

**UPDATED - LCP Statement: 13.10.09**

**This statement by the LCP Central Team at the Marie Curie Palliative Care Institute Liverpool (MCPCIL) is in response to the ongoing media coverage regarding care of the dying**

The Institute welcomes the recent engagement by the media regarding care of the dying. It has highlighted the need for clarity and understanding in this complex area, and also the need to raise societal awareness of issues relating to care in the last hours / days of life.

The Institute has pioneered the implementation and dissemination of the Liverpool Care Pathway for the Dying Patient (LCP). This framework is recognised nationally and internationally as leading practice in care of the dying to enable patients to die a dignified death and provide support to their relatives / carers. The Institute is dedicated to improve care of the dying through its research and development and its learning and teaching portfolio.

The LCP Central Team UK at the Marie Curie Palliative Care Institute Liverpool (MCPCIL) is privileged to continue to work with many doctors, nurses and other healthcare professionals who have made a significant contribution to education in care of the dying and the implementation of the LCP Framework. We believe this has enhanced the patient and relative experience of care at this sad and challenging time, and would like to commend you on your contribution. The heightened media awareness can offer the opportunity to further improve the education and training programmes used to support the implementation of LCP Framework to drive up quality for care in the last hours / days of life.

**1) It is important within this context to address the misconceptions that have been reported regarding the LCP Framework:-**

***The LCP Framework is a major initiative to improve care of the dying within healthcare.*** Fifteen years ago it was recognised that hospices had a model of a dignified death with support for relatives and carers, however, there was no plan in place outside of the hospice setting to support care in the last hours / days of life. The LCP is an integrated care pathway whose purpose is to transfer the key principles of the hospice model into the general health care settings. It supports clinical decision-making and is underpinned by education for doctors and nurses and other health care professionals. There is a systematic 10-step implementation process within a 4 phased service improvement model to support the appropriate use of the LCP.

***60% of people die in hospitals in this country. Doctors and nurses rarely receive training in care of the dying as part of their initial training*** and few receive ongoing training. Care of the dying needs to be recognised as part of the core business of our hospitals and we believe that training for those who care for dying patients should be made mandatory.

***When a patient is dying they generally eat and drink less – this is part of the normal physiological process of dying.*** Food and fluid is provided to dying patients at their request, and is not withdrawn within the LCP Framework. Fluids via a drip (artificial hydration) are given when the doctor / clinical team makes a clinical decision that this will be beneficial and not cause undue distress to the patient.

***We believe that recognition of dying is a complex decision making process which should be undertaken by the multidisciplinary team*** - in conjunction with the patient where possible and their relative / carer.

***Recognition of dying is not in itself a decision that automatically leads to withdrawal or withholding of care, treatment or interventions.*** It does however require a review of the current situation and current care, treatment and interventions – healthcare professionals need to stop, think, assess and change care according to the patient's individual needs.

***The patient's condition should be continually monitored in order to assess the patient's needs and to give support to the relatives/carers.*** Clinical experience has shown that in around 3% of cases, the patient's condition can improve and the patient is no longer deemed to be in the dying phase. A full re-assessment of the patient is then undertaken and an alternative management plan is put into place.

***The LCP ensures that beneficial treatments are continued to be given to the patient, including appropriate drugs for pain control, agitation and distress.*** Any medication or intervention that is no longer in the patient's best interests is discontinued following a full multidisciplinary team assessment.

***The LCP does not endorse continuous deep sedation,*** the LCP supports the management of distress caused by agitation and restlessness in patient's who are dying with medication given at an appropriate dose tailored to their individual needs, in relation to the severity of the symptom.

*"I am often surprised by misconceptions about how we treat the dying. Unless you see many dying patients every day it is hard to imagine how diverse death is. That is why clinical decisions on the prescription of analgesics, sedatives and fluids must be made on an individual patient basis.*

*Modern practice in evidence-based palliative medicine no longer requires that we administer toxic or life threatening doses of analgesics or sedatives to obtain adequate relief of pain and other symptoms.*

*Treatment with subcutaneous or intravenous fluids is occasionally indicated when dehydration causes distressing symptoms, but is futile in patients where poor oral intake is part of a general deterioration that is inevitable in a terminal illness. It is potentially harmful if administered to patients with heart failure leading to congestion of the lungs"*

**Dr Bill Noble**  
**President, Association for Palliative Medicine of Great Britain and Ireland**



## 2) The Research Evidence

The research evidence for improvement in care continues to be developed by researchers based both at the Institute and internationally. To date there is evidence that the LCP:

- Improves confidence for nurses who are using the LCP framework.
- Demonstrates reduced symptom burden.
- Improves anticipatory prescribing of medications for the 5 key symptoms that may develop in the last hours / days of life.
- Improves multi-disciplinary team working.
- Improves documentation of care delivery.

Research papers are available via our website. [www.mcpcil.org.uk](http://www.mcpcil.org.uk)

*The LCP offers a framework for managing the dying that assists non-specialists by systematising, as far as is sensible, their care — it is intended to ensure a minimum standard, to reverse this nation's legacy of bad death. It has nothing to do with therapeutic killing such as euthanasia or assisted suicide; it has everything to do with giving dignity to dying patients. ....The LCP is helping clinicians do a better job, but tools are only as good as the workman. Misuse means bad care.*

*Any profession will tell you that without education, continued skill maintenance, exposure and support, no one is able, or can be expected to be competent in a given area. In medicine, the care of the dying is no exception and most clinicians see only a handful of dying patients a year.*

*Practitioners need to be competent in communication, symptom control and care, and able to give account of the dying patients they care for.*

**Dr. Rob George, Consultant in Palliative Care**

### **3) The second round of the National Care of the Dying Audit Hospitals (NCDHA) was published 14.09.09. It shows that patients whose care is supported by the LCP are receiving high quality care in the last hours / days of life.**

The audit covers the use of the LCP in 155 hospitals, looking at the records of almost 4000 patients. The audit was led by the Institute 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.

This audit shows that standards of patient care remain high, and underlines the value of the LCP in providing a framework in which clinical judgement can be exercised for the benefit of individual patients. However, it does highlight areas for improvement including communication with patients and relatives, spiritual support and training and education. For further details please see our [www.mcpcil.org.uk](http://www.mcpcil.org.uk)

*"We need to make sure our doctors and nurses are well trained so that they can make the best use of the LCP. And at the centre of that training should be the understanding that individual needs are paramount"*

**Katherine Murphy, Director of the Patients Association: the Times 18.09.09**

#### 4) The development of LCP Version 12 – Consultation Exercise

Since 2007, the Institute, working with the National LCP Reference Group, Version 12 of the LCP has been under development. Wider consultation is currently underway, with the launch of the final document at the MCPCIL Conference –

“**Care of the Dying: Time to Make a Difference**” which will be held on the 25<sup>th</sup> November 2009 at the Royal Society of Medicine, London [www.rsm.ac.uk](http://www.rsm.ac.uk)

**Specific areas which have been strengthened in LCP Version 12 as part of the continuous quality improvement programme include:**

- Decision making support for starting the LCP
- Rewording of some goals to ensure that they are outcome-focused
- Introduction of new goals regarding artificial nutrition and hydration
- Simplification of the Care After Death section

**The current draft – draft 14, of version 12 can be found on the website – [www.mcpcil.org.uk](http://www.mcpcil.org.uk)**

#### 5) Resources

Marie Curie Cancer Care: -

<http://www.mariecurie.org.uk/forhealthcareprofessionals/liverpoolcarepathway>

Association of Palliative Medicine - <http://www.palliative-medicine.org/>

National Council for Palliative Care - <http://www.ncpc.org.uk/newsroom/lcp.html>

Care not Killing - <http://www.carenotkilling.org.uk/?show=842>

*“The Liverpool Care Pathway for the Dying Patient (LCP) has been developed over many years by doctors and nurses with expertise in palliative care - and Marie Curie Cancer Care is proud of its leadership role in this initiative.*

*The pathway has now been adopted by more than 150 hospitals across the UK and has enabled tens of thousands of people to experience dignified care, including pain control and the management of distress, in the last hours and days of life.*

*It is only appropriate for people who are clearly identified as being in the last hours and days of their life. The LCP must be used by staff who have had appropriate training. They must continually monitor the patient’s condition and have an on-going dialogue with the family.*

*This is reinforced by the recent National Care of the Dying Audit – Hospitals (NCDAH) conducted by the Clinical Standards Department of the Royal College of Physicians, the Marie Curie Palliative Care Institute Liverpool and the Department of Health End of Life Care Programme.*

*One of its key recommendations, which we firmly support, is that all hospitals should have a clear programme for continuous quality improvement for care of the dying.*

*The current discussion around the pathway shows how vital it is that there is continued investment in training to improve end of life care.”*

**Tom Hughes-Hallett, Chief Executive, Marie Curie Cancer Care**

*“A good death should be the norm not the exception in our society; any debate that drives up the quality of care in the last hours / days of life is welcomed. High quality care for the dying comes from well trained doctors and nurses working with patients, relatives and carers to alleviate pain and discomfort. The LCP is one model to support care in the last hours and days of life when it is recognised that a patient is dying.”*

**Deborah Murphy**  
**Associate Director Marie Curie Palliative Care Institute Liverpool**  
**National Lead Nurse - LCP**

*“If the passions aroused by the current debate could sustain and support the political and professional consensus needed to ensure continuous investment in staff, learning & teaching, clinical services and research and development; then it may be possible to continue to effect a significant improvement in care of the dying”*

**Professor John Ellershaw, Professor of Palliative Medicine**  
**Director Marie Curie Palliative Care Institute Liverpool**  
**National Clinical Lead - LCP**

***Care at this time is considered urgent - with only one opportunity to get it right to make a potential positive lasting memory for relatives and carers.***

***The Institute welcomes comments, constructive criticism and collaboration with individuals and organisations that also wish to improve care of the dying***

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