessment and care
 - Section 3 - Care after death
 - The LCP ICU is a multidisciplinary approach
 - Explanation of variance and variance analysis
 - Benefits of the LCP ICU to the clinical governance agenda
 - To improve the experience of the relative or carer in relation to care of the dying, grief, and bereavement
- 100% of ICU personnel can respond to the 5 key questions (equity across all ICU's)
 1. What is the LCP ICU?
 2. Why is the LCP ICU used in ICU?
 3. Who is the LCP ICU Facilitator for the LCP ICU Programme?
 4. Where can I find information regarding the LCP ICU?
 5. Have you had any education or training regarding the LCP ICU?
- Intensive Induction / education programme within the ICU – 80% of clinical staff in the environment aware of the project plans before considering implementation and have received a minimum of 30 minute corporate teaching session re LCP ICU
- 100% of clinical staff who will be responsible for delivering or contributing to care at the bedside have received 1 hour training in addition to the core 30 minute presentation by the end of the implementation phase
- The LCP ICU Project Group needs to consider clinical guidance – what is currently in place that may support the implementation of the LCP ICU – resuscitation guidance, prescribing guidance, the importance of anticipatory prescribing, local policies and procedures e.g. re hydration, skin management, DNA CPR, mouthcare, last offices and existing documentation

- Clear decisions need to be made about what is covered by the LCP ICU and what local documentation can be replaced by the LCP ICU or if specific documentation needs to remain
- Core information leaflets available:
 - Relative or Carers information leaflet
 - Facilities information leaflet
 - Coping with Dying leaflet
 - Bereavement Booklet
- Consider the value of an LCP ICU Resource Folder available within the clinical area
- Implement the LCP ICU:
 - Utilise appropriate educational support
 - Reflect on the process –
 - Managerial / Service Improvement
 - Educational
 - Research
 - Change management
 - Resource challenges
- Education Programmes vary greatly depending on the size and location of the clinical organisation & the level of existing knowledge but education is pivotal to success and this implementation process will have some core organisational elements in support of continuity, compliance audit and benchmarking
- High visibility in the Clinical area of the LCP ICU Facilitator is helpful in support of troubleshooting and sustained encouragement and momentum
- As the LCP ICU is used in the ICU local clinical reflection should be considered
 - Troubleshooting
 - Compliance
 - Knowledge gaps
 - What went well
 - What could we improve on

PHASE 3 : DISSEMINATION

STEP 6 – Maintaining and improving LCP competencies using reflective practice and post pathway analysis

STEP 7 – Evaluation and Further Training

STEP 8 – Continuous development of competencies in order to embed the LCP model within the clinical environment

Remember the 5 key areas need to be considered as always:

- ❖ Clinical Decision Making
- ❖ Management and Leadership
- ❖ Learning and Teaching
- ❖ Research and Development
- ❖ Governance and Risk

Key Actions during this phase

- LCP ICU used to support all expected deaths

- LCP ICU Facilitator reviews the LCP ICU each time it has been completed and discuss the outcomes of care

- Reflect on key challenges

This process of ongoing review each time an LCP ICU is used provides the opportunity for staff to actively engage in reflective practice. This practice should continue at least for the first few months after the introduction of the document. Taking the opportunity to reflect formally on and discuss the specific elements of the care delivered allows the transfer and cementing of knowledge and helps to build confidence in the use of the document. Such ongoing reflection not only has the potential to highlight any inherent challenges to the delivery of optimum care, but also provides an opportunity to acknowledge and celebrate success whenever appropriate.

Whilst ongoing reflection with the staff directly involved in the delivery of care using the LCP ICU is of paramount importance, it is also useful to take the opportunity to reflect in a more formal, quantitative way once a sizeable amount of LCP ICU's have been used within the unit.

Evaluation and review of current status will inform the direction of education for the future. It may highlight further educational needs for the future:

e.g.

- Spirituality
- Psychosocial skills
- Communication skills

PHASE 4: SUSTAINABILITY

STEP 9 – Organisational recognition that all staff are properly trained to look after dying patients and their carers within an agreed organisational / educational strategy

STEP 10 – To establish the LCP ICU within the governance / performance management agenda

Remember the 5 key areas need to be considered as always:

- ❖ Clinical Decision Making
- ❖ Management and Leadership
- ❖ Learning and Teaching
- ❖ Research and Development
- ❖ Governance and Risk

Key Actions during this phase

- LCP ICU supports all expected deaths

- Establish a framework of analysis to feedback to staff on a regular basis and to inform the Clinical Governance agenda

- LCP ICU / Care of the dying included in local ICU induction & mandatory training

- Develop formal strategy to reflect Care of the Dying within the ICU at performance management level

- In addition, using the LCP ICU to deliver and track care in the last hours or days of life facilitates comparative audit with other ICU's that are using the document.

- Learning from the LCP ICU project can be disseminated nationally / internationally

- Into the future ICU's should be able to participate in the National Care of the Dying Audit - Hospitals

“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.”

Professor Mike Richards

Chair: End of Life Care Strategy Advisory Board

Foreword of the National Care of the Dying Audit – Hospitals Audit Report 2007



“If a clinical provider is to thrive in our current economic climate and evolving healthcare landscape it will need to demonstrate that it is best in class. How we care for dying patients is an indicator of the patient experience across our organisations. The recommendations and performance indicators outlined in this national audit give healthcare workers, Chief Executives and Commissioners a clear direction of travel.

We need to build on the success of the Liverpool Care Pathway for the Dying Patient (LCP) as a vehicle to drive up sustainable and measurable quality care, to deliver excellence in care of the dying. This audit is a significant step towards the development of a national benchmark across all other health sectors.

We need to continue to inspire, motivate and truly empower our patients, carers, health care workers and Commissioners. Time is of the essence; care of the dying is everyone’s business”

Thomas Hughes-Hallett

Chief Executive of Marie Curie Cancer Care, and

Chair, End of Life Care Implementation Advisory Board

Foreword of the National Care of the Dying Audit – Hospitals Audit Report 2009