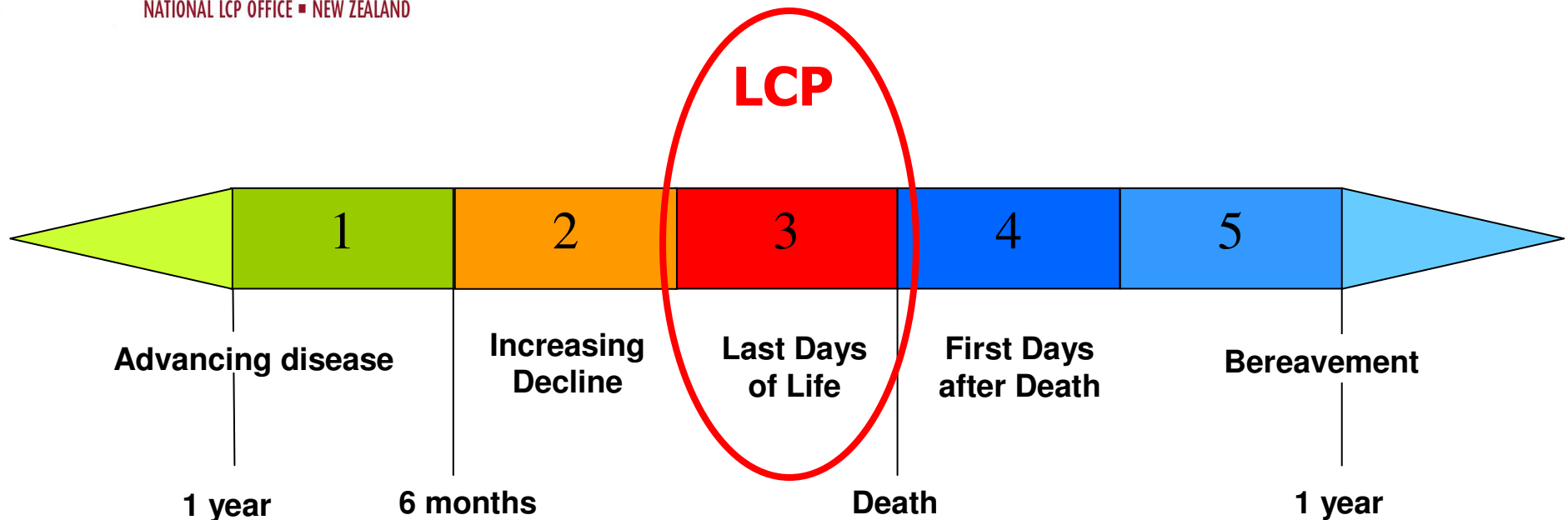


Improving Care of the Dying: Liverpool Care Pathway for the Dying Patient (LCP)

Theresa Mackenzie *RN MN*
National LCP Lead
14 September 2010



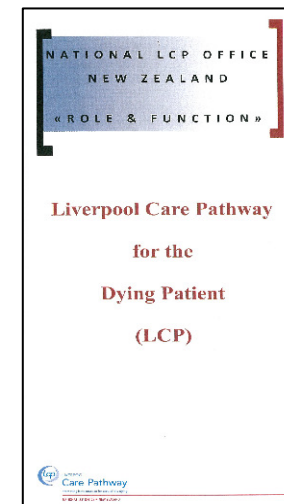
The Liverpool Care Pathway for the Dying Patient (LCP) is an evidence-based integrated care pathway for the last days and hours of life.

It is not the answer to all the challenges of care of the dying but it is a step in the right direction.

National LCP Office - NZ

NATIONAL LCP OFFICE ■ NEW ZEALAND

- Established Nov 2008
- Funded by the Ministry of Health to promote the sustainable implementation of the LCP across all DHBs in NZ
- National LCP information network includes:
 - National LCP Facilitators Group
 - Website www.lcpnz.org.nz
 - NZ LCP Newsletter
 - National LCP Training Days



NZ LCP Status Report at 10 September, 2010

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NZ Sites	Nov 2006	July 2008	Jan 2009	Mar 2009	Dec 2009	March 2010	Sept 2010
Community	0	7	7	8	8	9	9
Hospice (N=19)	5	12	14	16	17	17	17
Hospital (N=67)	4	8	8	9	13	15	19
Residential Care (N=800-900)	3	39	51	62	130	139	194
TOTAL	12	66	80	95	168	180	239

Hospices = those with inpatient units only; Hospitals = exclude psychiatric, maternity & private; Residential Care Facilities = varies 800-900 (Certified List of Providers)

Media Attention

- UK Daily Telegraph - Aug/Sept 2009
 - concern that ticking all the boxes could result in patients dying prematurely
 - promotes continuous terminal sedation and withdrawal of all food and fluids
 - akin to euthanasia
- The Chch Press – Sept/Oct 2009
 - mirrored the concerns in the Daily Telegraph article
- NZ Herald - July 2010
 - Letter to the editor expressing same concerns as above



LIVERPOOL

Care Pathway

Promoting best practice for care of the dying

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

The LCP is intended to replace clinical notes at the end-of-life – it is not a duplication of documentation

1 x Aim

To improve care of the dying in the last hours and days of life

2 x Key Themes

To improve the knowledge related to the process of dying

To improve the quality of care in the last hours and days of life

3 x Key Sections

Initial Assessment

Ongoing Assessment

Care after death

5 x Key Domains of Care

Physical

Psychological

Social

Spiritual

Cultural

Relative / Carer Information

Medication

Communication



Comfort

Understanding the changes
that may occur before death

Diminished need
for food and drink

Health Care Professional Information

- LCP supports but does not replace clinical judgement
- Diagnosing dying is complex
- All changes in care need to be discussed within the multidisciplinary team (MDT)
- LCP does not preclude the use of clinically assisted nutrition, hydration or antibiotics.
- Regular assessment and a formal MDT review must be undertaken every 3 days.
- Patients may be taken off the pathway if their circumstances change

The LCP neither hastens nor postpones death

People don't die because they are started on the LCP
- they are started on the LCP because they are dying.



6-10% of LCP's are discontinued



LIVERPOOL

Care Pathway

Best practice for care of the dying

LCP

Algorithm – Decision making in: diagnosing dying & use of the LCP supporting care in the last hours or days of life

Deterioration in the patient's condition suggests that the patient could be dying

Multidisciplinary team (MDT) assessment

- Is there a potentially reversible cause for the patient's condition e.g. exclude opioid toxicity, renal failure, hypercalcaemia, infection
 - Could the patient be in the last hours or days of life?
- Is Specialist referral needed? e.g. specialist palliative care or a second opinion

Patient is **NOT** diagnosed as dying (in the last hours or days of life)

Review the current plan of care

Discussion with the patient and relative or carer to explain the new or revised plan of care

Patient is diagnosed as dying (in the last hours or days of life)

Patient, relative or carer communication is focused on recognition & understanding that the patient is dying

Discussion with the patient, relative or carer to explain the current plan of care & use of the LCP

The Liverpool Care Pathway for the Dying Patient (LCP) is commenced including ongoing regular assessments

A full multidisciplinary team (MDT) reassessment & review of the current plan of care should be triggered when 1 or more of the following apply:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and or

Concerns expressed regarding management plan from either patient, relative or carer or team member

and or

It is **3 days** since the last **full** multidisciplinary team (MDT) assessment

Always remember that the Specialist Palliative Care Team are there for advice and support, especially if:
Symptom control is difficult and/or if there are difficult communication issues or you need advice or support regarding your care delivery supported by the LCP

Section One: Initial Assessment (Goals 1-9)

Initial assessment

- Informs each patient's individual plan of care
- Multidisciplinary
- Doctors "goals of care" – **red in column**
- Every 'goal of care' requires an assessment, and the documentation of subsequent actions and outcomes
- Achieved or Variance / Yes or No / Unconscious
- All 'goals of care' in **bold** are demonstrable and measurable



LIVERPOOL Care Pathway

Promoting best practice for care of the dying

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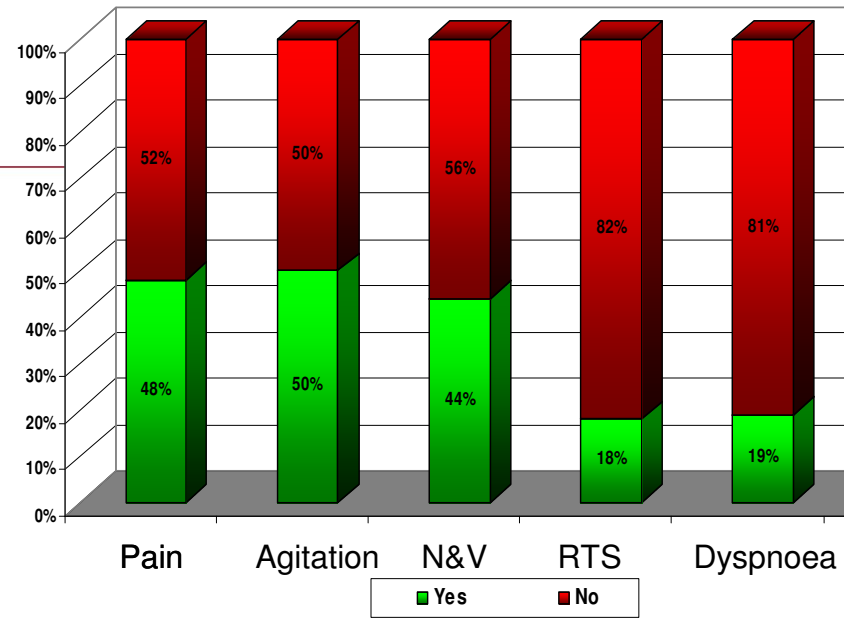
Retrospective Audit of Medication Goals

Post-LCP Audit of Medication Goals

RETROSPECTIVE BASE REVIEW AUDIT

Residential Care Facilities (n=7)

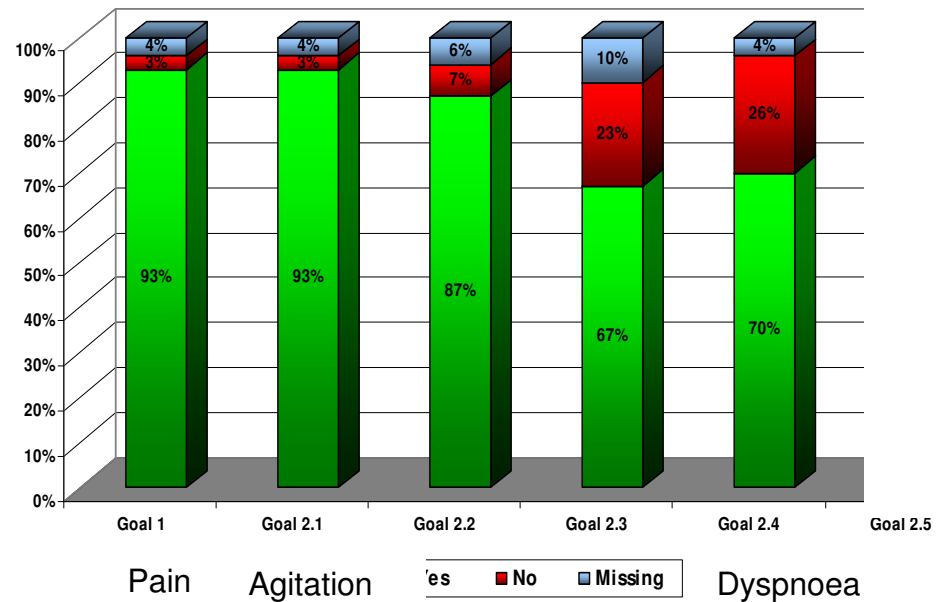
Pre Comfort Measures (n = 80)



POST LCP IMPLEMENTATION AUDIT

Residential Care Facilities (n=7)

Pre Comfort Measures (n = 80)



What is meant by 'Variance'

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- 'Variance' and 'No' are exception reporting
- does not mean there has been a failure to provide good care
- enables the use of clinical skill and judgment to deviate from the suggested plan of care in response to individual patients' needs
- makes the LCP a flexible and practical document
- the 'Variance Analysis Sheet' tells the patient journey

Communication

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Goal 1.1	The patient is able to take a full and active part in communication
Goal 1.2	The relative/carer is able to take a full and active part in communication
Goal 1.3	The patient is aware that they are dying
Goal 1.4	The relative/carer is aware the patient is dying
Goal 1.5	The clinical team have up to date contact information for the relative/carer as documented

Spiritual/Religious and Cultural Needs

Goal 2	The relative/carer has had a full explanation of the facilities available to them & a facility leaflet has been given.
Goal 3.1	The patient is given the opportunity to discuss what is important to them at this time eg. their wishes, feelings, faith, beliefs, values.
Goal 3.2	The relative/carer is given the opportunity to discuss what is important to them at this time eg. their wishes, feelings, faith, beliefs, values.
Goal 3.3	The patient is given the opportunity to discuss their cultural needs at this time.
Goal 3.4	The relative/carer is given the opportunity to discuss their cultural needs at this time.

Anticipatory prescribing

Goal 4.1

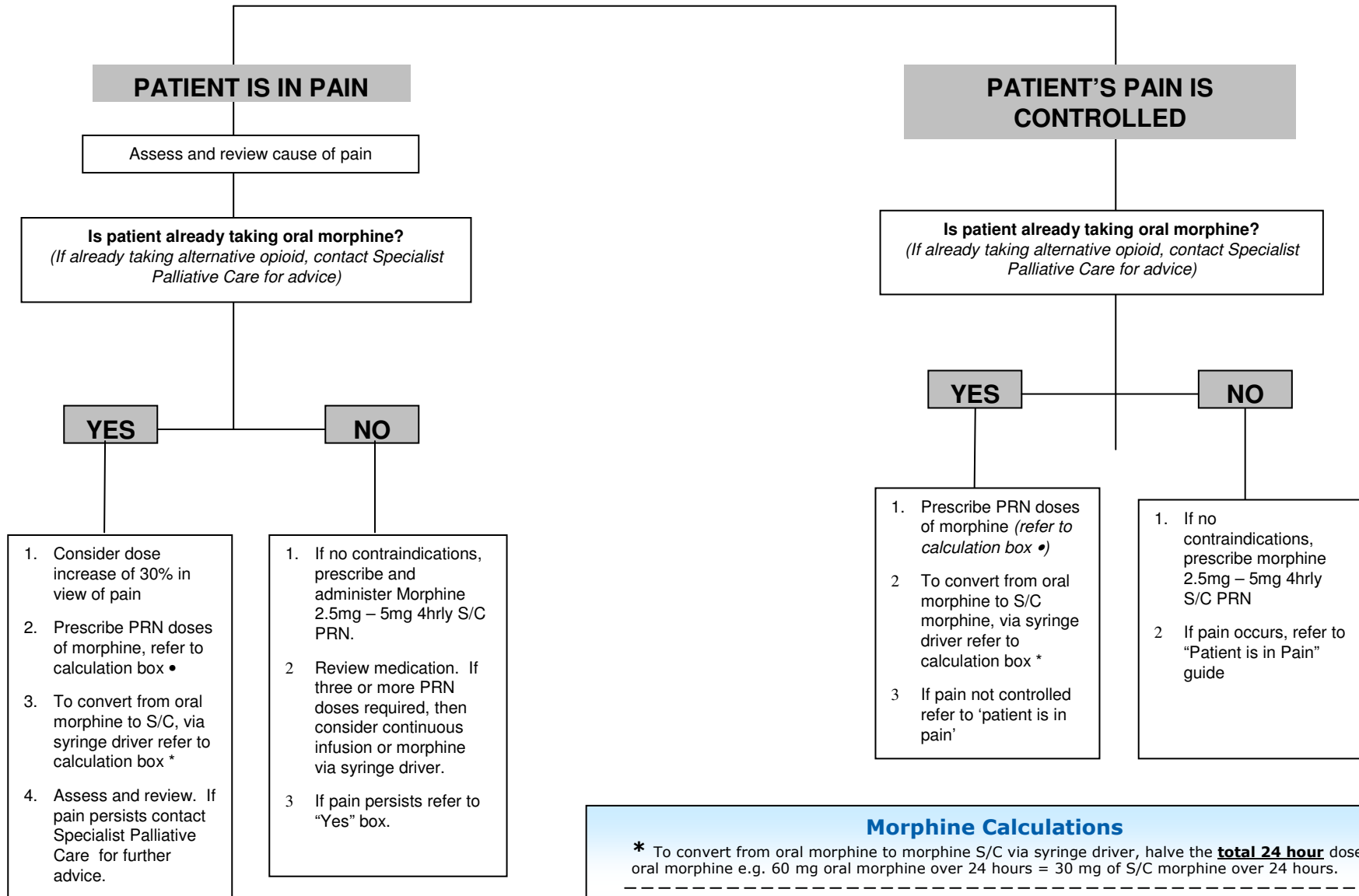
The patient has medications prescribed on a 'prn' basis for all of the following symptoms which may develop in the last hours or days of life:

- Pain
- Agitation
- Respiratory Tract Secretions
- Nausea / vomiting
- Dyspnoea

Goal 4.2

Equipment is available for the patient to support a continuous subcutaneous infusion (CSCI) of medication where required.

Pain

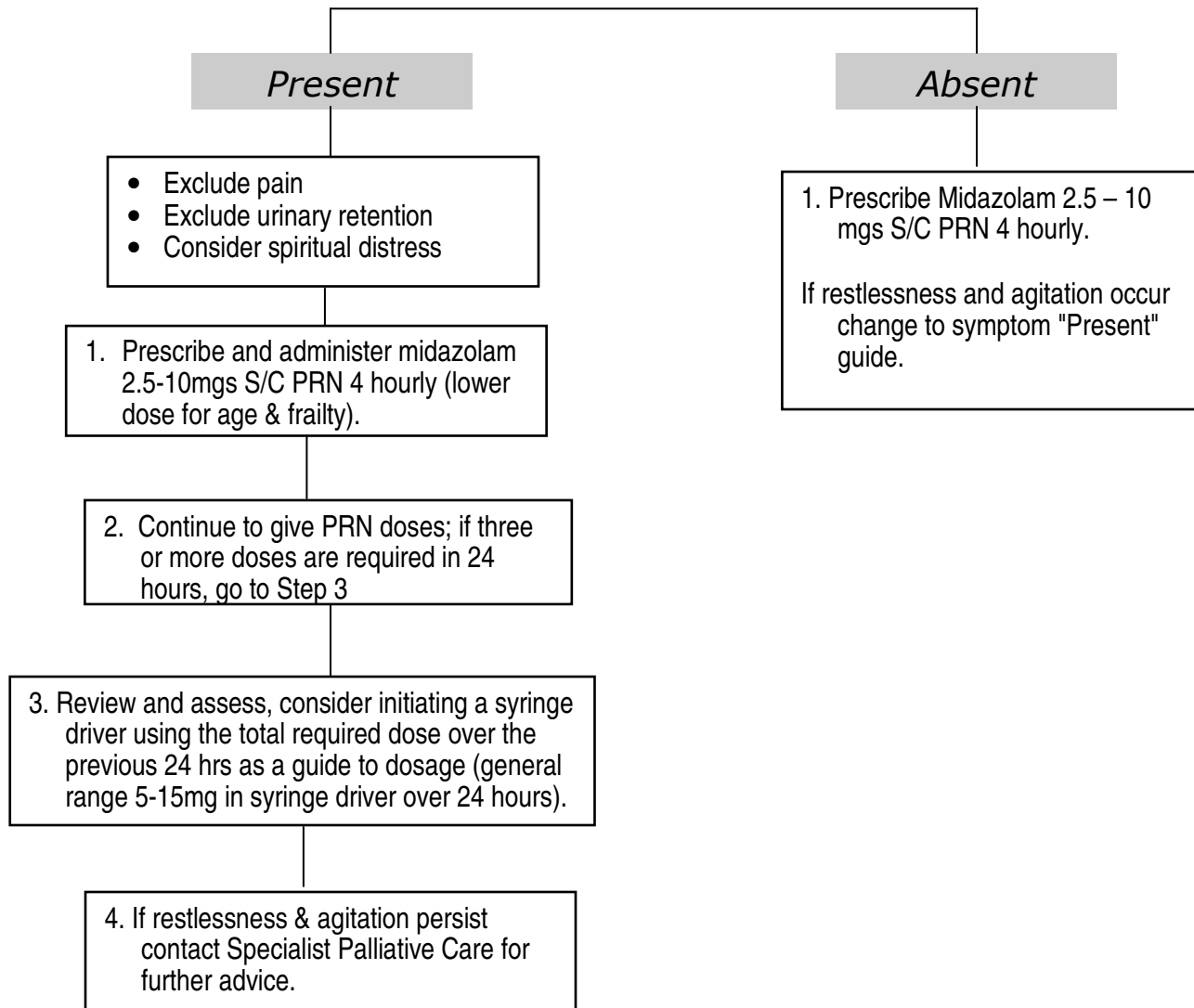


Morphine Calculations

* To convert from oral morphine to morphine S/C via syringe driver, halve the **total 24 hour** dose of oral morphine e.g. 60 mg oral morphine over 24 hours = 30 mg of S/C morphine over 24 hours.

• PRN doses of morphine should be one-sixth of the **24 hour dose** in the syringe driver e.g. morphine 30 mg S/C via a syringe driver will require 5 mg morphine S/C PRN 4hrly.

Terminal restlessness and agitation



Respiratory tract secretions

Early intervention may enable more successful management of this symptom

Present

Absent

- Explain symptoms to patient, family / whanau/other
- Reposition patient
- If persistent and causing distress move to next step

1. Prescribe Scopolamine patch PRN & Hyoscine N-butylbromide 20mgs S/C PRN 4 hourly

If respiratory tract secretions occur change to symptom "Present" guide

1. Prescribe / apply Scopolamine patch 1x over 72hrs (three days) (if available) **and** prescribe Hyoscine N-butylbromide 20mgs S/C PRN 4 hrly
2. Assess two hours after applying Scopolamine patch, if symptoms persist also administer stat Hyoscine N-butylbromide as charted (leave Scopolamine insitu).

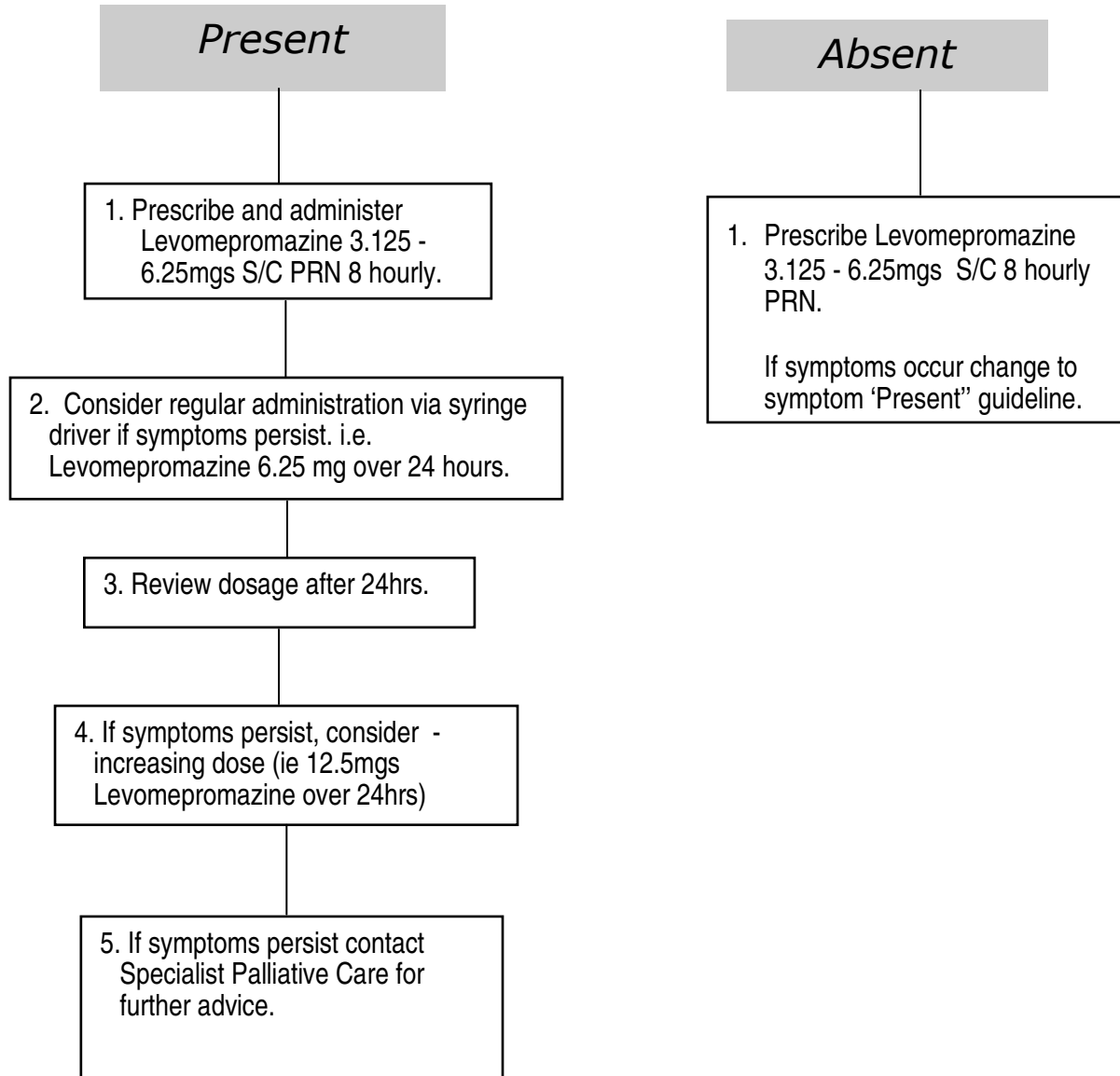
3a. Assess - if symptoms persist and stat dose of Hyoscine N-butylbromide **was** helpful.

Consider syringe driver, with Hyoscine N-butylbromide 60-80 mgs over 24 hours (leave Scopolamine insitu.)

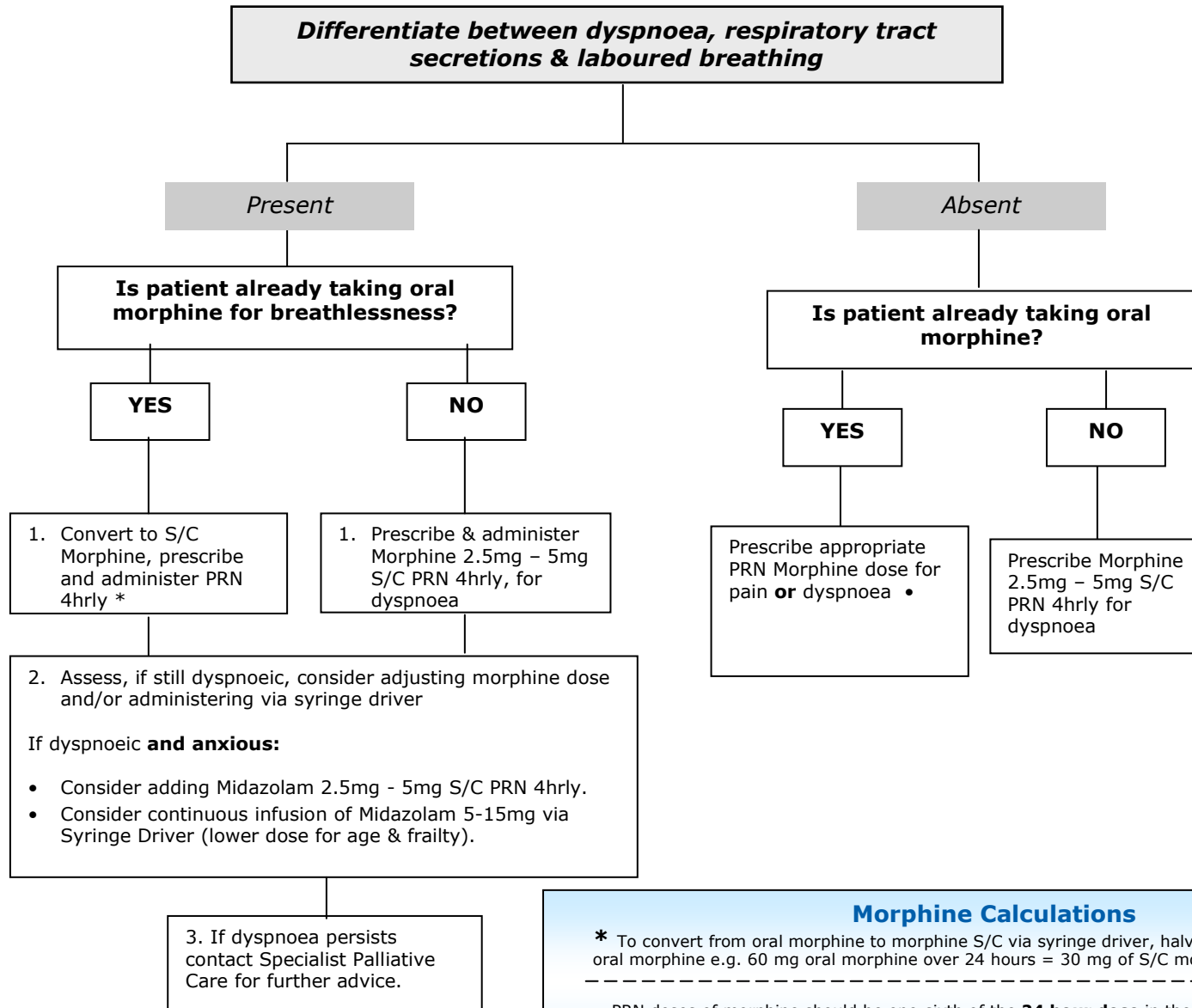
3b. Assess - if symptoms persist and stat dose of Hyoscine N-butylbromide **was not** helpful.

Contact Specialist Palliative Care for further advice.

Nausea and vomiting



Dyspnoea



Morphine Calculations

* To convert from oral morphine to morphine S/C via syringe driver, halve the **total 24 hour** dose of oral morphine e.g. 60 mg oral morphine over 24 hours = 30 mg of S/C morphine over 24 hours.

- PRN doses of morphine should be one-sixth of the **24 hour dose** in the syringe driver e.g. morphine 30 mg S/C via a syringe driver will require 5 mg morphine S/C PRN 4hrly.

Current interventions

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Goal 5.1	The patient's need for current interventions has been reviewed by the MDT: 5a Routine blood tests 5b Intravenous antibiotics 5c Blood glucose monitoring 5d Recording of routine vital signs 5e Oxygen therapy
Goal 5.2	The patient has a Do Not Attempt Cardiopulmonary Resuscitation order in place.
Goal 5.3	Implantable Cardiac Defibrillator (ICD) is deactivated.

Explanation of the plan of care

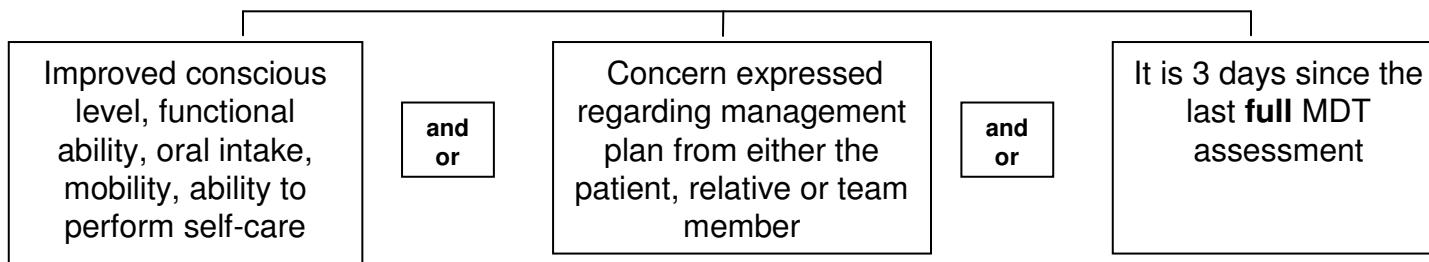
Goal 8	The patient's skin integrity is assessed
Goal 9.1	A full explanation of the current plan of care (LCP goals of care) is given to the patient.
Goal 9.2	A full explanation of the current plan of care (LCP goals of care) is given to the relative/carer. Relative / Carer Information Sheet
Goal 9.3	The LCP leaflets have been given to the relative/carer "What to expect when someone is dying" leaflet
Goal 9.4	The patient's primary health care team/GP practice is notified that the patient is dying.

Section Two: Ongoing Assessment and Care

“Stop, Think, Assess, Change”

Section 2: Ongoing assessment of the plan of care

Undertake an MDT assessment & review of the current management plan if:



Consider the support of the specialist palliative care team and/or a second opinion as required.

Document all reassessment dates and times on page 3

ORGANISATION'S
LOGO

Date:

Day:

SECTION 2 ONGOING ASSESSMENT OF THE PLAN OF CARE						
Undertake an MDT assessment & review of the current management plan if:						
Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care	and or	Concern expressed regarding management plan from either the patient, relative or team member	and or	It has been 3 days since the last full MDT assessment		
Consider the support of the specialist palliative care team and/or a second opinion as required. Document all reassessment dates and times on page 3 of this document.						
Goals to be recorded at each MDT assessment (90 minutes in time) A = Achieved V = Variance (i.e. exception recording)						
	0400	0800	1200	1600	2000	2400
Goal a: The patient does not have pain Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use an appropriate pain assessment tool if appropriate. Consider PMA analysis for patient if applicable.	V	A				
Goal b: The patient is not agitated Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity.	A	A				
Goal c: The patient does not have respiratory tract secretions Consider positional change. Discuss symptom & plan of care with patient, relative or carer. Medication more effort when given as soon as symptom occurs.	V	V				
Goal d: The patient does not have nausea Verbalised by patient if conscious.	A	A				
Goal e: The patient is not vomiting	A	A				
Goal f: The patient is not breathless Verbalised by patient if conscious, consider positional change and use of a fan.	A	A				
Goal g: The patient does not have urinary problems Use of pads, urinary catheter as required.	A	A				
Goal h: The patient does not have bowel problems Monitor - constipation / diarrhoea. Monitor skin integrity. Bowels last opened:	A	A				
Goal i: The patient does not have other symptoms Record symptom here: If no other symptoms present - record N/A	N/A	N/A				
Goal j: The patient's comfort & safety regarding the administration of medication is maintained The patient is only receiving medication that is beneficial at this time. If CSCI via syringe driver in place a monitoring sheet must be in progress. SAC sufficient in stock for PRN medication (if required) If no medication required - record N/A	A	A				

WHAT VARIANCE OCCURRED & WHY? (what was the issue?)	ACTION TAKEN (what did you do?)	OUTCOME (did this solve the problem?)
<p>Pt grimacing & moaning when turned.</p> <p>Signature: J Brown Date / Time: 23-4-10 0400hrs</p>	<p>Given Morphine 2.5mg s/c as prescribed for incident pain.</p> <p>Signature: J Brown Date / Time: 23-4-10 0410hrs</p>	<p>Pt appears comfortable & settled.</p> <p>Signature: J Brown Date / Time: 23-4-10 0430hrs</p>
<p>Pt developing pooled secretions. Breathing becoming more rattley & concerning to family.</p> <p>Signature: J Brown Date / Time: 23-4-10 0400hrs</p>	<p>Explanation re: Respiratory Tract Secretions given to family. Pt repositioned on side with head raised.</p> <p>Signature: J Brown Date / Time: 23-4-10 0400hrs</p>	<p>Noisy breathing decreased.</p> <p>Signature: J Brown Date / Time: 23-4-10 0400hrs</p>
<p>Noisy secretions increasing.</p> <p>Signature: K Black Date / Time: 23-4-10 0800hrs</p>	<p>Scopolamine patch applied to R) side upper chest. Plan of care to monitor effectiveness of medication explained to family.</p> <p>Signature: K Black Date / Time: 23-4-10 0810hrs</p>	<p>Pt reassessed 2hrs post-patch application – RTS less – breathing quieter. Family feeling less concerned.</p> <p>Signature: K Black Date / Time: 23-4-10 1000hrs</p>

Section Three: Care After Death (Goals 10-12)

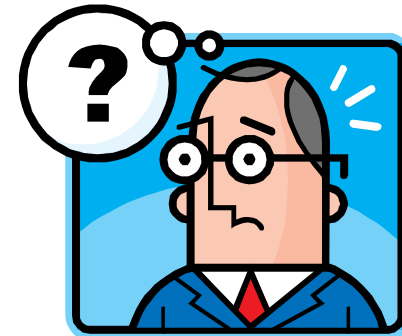
Care After Death

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Goal 10	Last offices (i.e. care of the deceased/ tūpāpaku) are undertaken according to policy and procedure.
Goal 10.1	Arrangements for blessing room / bed space made.
Goal 11	The relative/carer can express an understanding of what they will need to do next and are given relevant written information. "Before Burial or Cremation" booklet
Goal 12.1	The primary health care team / GP is notified of the patient's death.
Goal 12.2	The patient's death is communicated to appropriate services across the organisation.

Media Attention

- If you 'tick all the LCP boxes' will this cause patients to die prematurely?
- Does the LCP promotes continuous terminal sedation?
- Does the LCP sanction denial of food and fluids for dying patients?
- Is the LCP akin to euthanasia?
- What do you think.....



Endorsements

- **Ministry of Health** – funds the National LCP Office NZ to promote and coordinate the sustainable implementation of the LCP across all DHBs
- **Health and Disability Commission** – fits with Code of Rights
- **Father Michael McCabe, NZ Catholic Bioethic Centre** – the LCP does not sanction euthanasia or suicide, or mandate any unethical actions



**How a person
dies lives on in
the memories
of those who
survive....**

10 Key LCP Messages

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

For more information
contact:
National LCP Office NZ:
www.lcpnz.org.nz

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