

The Marie Curie
Palliative Care Institute

LIVERPOOL

LCP CENTRAL TEAM MCPCIL

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

**Within a 4 phased Service
Improvement model**

April 2010

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INTRODUCTION

The aim of the LCP continuous quality improvement programme is to translate 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 that can be downloaded from our web site www.mcpcil.org.uk. *(The International model has a 5th Phase which reflects the model of a national office within a given state, region or country).*

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 UK 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 (NCDHAH), 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 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 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

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.

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

Phase 1 Induction	STEP 1	Establishing the project – preparing the environment
Phase 2 Implementation	STEP 2	Develop the Documentation
	STEP 3	Base Review / Retrospective audit of current documentation
	STEP 4	Induction / Education Programme – Pilot Site
	STEP 5	Clinical Implementation of the LCP in pilot sites
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 who work with people who are dying are properly trained to look after dying patients and their carers within an agreed organisational / educational strategy
	STEP 10	To establish the LCP within the governance / performance agenda within the organisation / institution

“Phase 1 took us 6 months but it was time well invested and made the rest of the process easier. “

Specialist Palliative Care Clinician

Further information re change management guidance:

See the website: www.modern.nhs.uk/improvementguides

Phase 1: INDUCTION
STEP 1 – Establishing the Project – preparing the environment

➤ **Preparing the environment**

- Gain specialist palliative care support
- Gain Executive endorsement
- Pilot site identified for introduction of the LCP i.e. - a ward area / unit / department or directorate / GP practice

➤ **Register with the LCP Central Team** (www.mcpcil.org.uk)

➤ **Engage the education spread model** provided by the LCP Central Team

“People responsible for planning and implementing change often forget that while the first task of change management is to understand the destination and how to get there, the first task of transition management is to convince people to leave home”

William Bridges

For more information read:

Bridges. (2003) *Managing transitions: Making the most of change*, (2nd Edition) London, Nicholas Brearley.

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 of a clinical area. 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 model 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.

Individuals may modify their behaviour and participate in change during the course of a focused improvement effort, but if they do not emerge from the effort with fundamentally new capabilities or beliefs the performance benefits erode away and sustainable change is lost.

The LCP is only as good as the teams using it and must be underpinned by a robust ongoing education and training programme.

Preparing the Environment

Implementation of the LCP will require top down and a bottom up approach.

Executive support i.e. senior management support within the organisation is essential for the success of implementing the LCP. A small group of enthusiastic individuals are unlikely to succeed without executive support.

A Local Steering Group is then essential to take the project forward. Identify key players within the organisation / network / Strategic Health Authority (SHA) / health economy.

Clinical Decision Making

Whilst a Local Steering Group is essential to take the project forward and identify key players within the organisation / health economy. This will need to be led by clinicians with expertise in or who specialise in palliative care to drive this agenda.

A full understanding of the LCP is required including:

- layout of the document – importance of goals and outcomes
- the importance of the recognition and diagnosis of dying
- the three sections of the LCP
 - Section 1 - initial assessment and care
 - Section 2 – ongoing assessment and care
 - Section 3 - care after death
- the LCP is a multidisciplinary approach
- explanation of variance and variance analysis
- benefits of the LCP to the clinical governance agenda

A lead implementer will need to be nominated. At the initial meeting it is important to discuss with the key players the aims of the LCP project:

- to empower generic workers
- to improve care for the dying patient
- to demonstrate outcomes of care for dying patients
- To improve the experience of the relative or carer in relation to care of the dying, grief, and bereavement.
- To determine that care of the dying is part of the core business of the organisation
- To promote care of the dying as a quality indicator at governance and risk / performance management level within the organisation.

Management and Leadership

A Local Steering Group is essential to take the project forward. Identify key players within the organisation / Health economy. This will need to be led by clinicians with expertise in or who specialise in palliative care to drive this agenda.

- The nomination of a Lead Doctor
- The nomination of a Lead Nurse
 - A project Lead should be identified and may be the Lead Doctor or nurse or another nominated person
- The ability of the organisation to link directly with a Palliative Care Specialist

- The endorsement of the Project
 - by the chosen pilot organisation
 - by an academic organisation / University
- The availability of administrative support
- The ability to adopt a recognised change management model.
- Registration with the LCP Central Team, including a letter of endorsement from the CEO / Management of the organisation.

Pilot site identified for introduction of the LCP e.g. an in patient unit / ward area / unit / department / Care Homes / Hospice / GP Practice

It is not possible to implement the LCP project across a large health care setting without first establishing successful pilot sites. This is due to the intensity of the education programme required to successfully implement the LCP.

It is imperative to ensure that the steering group recognises that the process of implementation will take time and although at the outset an improvement in the documentation of care provision will be demonstrated, statistically significant evaluation data will not be achieved in the first six months.

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 a key change agent in the environment will be needed, although the scope of this role should change over time a change agent in the environment will always be required.

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.

The LCP Workshop focuses on techniques for priming the environment for change. It is helpful if key staff can attend this day prior to the commencement of the implementation phase. It discusses the concept of pathways, the development of the LCP, and also enables staff to understand the purpose and process of base review. In addition the key leads / champions are encouraged to identify issues relating to implementation of the LCP into their own environment.

LCP Facilitator / Key Champion

The LCP Central Team within the Marie Curie Palliative Care Institute Liverpool (MCPCIL) suggests an LCP Facilitator approach. The LCP Facilitator / key champion is advised to attend an LCP Workshop and familiarise themselves with the 10 step Continuous Quality Improvement Programme. All Facilitators will need to consider an exit strategy for themselves if the post is fixed term and a sustainability model for the LCP programme within the clinical environment.

Suggested Models

Hospital

1 Whole time equivalent (WTE) LCP Facilitator linked with the Hospital Specialist Palliative Care Service for approx 1 yr – Hospitals of 500+ beds may require more than one facilitator & or a facilitator for up to 2 yrs and then clarify ongoing facilitator support.

Hospice

Sessional commitment from an LCP Facilitator for approx 6 months and then clarify sessional / part time facilitator support

Community

Depending on size of locality – 1 WTE LCP Facilitator attached to the Community Palliative Care Service for approx 6 – 12 months and then clarify sessional / part time facilitator support

Care Home

Depending on number of beds & number of doctors covering – sessional LCP Facilitator for 1 year linked with community or hospice palliative care service and then clarify ongoing facilitator support

Testing the Change Ideas

The LCP Central Team recommends consideration of the use of the PDSA cycle (Deming 1994) as part of the model for improvement. This enables you to implement the LCP into a pilot site and learn from its potential impact. This is quite different from the approach traditionally used in healthcare settings.

There are 4 stages to the cycle:

Plan	Agree the change to be implemented
Do	Carry out the change & measure the impact
Study	Study data before and after the change and reflect on learning
Act	Plan the next change cycle or implementation

This PDSA Cycle supports the key questions:

- What are we trying to achieve?
- How will we know if the change is an improvement?
- What changes can we make that will sustain the improvements we seek?

Further reading:

Deming, W. Edwards. (1994). The New Economics for Industry, Government, Education. Second Edition. Massachusetts Institute of Technology Centre for Advanced Engineering Study. Cambridge, Massachusetts

A review of existing educational resource within your own locality and development of new material See *web site for existing information resources* www.mcpcil.org.uk will be required.

Production of key action plans / project plan to support educational initiatives are necessary. Where possible you will need to have the ability to utilise palliative care resources for the development of educational material

Research and Development

The Steering Group will need to consider what success looks like and how to measure improvement. A reflective process will need to be created.

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

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.

The Steering Group will need to take ownership of the governance and risk agenda for this project. 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 and ensure it reflects best governance both in clinical, business and quality assurance.

Register with the LCP Central Team (MCPCIL)

Registering the project with the LCP Central Team brings a number of benefits. The LCP Central Team can offer much support and advice on implementing and sustaining the use of the LCP at various milestones throughout the implementation process. For example, data from the recommended retrospective audit of practice (Base Review – see step 3) can be analysed by the LCP Central Team and fed back to implementing teams, not only in the form of a data base but also as part of a power point presentation which can be used to provide feedback locally to staff. The LCP Central Team will also undertake analysis of the first 20

pathways used (see step 6). Registration provides the opportunity for organisations to receive up to date information regarding the pathway, including updated versions of the document and news of developments.

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

Phase 2: IMPLEMENTATION

STEP 2 – Development of Documentation

STEP 3 – Base Review / Retrospective audit of current documentation

STEP 4 – Induction / Education Programme / Pilot Site

STEP 5 – Clinical Implementation of the LCP in pilot sites

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:

- Contact LCP Central Team (MCPCIL)
- Local Steering Group meets to discuss the National LCP generic version - UK and amend prompts according to local need. It is important that the Goals on the LCP remain the same, to enable benchmarking in the future.

🌐 [MCPCIL Website – www.mcpcil.org.uk](http://www.mcpcil.org.uk) 🌐

Please review the LCP Goal Definitions / Data Dictionary Document which can be found on the MCPCIL website.

The Steering Group needs to consider clinical guidance – what is currently in place that may support the implementation of the LCP – resuscitation guidance, prescribing guidance, the importance of anticipatory prescribing, local policies and procedures e.g. re hydration, skin management and existing documentation

Clear decisions need to be made about what is covered by the LCP and what local documentation can be replaced by the LCP or if specific documentation needs to remain.

Core information leaflets are recommended by the LCP:

- Relative / Carers information leaflet
- Facilities information leaflet
- Coping with Dying leaflet
- Grief and Bereavement information

- Supportive documentation identified, and leaflets produced.
- Obtain 20 original Base Review Proformas
- Review 20 sets of current documentation in accordance with the Guidance Notes for a Base Review

Participating organisations are encouraged to undertake a retrospective audit (Base Review) of the routine documentation of care given to dying patients in their organisation / Institution. The main purpose of this exercise is to highlight and reinforce the need for change.

The base review involves organisations identifying a set of 20 recent consecutive notes from within the proposed pilot area. The information contained within the notes is then scrutinised for evidence that appropriate care has been delivered in the dying phase against the goals of care identified on the LCP.

Send completed (anonymised) proformas to the LCP Central Team – Evaluations Unit
(this system will be electronic from early 2010)

- Base Review Analysis and associated report available in 4 - 6 weeks
- It may be appropriate to undertake more than 1 Base Review across an organisation – for further advice – contact the LCP Central Team

- Intensive Induction / education programme within the pilot site – 80% of staff in the environment aware of the project plans before considering implementation
- Ensure an LCP Resource Folder is available within the clinical area.

- Implement the LCP into the pilot site
 - Utilise appropriate educational support
 - Reflect on the process –
 - Managerial / Service Improvement
 - Educational
 - Research
 - Change management
 - Resource challenges
 - Identify Variance as recorded for cultural, traditional, structural differences and consider consequences

High visibility in the Clinical area of the LCP Facilitator / key champion and Specialist Palliative Care Team is helpful in support of troubleshooting and sustained encouragement and momentum.

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.

Attendance at an LCP workshop run at a number of locations across the UK may be helpful at this time to network with other facilitators re challenges, troubleshooting and successes

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 Framework 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

- Review the LCP each time it has been completed and discuss the outcomes of care
- Reflect on key challenges

This process of ongoing review each time a LCP 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 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's have been used within the pilot sites.

- Check for the first 20 completed LCP documents. Reflect regularly within your local team on progress
- Obtain 20 post pathway analysis forms from LCP Central Team
(this system will be electronic from early 2010)
- Complete post pathway analysis
- Return completed forms according to guidance to LCP Central Team
- The LCP Central Team will analyse data within 4 weeks of receipt.

- Organisation to feedback / disseminate findings within pilot area
- Consider a wider dissemination and sustainability model to meet:
 - Managerial / Service Improvement
 - Educational
 - Research Agendas
 - Make a decision whether to initiate the dissemination of the LCP across the organisation / institution beyond the pilot sites

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
- Religion

- Develop a Support Network for the LCP Facilitators / Key Champions within the clinical areas

Maintaining ongoing education around the LCP and more generally around palliative care has proven to be pivotal to the continued success of the LCP framework.

One mechanism for sustainable education and dissemination of the LCP has been to develop a link nurse programme. The LCP Central Team would recommend that there is a lead facilitator / key champion within each clinical area when the LCP is implemented. The value of getting these clinicians together to network and share challenges and successes can be extremely helpful.

An example of how this can be achieved is the Palliative Care Team Network Nurse Programme that has been running for some years within the Royal Liverpool and Broadgreen University Hospitals NHS Trust. The aim of this programme is to enhance the knowledge and skills of interested generic nurses in the palliative care approach (via regular liaison with the Hospital Specialist Palliative Care Team - HSPCT) to enable them to take a lead role in the management of patients with palliative needs, including those in the last days of life.






The programme specifically addresses issues such as the management of pain and other symptoms, communication and psychological support, care of the dying, and dealing with complex placement issues. Network Nurses are encouraged to share their knowledge and skills (including how and when to use an LCP) with others in their immediate environment using a cascade model of teaching. The Programme was subjected to a questionnaire evaluation (Jack et al, 2004) where respondents reported that it had been beneficial, particularly in providing them with increased palliative care knowledge, support and important networking opportunities. This process is currently being re evaluated in 2010.

Phase 4 : SUSTAINABILITY

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

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

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

- Decision made by Institution and ratified by LCP Central Team for a wider dissemination within a research based framework to disseminate and analyse the LCP more widely beyond the organisation / institution but led by the key personnel within the organisation / institution
- The LCP is recognised within the mainstream health care agenda within the organisation / institution and local health economy.
- Any alteration to the LCP or associated information carrying the LCP logo must be ratified by the LCP Central Team
- All participating sites must be registered with the LCP Central Team
- Establish a framework of analysis to feedback to staff on a regular basis and to inform the Clinical Governance agenda
- Develop formal strategy to reflect Care of the Dying within the organisation / Institution at performance management level

The structure of the LCP makes it relatively easy to audit and, through the establishment of links with local clinical audit departments, it should be possible to provide ongoing relevant and up to date information concerning aspects of the delivery of care in the dying phase. This type of information is also likely to be useful in performance management within an organisation

In addition, using the LCP to deliver and track care in the dying phase facilitates comparative audit with other organisations that are using the document. Data can be brought together to illustrate care in a wider context and to allow organisations to understand their own level of comparative performance in relation to similar settings.

The second round of an audit of care of the dying with hospitals using the LCP in England and a pilot in Northern Ireland was undertaken in 08 / 09 and published 14th September 2009.

The audit enables hospitals and their trusts to benchmark their performance against national findings on a range of domains, including:

- ❑ Physical comfort of the patient
- ❑ Psychosocial & spiritual aspects of care
- ❑ Communication
- ❑ Information giving & receiving
- ❑ Following appropriate procedures

The audit shows that patients on the Liverpool Care Pathway for the Dying Patient (LCP) are receiving high quality care in the last hours or days of life.

The audit in England 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 model in which clinical judgement can be exercised for the benefit of individual patients.

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Results / Reports from NCDHA Round 1 (2006 / 2007) & Round 2 (2008 / 2009) can be found within the 'Research & Development' Section

The recently published End of Life Care Strategy UK recommends the LCP or similar framework be 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

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”

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 and must be underpinned by a robust education and training programme.

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