

NATIONAL CARE OF THE DYING AUDIT – HOSPITALS (NCDHAH)

Round 1 – 2006 / 2007

Workshop Summary Document

Workshop Questionnaire Results

As part of the process, an exit questionnaire was completed by participants in each of the three workshops. More than 90% of participants agreed (ie either agreed or strongly agreed) that the report contained the right amount of information and that the information was useful. Eighty-five per cent agreed that the information was easy to understand. There was an overwhelmingly positive view of the usefulness of the workshops in terms of sharing elements of good practice, gaining a better understanding of the data and beginning the process of action planning for improvement (> 90% agreement). Eighty-eight per cent of participants thought that participation in the National Audit would make a difference to care of the dying in their own organisation.

National Care of the Dying Audit – Hospitals (NCDHAH) Workshops

During each workshop, participants were asked to identify and, in two of the workshops, to write down any barriers to the delivery of good end of life care that they thought were impacting in their own environments. This information was themed by the workshop facilitators on display boards and was then further clarified and discussed in the open forum. Participants were then asked to identify potential solutions to the barriers previously identified along with any examples of good practice. In a similar manner, these items were themed by facilitators in discussion with the group. The main themes identified, which are discussed in detail below, were:

- Raising/maintaining the profile of end of life care
 - Nationally and locally
 - Trust provision of supporting literature
 - LCP facilitators
 - Education, Training and Audit
- Making best use of the LCP
 - Death as a failure/Diagnosing Dying
 - Compliance with the document (lack of consistency in completing the LCP)

Raising/Maintaining the profile of end of life care

There was general recognition of the importance of raising the profile of care of the dying both nationally and locally (within trusts) in order to promote higher standards of education, training and resource provision. Nationally, care of the dying was recognised to be competing with many other initiatives in an ever changing 'political' context. Specifically, despite the national roll out of communication skills training from the Department of Health (from 2006), several participants highlighted a 'lack of investment nationally in communication skills training' which, they felt, could be a particular barrier to the appropriate use of the LCP and, thus, to the delivery of good end of life care. Using positive feedback from the National Audit was seen as a potential method for raising the profile of end of life care nationally, as was the creation of national LCP Champions.



Participants highlighted that care of the dying was ‘not relevant to payment by results’ which, they felt, meant that it was unlikely to be a natural priority for individual trust boards. Others pointed out the potentially negative impact that local organisational and structural changes within trusts could have on maintaining a high profile for care of the dying. Solutions offered involved finding ways of engaging the Executive Board and senior medical staff. One innovative example included building feedback on care of the dying into the existing performance management system already in operation across the trust. Benchmarks of completion of LCPs were now regularly fed back in a ‘language’ (ie ‘traffic light’ system) that could be readily understood by the Trust Board. Other examples included: presenting end of the life care information/data at board meetings and grand rounds: identifying a medical lead for end of life care; determining a mechanism for regular dialogue with the Chief Executive and Chief Nurse. Some hospitals had increased the visibility of end of life care and the LCP by using display boards in ‘recreational’ areas (eg dining rooms) to feedback information such as the results from the national audit. Others ‘marketed’ end of life care via staff magazines and others placed all trust policies re end of life care as ‘pop ups’ on the trust intranet.

Maintaining and raising the profile of end of life care was deemed to be important to maximise the availability of resources to ensure the sustainability of the LCP within a given environment. Three major areas in particular were raised as vital in this regard: the funding of supporting literature; LCP facilitators and ongoing education, training and audit.

Supporting Literature

Supporting information is vital to strengthen the verbal communication taking place at this challenging time. Several organisations highlighted the issue of a lack of funding for the purchase of information leaflets to support the use of the LCP. One organisation reported, however, that as a direct result of their participation in the national audit and the concomitant increase in general awareness of care of the dying, the trust had agreed to fund the purchase of supporting literature.

LCP Facilitators

Many highlighted the importance of an LCP facilitator, or equivalent to oversee the roll out and support the ongoing use of the LCP. Specifically, participants expressed fear surrounding the imminent loss of funding for existing facilitators, particularly with regard to the impact on already over stretched staff in terms of sustaining the LCP. For example, “... facilitator leaving – 2 nurse CNS told to ‘take over’ – very worried will be unable to sustain”; “No LCP facilitator, PCS Team trying to do training”, ‘staff shortages’, ‘no admin support’, ‘team too small’. Potential solutions/examples of good practice included lobbying the cancer network for the recruitment of an LCP facilitator within each sizeable acute trust. Many recognised the need for increased availability and flexibility of such a post-holder – eg working nights/evenings etc.

Education, Training & Audit

Major functions of existing LCP facilitators include the organisation of opportunities for education and training in end of life care (and in particular in use of the LCP) and to undertake regular audit in care of the dying. With regard to the latter, several participants highlighted the lack of engagement of trust audit departments as a major threat, particularly in the event of the loss of a facilitator. Participants felt that ongoing audit and feedback of performance on end of life care was vital and that work needed to be undertaken to promote this within the organisation (ie audit departments). Having senior management monitor these regular reviews was also suggested as a way of promoting end of life care. This very much links with the idea of integrating end of life care within the performance review systems highlighted above.



A perceived dearth of appropriate education and training in broader palliative care, end of life care and even more specifically, the LCP was identified as a major barrier to improved delivery by many participants. Some suggested making end of life care part of the core curriculum in nursing and medical training courses. In order to address this issue, one trust had successfully secured funding for the development of a level 3 module on End of Life Care with their local university.

A lack of and structured educational opportunities and mandatory training for qualified personnel was specifically identified as a barrier to improved care. Some stressed the difficulty of encouraging doctors to attend training that is not mandatory. There were some examples of innovative trust level interventions. One trust had introduced LCP training into the F1 teaching programme and another was asked to be involved within the protected teaching time on the F1 and F2 programmes. With regard to mandatory training in care of the dying, one trust had introduced specific end of life education as part of the induction programme for junior doctors. Another had created an e-learning opportunity primarily for new doctors regarding the LCP – specifically how to complete it appropriately and to understand the principles underpinning it. More informal opportunities included, link nurse ‘away days’, setting up dedicated courses on end of life care and the LCP and incorporating these into existing trust education opportunities.

Opportunities for two specific areas of education and training were prioritised: symptom control and communication. The national audit results for the latter highlighted room for improvement, particularly surrounding communication with patients. The provision of multi-professional education (eg including AHPs, clerical staff, as well as non-professionals and volunteers) was also highlighted as an important factor as collaborative education is part of the Palliative Care Education Strategy. Some hospitals had liaised with and involved their chaplaincy team in their education programme.

However, staff shortages, time pressures and lack of access to staff working nights were recognised as potential challenges to the successful provision of more formal education and training opportunities. Some innovative solutions and examples of best practice offered included: direct, on the spot education of key staff; the use of ‘3 minute windows’ – ie taking advantage of one-to-one informal ward visits to focus on specific elements within the LCP that are challenging; having ward information folders available in each environment to support knowledge and care delivery; a member of the palliative care team to work nights for a period of time to educate night staff.

Making best use of the LCP

The LCP aims to support the delivery of best practice in the last days and hours of life. However, the perception of death as a failure in the acute setting, alongside the challenge of accurately ‘diagnosing dying’ was highlighted as being a major barrier to timely use of the document. Work is currently underway within the Marie Curie Palliative Care Institute Liverpool (MCPCIL) to explore the latter issue in order to support clinician decision making.

However, a further threat to optimum impact of the LCP is the level of compliance with certain elements of the document. The amount of ‘missing’ data in particular parts of the document was highlighted by many as a potential barrier to best practice. In line with the findings from the audit, the care after death section and goals other than those focused into the physical welfare of the patient, were highlighted as requiring most work. Some suggested that the wording of



particular goals (eg 3b, 5, 6, 14, 17, 18) was somewhat ambiguous and changes to the wording may result in improved documentation. Others felt that the care after death section could be partitioned and particular members of staff (eg nurses, ward clerks, bereavement officers) identified to complete certain goals. One organisation had opened discussions with their bereavement office to take on completion of the whole section. For others, better explanation of the meaning of variance was suggested as a means to improve the situation. Other potential solutions included working closely with other trust employees (eg head of clinical practice) to make compliance with the documentation part of trust policy. Better education around use of the document was also felt to be key in improving documentation, including working with staff on nights where appropriate. One trust had developed an e-learning package to address the challenge of teaching medical staff (and others) about the document and how to use it appropriately. An example of a practical solution to promoting better compliance was placing a sticker on the document to remind colleagues that it is a legal document.

The above is a summary based on the main elements discussed at the three workshops. Participants were also asked to provide more detailed summaries of their examples of good practice for wider dissemination and we are extremely grateful to those who sent examples in. All submitted examples can be viewed on the website www.mcpcil.org.uk and we would encourage you to keep sending them in.