

The Marie Curie
Palliative Care Institute

LIVERPOOL

**LCP CENTRAL TEAM UK
MCPCIL**

**10 Step Continuous Quality
Improvement Programme
(CQIP) for Care of the Dying
using the LCP Framework**

**Within a 4 phased Service
Improvement model**

August 2009
(Review November 09)

**This version has been adapted
for use in New Zealand only**

August 2011
(With the permission of the LCP Central Team UK)

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The 10 Step Continuous Quality Improvement Programme for Care of the Dying using the LCP Framework

The LCP Framework is a Continuous Quality Improvement Programme that can transform care of the dying within an environment. The implementation of the Framework will create a change situation. Recognition of the fundamental aspects of a change management programme is pivotal to success to empower, enable and engage those with whom you work. The Service Improvement Model used at the Marie Curie Palliative Care Institute Liverpool (MCPCIL) and promoted for use in New Zealand by the National LCP Office is a 4 phased approach to change management.

The LCP Central Team at the Institute has developed a 10 Step Continuous Quality Improvement Programme for Care of the Dying using the LCP Framework.

“At first I found the thought of the task ahead to implement the LCP was overwhelming but then I broke the plan down into smaller pieces and realised if I took the time to prepare the environment and gain endorsement from my steering group then the next steps would be easier. “

Lead nurse – LCP Project lead

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

Specialist Palliative Care Clinician

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**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 community / GP practice
- **To register an LCP project in New Zealand - contact the National LCP Office NZ Administrator via email nationalLCPadmin@arohanuihospice.org.nz or phone (06) 3502311 Mon-Fri 9-4.30pm for registration information, or alternatively go directly to the National LCP Office NZ website www.lcpnz.org.nz and click on the hyperlink to access the on-line registration form via the Marie Curie Palliative Care Institute Liverpool website.**
- **Develop an Education Programme – advice and support provided by the National LCP Office NZ**

“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 Framework 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.

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 site/ organisation / District Health Board/ national body.

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 / carer in relation to care of the dying, grief, and bereavement.
- to promote care of the dying as a quality indicator at governance / performance management level.

An introduction should also be given regarding key aspects of the LCP including:

- layout of the document – importance of goals and outcomes
- the importance of the diagnosing 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 multiprofessional
- the LCP replaces all previous documentation and is the legal document for patient care
- explanation of variance and variance analysis
- benefits of the LCP to the clinical governance agenda

Pilot site identified for introduction of the LCP e.g. a Hospice inpatient unit/ GP practice-Community setting /Residential Care facility / Hospital unit or ward.

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.

Testing the Change Ideas

The LCP Central Team UK 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

The National LCP Office NZ has the 'LCP Reflective Data Cycle' available for use as a continuous quality improvement tool developed by Amanda Taylor and based on the PDSA Cycle:

- 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

www.modern.nhs.uk/improvementguides

LCP Facilitator

The National LCP Office NZ supports the LCP Central Team UK dedicated LCP Facilitator approach. We recommend the LCP Facilitator is a Registered Nurse with a minimum of 2 years experience in specialist palliative care and preferably a post-graduate qualification in palliative care. The LCP Facilitator is advised to attend a National LCP Training Day to familiarise themselves with the four phase Service Improvement Model and its 10 step continuous quality improvement programme that underpins the successful implementation of the LCP in practice. All LCP Facilitators will need to consider a sustainability model for the LCP programme within the clinical environment and an exit strategy for themselves if the post is fixed term.

Suggested LCP Facilitator FTE for NZ LCP Projects:

Hospital

1.0 FTE dedicated LCP Facilitator linked with the hospital's Specialist Palliative Care Team for 2 years. Tertiary hospitals of 500+ beds may require more than one facilitator or an ability to extend the contract if implementation is not completed within 2 years and/or there is an expectation to implement the LCP in other satellite/rural hospitals in the region.

Hospice (6-20 inpatient beds)

0.5 FTE dedicated LCP Facilitator for approx 6 months.

Community

The FTE required is influenced by a combination of factors including the generalist/specialist service configuration, total population, access to GP support, and whether the local specialist palliative care service supports the LCP. Contact the national LCP Office for further advice.

Residential Care

The FTE required is dependant on the facility's level of care (i.e. Stage 1 or hospital-level care, Stage 2 or rest home level care; and/or Stage 3 or dementia care), number of beds, number of GP's providing service to residents, and links to a specialist palliative care service.

Specialist palliative care experience is recommended for NZ LCP Facilitators. Contact the National LCP Office NZ for advice, support and an *example* 'LCP Facilitator' position description www.lcpnz.org.nz .

Registering an LCP Project with the National LCP Office NZ

It is in your interest to register and check that we have your details on the data base so that we can offer you support

Registering your LCP Project with the National LCP Office NZ brings a number of benefits:

- LCP project management advice and support in the NZ context of end-of-life care
- Pre and post-implementation electronic audit advice and support
- Access to ratified LCP NZ generic version 12 document, and associated resources
- LCP document control to support compliance with your version 12
- LCP teaching resources
- Support information/brochures for family/whānau
- National LCP Training Days
- Membership on the National LCP Facilitators Group
- Access to the national LCP information network in NZ
- Access to the LCP Reflective Data Cycle - a continuous quality improvement tool

To register an LCP project in New Zealand:

- contact the National LCP Office Administrator directly via email nationalLCPadmin@arohanuihospice.org.nz or phone (06) 3502311 Mon-Fri 9-4.30pm for registration information
- alternatively, go directly to the National LCP Office NZ website www.lcpnz.org.nz and click on the hyperlink to access the on-line registration form via the Marie Curie Palliative Care Institute Liverpool website.

National LCP Office NZ - Learning and Teaching Activities

The National LCP Office NZ facilitates National LCP Training Days across New Zealand. These are advertised in the 'Kai Tiaki' nursing journal and on our website www.lcpnz.org.nz.

The National LCP Training Day focuses on techniques for priming the environment for change. Key staff are encouraged to 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 retrospective Base Review and post-LCP implementation audits. In addition the key leads / LCP Facilitators are encouraged to identify issues relating to implementation of the LCP in their own clinical areas.

Phase 2: IMPLEMENTATION
STEP 2 – Development of Documentation

- **Local Steering Group meets to discuss LCP and amend prompts to the core NZ LCP document according to local need. It is important that the Goals on the LCP remain the same to enable benchmarking in the future.**
- **Locally adapted LCP document is sent to National LCP Office for compliance before use.**
- **Supportive documentation identified, and leaflets produced.**

The local steering group should review the NZ LCP document and amend it according to local need. However, it is vital that the goals on the pathway should not be altered as this would mean that the document would become fundamentally different from the LCP and might not be suitable to be included in any future benchmarking or National Audit programmes. Nevertheless, the prompts, which support the goals, can be adapted to better reflect local practice, provided that they do not alter the meaning of the stated goals. Extra goals may also be added to the document should the need arise locally. The LCP 'Goal Definition / Data Dictionary' provides a rationale for each goal and is an excellent resource to guide local the steering group when reviewing the document. Please send your locally adapted document to the National LCP Office for compliance before it is used in practice.

© National LCP Office NZ Website – www.lcpnz.org.nz ©

Please review the LCP Goal Definitions / Data Dictionary Document which can be accessed on the National LCP Office NZ 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. 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, including the 'Before Burial and Cremation' booklet published free of charge by Birth, Deaths and Marriages, NZ Department of Internal Affairs.

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You can view a selection of leaflets on the website

Phase 2: IMPLEMENTATION
STEP 3 – Base Review / Retrospective audit of current documentation

- **Contact the National LCP Office NZ**
- **Use the username and password provided at registration to access the retrospective Base Review electronic audit tool on-line via the MCPCIL website**
- **Review 10-20 sets of current documentation in accordance with the Guidance Notes for a Base Review audit**
- **It may be appropriate to undertake more than one Base Review across an organisation i.e. differing wards of a large hospital. For further advice, contact the National LCP Office NZ**

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.

The electronic audit tool and a set of guidance notes are available on-line via the MCPCIL website using the 'username' and 'password' you receive at the time you register the organisation/site. If you have questions/queries/comments related to coding of information from your case notes on to the electronic audit tool, or regarding any aspect of the LCP NZ generic version 12, please contact the National LCP Office NZ on phone (06) 3502311 Mon-Fri 9-4.30pm.

If you experience any problems accessing the audit tool, submitting or saving any of this information, you require one of your cases to be 'unlocked, or you are not able to access your end report, please contact MCPCIL Evaluations Unit via email evaluations.unit@rlbuht.nhs.uk. In this case, you will need to allow for the time difference between NZ and the UK, so you may not receive a reply for 24-48 hours.

Patient demographic information regarding primary diagnosis, gender, ethnicity and age is also collected. To ensure patient confidentiality, all data collected is anonymised.

Once data entry is complete, an automated report in 'real-time' of the analysed data is generated. Feedback consists of simple charts in a powerpoint presentation that illustrate, at a glance, where the documentation of care is good and where it might be improved.

Phase 2: IMPLEMENTATION
STEP 4 – Induction / Education Programme / Pilot Site

- **Implement intensive education programme over a 6-week period to include all members of the clinical team.**
- **Ensure an LCP Resource Folder is available within the clinical area.**

Education at this stage is primarily focused on making sure that staff understand the document fully and are able to complete it accurately (see the goal definitions / data dictionary document on the website). It is recommended that at least 80% of staff receive education prior to using the LCP in practice. This includes medical, nursing, health care assistants and allied health staff.

© National LCP Office NZ Website – www.lcpnz.org.nz ©

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

NB: There are two LCP Goal Definitions / Data Dictionaries – one for LCP NZ Version 11 and one for LCP NZ generic Version 12.

They may, in addition, require education related to the wider issues involved in using the LCP such as communication skills, pain and symptom control, cultural and spiritual issues. The provision of a resource folder containing relevant evidence-based documentation and guidance is recommended to support the implementation process.

Increasingly, a package of educational and information resources is being sought to support the endeavours of LCP facilitators in providing timely educational input at an appropriate level to support the implementation and sustainability of the LCP in the local environment. A project has recently begun within the Marie Curie Palliative Care Institute (MCPCIL) to develop and evaluate an 'Educational Toolkit' for use with the LCP. The planned 'action research' based project will develop a variety of learning resources, both lecture format and more informal teaching approaches to support medical and nursing colleagues in their use of the LCP.

The National LCP Office NZ can provide support and advice with regard to a variety of teaching approaches and will work with the LCP Central Team UK to adapt any teaching resources from the 'Educational Toolkit' that are appropriate for the NZ context.

Phase 2 : IMPLEMENTATION

STEP 5 – Clinical Implementation of the LCP in pilot sites

- **Implement – use the LCP in the clinical area / Pilot site(s).**
- **Provide educational support within the clinical area to staff when patients are cared for on the LCP.**

Once the relevant group of staff has received educational, the implementation phase can begin. This is likely to be the most 'hands on' phase of the project, where LCP facilitators/ key champions / members of the specialist palliative care team will need to ensure that they are available within the pilot sites to offer ongoing support when the document is used. Maintaining a 'high profile' during this period is imperative for success, as is ensuring strong links between staff in the pilot areas and the Specialist Palliative Care Team. Liaison between staff and the LCP facilitator/specialist team each time an LCP is used is a good way to increase knowledge and confidence in caring for dying patients and their families/whānau.

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 & availability of educational programmes.

A project has recently begun within the Marie Curie Palliative Care Institute (MCPCIL) to develop and evaluate an 'Educational Toolkit' for use with the LCP. The planned 'action research' based project will develop a variety of learning resources, both lecture format and more informal teaching approaches to support medical and nursing colleagues in their use of the LCP.

The National LCP Office NZ can provide support and advice with regard to a variety of teaching approaches and will work with the LCP Central Team UK to adapt any teaching resources from the 'Educational Toolkit' that are appropriate for the NZ context.

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More information on National LCP Training days (including dates, venues and cost) can be found on the website

Phase 3 : DISSEMINATION
**STEP 6 – Maintaining and improving LCP competencies using
reflective practice and post pathway analysis**

- **Review the LCP each time it has been completed and discuss the outcomes of care**
- **Reflect on key challenges**
- **Post Pathway Analysis of first 20 LCP's used in the environment**

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.

The post-pathway electronic audit tool and a set of guidance notes are available on-line via the MCPCIL website using the 'username' and 'password' you receive at the time you register the organisation/site. If you have questions/queries/comments related to coding of information from your case notes on to the electronic audit tool, or regarding any aspect of the LCP NZ generic version 12, please contact the National LCP Office NZ on phone (06) 3502311 Mon-Fri 9-4.30pm.

If you experience any problems accessing the audit tool, submitting or saving any of this information, you require one of your cases to be 'unlocked, or you are not able to access your end report, please contact MCPCIL Evaluations Unit via email evaluations.unit@ribuht.nhs.uk. In this case, you will need to allow for the time difference between NZ and the UK, so you may not receive a reply for 24-48 hours.

Patient demographic information regarding primary diagnosis, gender, ethnicity and age is also collected. To ensure patient confidentiality, all data collected is anonymised.

Once data entry is complete, an automated report in 'real-time' of the analysed data is generated. Feedback consists of simple charts in a powerpoint presentation that highlights any improvements in the documentation and environment since the implementation of the LCP.

The information gained from the audit can point to areas where further education or training would be useful and can lead to appropriate amendments to the ongoing education programme. It can also provide useful information about organisational issues, such as the availability of resources.

The feedback report is of a similar format to that of the Base Review. The reports are designed to provide useful information in an accessible and easily interpretable format, using bar charts to illustrate the proportion of 'achieved' (goal met), 'variance' (goal not met) and 'not applicable' coded on the pathway at the time of delivery of care, along with the proportion of missing data (i.e. nothing coded on the pathway against that particular goal). This element of evaluation will inform the direction of education development for the future.

Phase 3: DISSEMINATION STEP 7 – Evaluation and Further Training

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
- Cultural aspects

Phase 3 : DISSEMINATION STEP 8 – Continuous development of competencies in order to embed the LCP Framework within the clinical environment

- **Regular update teaching sessions within the clinical environment according to identified training needs using the LCP 'Reflective Data Cycle'.**
- **Develop a support network for the LCP Resource Nurses / 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 LCP resource nurse/champions programme. The National LCP Office NZ would recommend that there is a minimum of two-three LCP resource nurses/champions 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. Having more than one LCP resource nurse/champion per area mitigates the risk of loss of LCP knowledge and skill related to staff attrition. These roles are excellent for nurses who are interested in palliative care/end of life care and looking for roles to extend their practice when developing their nursing portfolio.

The National LCP Office NZ can provide information on existing programmes that enhance the knowledge and skills of nurses and health care assistants interested in learning more about the palliative care approach via regular meetings facilitated by the LCP Facilitators. The LCP resource nurse/champion role enables nurses to take a lead role in the

management of patients with palliative needs in hospital, residential care and community care settings, including those in the last days of life.

It is recommended that LCP resource nurse/champion group meetings specifically address issues such as the management of pain and other symptoms, communication and psychological support, care of the dying, and dealing with complex issues. LCP resource nurses/champions 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. In the UK, a similar network nurse 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 the UK in 2009.

A project has recently begun within the Marie Curie Palliative Care Institute Liverpool to develop and evaluate an 'Educational Toolkit' for use with the LCP. The planned 'action research' based project will develop a variety of learning resources, both lecture format and more informal teaching approaches to support medical and nursing colleagues in their use of the LCP and includes more information on the UK Network Nurse Programme.

The National LCP Office NZ can provide support and advice with regard to a variety of teaching approaches and will work with the LCP Central Team UK to adapt any teaching resources from the 'Educational Toolkit' that are appropriate for the NZ context.

The LCP 'Reflective Data Cycle' (RDC) is a continuous quality improvement tool that was developed by Amanda Taylor as an LCP Facilitator working for Arohau Hospice in 2007. The RDC enables locally driven continuous quality improvement for the dying and their families/whānau and is available on request from the National LCP Office NZ. RDC data entry is based on the goals of care in the LCP and requires administrative support. The analysed data enables the information gathered to be fed back to staff locally, which in turn informs the ongoing training needs of staff.

One of the National LCP Office NZ future projects is to develop a system that will enable national benchmarking for the care of dying patients and their families/whānau based on the data collected locally across care settings using the RDC.

There is a National MCPCIL Conference held annually which provides an effective forum not only for clinicians to keep up to date with developments, but to disseminate work that they may be undertaking locally themselves.

☉ To access more information about the 'Reflective Data Cycle' and LCP champion/resource nurse role go to the [National LCP Office NZ Website – www.lcpnz.org.nz](http://www.lcpnz.org.nz) ☉

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

- **Ongoing sustainable education and support programmes need establishing within the organisation in support of the LCP to continue to embed the LCP framework within the culture of an organisation / Institution.**

Passing on specialist skills and knowledge to generic healthcare workers for further dissemination directly into the clinical environment is a valuable mechanism in the spread and sustainability of the LCP framework. It is vital, however, that such clinicians are able to develop skills that will allow them to facilitate the work of others. This means that they will need to be updated regularly in all aspects of palliative care and end of life care, but most importantly in current developments relating to the LCP.

The organisation, with the support of Specialist Palliative Care Service and existing educational leads, need to coordinate ongoing LCP education appropriate for the clinical staff within the organisation in support of improving knowledge and skills in the delivery of end of life care, with the role of the specialist service clearly defined.

A project has recently begun within the Marie Curie Palliative Care Institute Liverpool to develop and evaluate an 'Educational Toolkit' for use with the LCP. The planned 'action research' based project will develop a variety of learning resources, both lecture format and more informal teaching approaches to support medical and nursing colleagues in their use of the LCP and includes more information on sustainability models.

The National LCP Office NZ can provide support and advice with regard to a variety of teaching approaches and LCP sustainability, and will work with the LCP Central Team UK to adapt any resources from the 'Educational Toolkit' that are appropriate for the NZ context.

Phase 4 : SUSTAINABILITY

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

- **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**

One of the major challenges to organisations using the LCP framework is to find ways to spread and sustain the use of the LCP beyond the initial implementation phase.

A project has recently begun within the Marie Curie Palliative Care Institute to develop and evaluate an 'Educational Toolkit' for use with the LCP. The planned 'action research' based project will develop a variety of learning resources, both lecture format and more informal teaching approaches to support medical and nursing colleagues in their use of the LCP and includes more information on sustainability models. The development of the toolkit and the LCP Resource Nurse Programme (see Step 8) will undoubtedly be important elements in this regard, but equally vital is the timely feedback of data on progress both to clinical staff working with the document, staff responsible for the delivery of education and to organisational managers who have responsibility for the allocation of scarce resources.

The National LCP Office NZ can provide support and advice with regard to a variety of teaching approaches and LCP sustainability, and will work with the LCP Central Team UK to adapt any resources from the 'Educational Toolkit' that are appropriate for the NZ context.

The structure of the LCP makes it relatively easy to audit and, through the use of the LCP 'Reflective Data Cycle' (RDC), 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. One of the National LCP Office NZ future projects is to enable national benchmarking for the care of dying patients and their families/whānau based on the data collected locally across care settings using the RDC.

The first UK National Care of the Dying Audit – Hospitals (NCD AH) was undertaken by the MCPCIL and the Royal College of Physicians supported by Marie Curie Cancer Care & the Department of Health UK. This assessed the quality of care given to 2672 patients who died across 94 hospital trusts in 118 hospitals in 2006 / 07. The quality of care for each patient had been documented through the use of the LCP. Each hospital provided information on up to 30 patients. Over half of the patients reported did not have cancer.

The audit enabled 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 second round of this national audit commenced October 2008 and results are now available on the Marie Curie Palliative Care Institute website.

In NZ, a preliminary national documentation benchmarking exercise based on the contribution of anonymised retrospective Base Review and post-LCP implementation data from seven NZ residential care facilities, six NZ hospices and four NZ hospitals was undertaken in June 2009 which demonstrated the national audit capability of the LCP.

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Results / Reports from UK NCDHA Round 1 & 2

The aim of the NZ Palliative Care Strategy is to set in place a systematic and informed approach to the provision and funding of palliative care services through the implementation of the following vision:

All people who are dying and their family/whānau who could benefit from palliative care have timely access to quality palliative care services that are culturally appropriate and are provided in a coordinated way.

Minister of Health, 2001

The Draft Specialist Palliative Care Service Specifications (Feb 2008) recommend last days of life care programmes as a purchase unit “for people in whom death is expected within days rather than weeks regardless of setting”. This recognises that dedicated systematic approaches and pathways have a key role in improving end of life care. It is acknowledged that many dying people will never require direct specialist palliative care involvement. These programmes can be implemented across all settings. The role of the specialist palliative care service should be to:

1. Provide leadership and collaborate in the development of a District approach to end of life care.
2. Implement specific end of life care pathways within specialist palliative care inpatient units.
3. Work collaboratively with generalist providers in order to implement these programmes in people’s homes, residential care facilities and public hospitals.
4. Support ongoing sustainability of last days of life programmes.”

The Specialist Service Specification was developed by a subgroup of the Palliative Care Cancer Treatment Working Party between 2006 – 2007.

“I personally support the use of the LCP to help ensure all dying patients receive quality care in the last days and hours of their lives. I consider the LCP model of care to be consistent with the Code of Health and Disability Services Consumers’ Rights.”

Ron Paterson – Health and Disability Commissioner
 June 2009.

LCP Version 12

The Version 11 document was reviewed and generic Version 12 was launched in the UK on November 25th 2009 at the National LCP Conference at the Royal Society of Medicine, London. The LCP NZ generic version 12 document was subsequently ratified by the MCPCIL LCP Central Team and made available for use in NZ from April 2010.

Care of the dying patient and their family/whānau can be supported effectively by either version of the LCP. The ethos of the LCP generic document has remained unchanged. However, based on the robust MCPCIL LCP Central Team's document review process, the National LCP Office and its governing body has accepted that NZ need to adopt LCP generic Version 12. Not to do so is considered detrimental in our long term interest considering the global quality tool which LCP is.

The National LCP Office actively encourages NZ organisations currently using LCP Version 11 to transition to LCP NZ generic Version 12.

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