Making a difference: integrating the Liverpool Care Pathway into practice

Historically, end of life care within the National Health Service (NHS) has had a comparatively low profile, with variable, disjointed care and poor communication between providers. The implementation of the End of Life Care Strategy in 2008 acknowledged that change was needed to provide consistent, high quality end of life care delivered with dignity and respect.

Research has revealed that people are still not dying in their place of choice. Of the 56–74 per cent of people who wish to die at home or in a care home, only 35 per cent do so; most deaths (58 per cent) still occur in hospital. In the United Kingdom, the number of deaths per year is likely to increase by 17 per cent between 2012 and 2030, therefore we need to improve end of life care now.

While palliative and end of life care is provided by an extensive range of health professionals, the primary healthcare team has an increasingly essential role in delivering palliative care to those at home. With this in mind, the vision of the Department of Health (DH) was for a more modern, reactive, high quality service which could be delivered to people closer to home, thus seeking to avoid unnecessary hospital admissions.

The National Institute for Health and Clinical Excellence (NICE) proposed and introduced three frameworks to improve the delivery of end of life care which were rolled out by the End of Life Care programme from 2005-2008. These were:

- The Gold Standards Framework (GSF)
- Preferred Priorities for Care (PPC)
- The Liverpool Care Pathway (LCP)

Evidence has shown that confidence of those healthcare professionals delivering end of life care using these frameworks has improved and that their use has reduced unnecessary hospital admissions, thereby increasing the chance of patients dying in their preferred place of care.

The Liverpool Care Pathway

The LCP is the recommended best practice framework for care of the dying patient. The framework centres on transferring the advances of hospice care into the community and providing the primary healthcare team with the tools to enhance and develop the quality of end of life care. It facilitates the documentation process of care and monitoring of results, and has provided a support framework for generalist health professionals caring for dying patients and their families. The LCP comprises three sections: initial assessment and care; ongoing assessment and care, and care after death. It establishes the appropriate delivery of care by centreing on the physical, psychological and spiritual comfort needs of both the patient and their family.

The standard of delivery of care is measured by reference to 18 specific goals across the three domains (Box 1).

The Project

To meet the end of life needs of a local population and as part of a community nursing initiative, we worked with the Marie Curie Cancer Care Institute to introduce the LCP into the community nursing team. The aim was to improve quality of care for the dying patient and their family, and to reduce crisis intervention and inappropriate hospital admissions. We had approximately one year to introduce this.

Documented care standards such as symptom control and communication were audited before and after the LCP was introduced in order to assess whether or not the LCP had improved these. Information from nursing records and the LCP documentation elicited patient’s gender, age, diagnosis and time the patient spent on the pathway.

Between July 2005 and February 2006 using the version 11 LCP documentation, the community nursing team and the Marie Curie Cancer Care Institute undertook a baseline audit review of patients

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Hertfordshire Community Nursing Team
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Cheryl Manners, Team Lead, Community Nursing and Therapy, Hertfordshire.
Sharon Roberts, Community Macmillan Nurse, Palliative Care Service, Hertfordshire.

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who had died at home in order to identify the current level of documented end of life care. The results do not necessarily reflect the standard of care delivered, merely the standard of documentation of care.

During this time extensive training was delivered to the General Practitioners (GPs) and community nursing staff. By October 2006, the LCP was introduced into practice. From 2006 to 2011, three data audits were undertaken (October 2006 to March 2008, April 2008 to July 2010, July 2010 to February 2011), again using the version 11 LCP documentation for comparison to the pre-implementation audit and to demonstrate any improvement in documented practice.

Originally, the project started using a single GP surgery, but it became apparent that this would only yield data from 5 or 6 patients (due to the small population size served by this surgery), insufficient for the purposes of audit. In order to compile enough data, we expanded the project to cover three GP surgeries. This produced the requisite sample size. Therefore, whilst the baseline review originally had a sample size of 13, all the post audits had a sample size of 11.

**Audit results**

Figure 1 shows patient demographics and hours the patient spent on the LCP. The number of patients in residential care homes on the LCP increased from zero at the baseline audit to five at final audit.

In terms of meeting the goals outlined in the three domains of care (Box 1), the results are as follows:

- **Goals 1-3: Comfort measures** - the results showed a dramatic improvement - 100% achieved by the 3rd audit
- **Goals 4-6: Psychological insight and Religious/Spiritual assessment** - although not 100% achieved, improvement was noted (NB. The documentation development by the Marie Curie Cancer Care Institute for version 12 has included more of the spiritual elements)
- **Goals 9-11: Communication** - 100% achieved in both the 2nd and 3rd post audit, as were assessment and ongoing care goals.
- **Goals 12-18: Care after death** - the out of hours service required more education on completing the paperwork when the patient died within their timeframe (Figure 2)

**Discussion**

The pre- and - post audit statistics clearly show that the introduction of the LCP has improved documentation and consequently improved quality of care for the dying patient in this community setting. This reflects the work of Veerbeek et al., who noted that specialist documentation assists with structuring care from a multi-professional approach; the introduction of the LCP has assisted with increased documentation of the dying patient. However, the audits showed that care after death requires further exploration to improve both care and communication between families, health professionals and the out of hours services.

The LCP has decreased crisis intervention and unnecessary hospital
admissions. Since its introduction, no complaints regarding end of life care have been received; indeed greater positive feedback has been noted. In part, this may have been achieved because the LCP keeps families more informed and aware of what is happening, which in turn better prepares them for dealing with bereavement issues. The LCP documentation facilitates symptom control, and advance planning of medication via the LCP means symptoms are alleviated sooner.

Since the first post audit, many patients with a non-cancer diagnosis are utilising the LCP, as are residential care homes. Thus, many patients who would previously have been admitted to hospital died in the place they regarded as home, receiving care from staff familiar to them and supported by the community nursing staff.

As the confidence and knowledge of the staff increased, the hours the patient spent on the LCP ran more in accordance with guidelines. Verbeek et al. noted that the average length of LCP use was longer in the community than hospital. Walker and Read noted that nurses felt the LCP enhanced symptom control due to anticipatory prescribing which avoided delay in administering the medication. Nurses also stated that the LCP documentation provided a time saving structure to assist them in communicating more effectively with families and patients.

The following statement by a bereaved relative shows why the LCP is important:

“Once home from hospital he declined very rapidly, but this was met with an immediate response by the community nursing team. I rarely had to ask questions as I was advised with care each time the team visited, regarding any changes or any decline in his condition, and consulted in every aspect of his care. He was put on a pathway for dying adults in the last few days of his life. This was explained to me in full and meant his comfort was the number one priority for any healthcare professional entering the house. I will be forever grateful for the team who looked after us at home and I feel because of this he had the best passing”. (June 2011).

The Hertfordshire Community NHS Trust has now developed a community nursing end of life care group which meets every two months. This group was developed to utilise the model used within the trust to assist and support other localities in introducing the LCP into their way of working. It has moved forward considerably since then with all areas having identified an initial practice to work with and develop. It is hoped that eventually by sharing ideas and supporting each other within the group, the LCP can be successfully implemented into all areas within the trust in the not-so-distant future.
Conclusion
Introducing the LCP as a supportive assistance tool into this community setting has materially increased the community nurses’ confidence and knowledge regarding end of life care, and has allowed patients to die in their preferred location. It has greatly improved communication between the multi-disciplinary team and facilitated a closer collaborative way of working. Anderson and Chojnacka\textsuperscript{11} found the LCP documentation reduced the amount of paperwork in the dying phase and meant nurses could spend longer with patients and families. In addition, only one document for the whole multi-professional team is required.

There are no second chances with end of life care, therefore the right assessment tools and pathways are required to provide consistent coordinated care to make it possible for people to have a dignified death in their place of choice. Veerbeek \textit{et al}\textsuperscript{11} note that the LCP has assisted with improving documentation and symptom management and therefore it has been able to present examples for future education and development of the dying patient. It is felt that by continuing to use LCP as an assessment tool best practice and high quality care in this ever-expanding and complex area of nursing can be maintained. By continuing to use the LCP in practice we can improve the statistical evidence via audit purposes of the advantages and limitations that care pathways can provide\textsuperscript{6}.

References

Editor’s note
As you are no doubt aware, and have probably discussed with your patients, the Liverpool Care Pathway has been the cause of much debate.

Numerous press articles during 2012 presented cases of patients being ‘put on the pathway’ without any discussion with the patient’s family - indeed, a 2011 study by the Royal College of Physicians found that overall, 4 percent of families (and in a third of hospitals), were not informed. Where agreement from family was sought, full information about the pathway and what to expect was not given. It would also seem that some patients who were not terminal were also placed on the pathway, prompting concerns that it was being used to hasten death in elderly patients to free up beds. Some relatives are taking police to investigate what they believe is murder, rather than an agreed care plan. Complaints fall into four main categories: families are not being consulted; predicting when death is imminent is impossible, so knowing when to start the pathway is guesswork (or euthanasia); withholding fluids and removing drips will ensure death; and that the use of sedatives doesn’t allow final ‘goodbyes’.

The furore from both relatives and health care professionals prompted the Department of Health to produce a consensus statement from among others, the Royal Colleges of Nursing and General Practitioners, agreeing best practice for the LCP. However, in a dramatic move, at the end of October 2012, the NHS National End of Life Care Programme began an inquiry into the LCP and its delivery. In November 2012, the Health Secretary proposed that relatives of terminally ill patients would have to be consulted before a decision to withdraw food or water is taken. This proposed instruction is part of series of changes to the NHS Constitution which are currently out to consultation.

Do you agree that a review is required? Have your experiences been positive or not? Email me at JCN with your views to deborah.glover@cnj.co.uk

How to Master Nursing Calculations (2nd Edition)
Author: Chris Joan Tremain
Publisher: Kogan Page Ltd
ISBN: 978-0-74946753-1
Cost: £12.99
This book is described as ‘ideal practice for learning key numeracy skills’. It is designed to help improve arithmetic skills in preparation for nursing courses and, the author suggests, as the perfect companion for training and the early years of your career.

In order to review this book I read and completed the practice questions and was surprised to discover how much I had forgotten about basic arithmetic. I found the simple explanations and examples easy to follow and was able to quickly refresh my memory and hone my skills in key areas of calculation. The chapter progression is logical and the examples clear and easy to follow.

I would recommend this text as appropriate for all nurses, regardless of experience, and particularly as a refresher for those embarking on degree modules such as Independent Prescribing where numeracy skills are an essential element of the course.

Karen Dorner, DN Sister, RGN, BSc Community Nursing

Palliative Care, Ageing and Spirituality
Author: Elizabeth MacKinlay
Publisher: Jessica Kingsley Publishers
ISBN: 978-1-8490-5290-0
Cost: £11.99
The book is focussed towards older adults and provides both examples and insight into understanding the complexities of spiritual end-of-life issues. The partnership between the person nearing end-of-life and caregiver, however loving and supportive, can be very stressful and difficult at times throughout this journey. The health and wellbeing of the caregiver is fully addressed within the book.

This book covers important end of life issues that impact on both the dying person and their relationships with others. Grief, loss, acceptance, relationships, the final days/hours and learning to live without a partner are all addressed. Real life experiences are quoted throughout each chapter of the book bringing a sense of what was most relevant to their relationship at that time. I feel this book provides a gentle but emotive introduction into preparing for the final journey of life.

Jean Kelly, Registered Nurse Palliative Care , Walsall, West Midlands