September 2007

LIVERPOOL

Care Pathway

Promoting best practice for care of the dying

NEW ZEALAND NEWSLETTER

EDITORIAL

National Focus on LCP

If the NZ Symphony Orchestra were to play without a conductor, audience numbers would likely be reduced, with some perhaps going along out of interest to hear the resulting discord! The true value of LCP as a national and international benchmarking tool for improving end of life care will only be truly realized through a coordinated approach. This will ensure consistency of application and effective management of the data generated by a national roll-out.

At present there is some very positive activity around implementation of LCP across the country, but how much more could be achieved if there was effective support for these centres. Prevention of fragmentation and support for ongoing sustainability of the LCP are key issues in this regard.

Care pathways for the dying are now established within new National Specialist Palliative Care Service Specifications and indications from the Ministry of Health suggest these will soon be funded and promoted through Cancer Networks. This makes the need for some "conducting" at a national level more compelling.

One can imagine a National LCP Centre would run foundation training days, advise on regional roll-out project management and assist in trouble-shooting across the country. There would also be an increasing role for data monitoring and linking with Liverpool to allow international benchmarking and research. A National Centre would also have significant initial work to do in assisting with a national roll-out. Later the focus of the work would become more about sustaining the LCP model and co-ordinating the data set.

Dianne Boon (LCP Facilitator) with Folole Fai, Charge Nurse Ward 26, Palmerston North Hospital, where the LCP is currently being implemented.

There are several stakeholders very interested in LCP development, and they recognise to a greater or lesser extent the need for a National Centre. We hope that discussions with Hospice New Zealand, the Ministry of Health and other stakeholders will result in a strong model for New Zealand that can successfully promote and assist in monitoring this excellent tool for improving end of life care.

This newsletter has emphasised previously the role of specialist and generalist palliative care providers and the need for specialist providers to champion LCP in their area. A National Centre grounded in such a specialist unit may also provide the best model for national coordination. We hope that the next symphony will impress the whole audience!

Dr Simon Allan
Director of Palliative Care
AROHANUI HOSPICE

Commonly asked questions...

1. What is the cost to implementing the Liverpool Care Pathway?

There is currently no cost to register with Liverpool Central and for the baseline line audit work they do. Implementation itself will involve the cost of an LCP facilitator (or equivalent role) with administrative support. This cost will apply for the duration of the implementation phase only though some ongoing investment in sustainability measures, such as a regular audit cycle, should be considered as part of an organisations wider quality improvement programme.

In a similar way on going support for staff and facilities post implementation should not be forgotten though can be largely absorbed, as in the case of aged residential care for example, by the hospice community nursing team's work and education outreach. As with any quality improvement development there is a cost, though it has to be balanced with the benefits to be gained from introducing the LCP.

2. How long does implementation take?

As a general rule implementation will take around two months per site. This is very much a rule of thumb and will vary depending on the type of organisation and experience/preferences of the LCP Facilitator involved. In some cases implementing on two sites concurrently e.g. across two hospital wards, can work successfully and may not take the same time as if one implementation followed the other.

In thinking about the time involved it is important to factor in the preparation, the education and actual implementation phases and follow a set project plan. It is also important to factor in the unexpected, as care of patients and its associated challenges can impact on the best laid plans.

Recent Publications

1. Hugel H, Ellershaw J, Gambles M (2006) - *"Respiratory Tract Secretions in the Dying Patient: A comparison between Glycopyrronium and Hyoscine Hydrobromide."* Journal of Palliative Medicine. Vol. 9 (2) pp. 279-84.
2. Keane B, Taylor A, Clark J (2006) - *"Meeting the needs of patients in the last days of life."* Kai Tiaki Nursing New Zealand 13 (2): 12-14.
3. Matthews K, Gambles M, Ellershaw J, Brook L, Williams M, Hodgson A, Barber M (2006) - *"Developing the Liverpool Care Pathway for the Dying Child."* Paediatric Nursing 18 (1): 18-21.
4. Taylor A, Randall C (2006) - *"Process mapping: Enhancing the implementation of the Liverpool Care Pathway."* International Journal of Palliative Nursing 13 (4) 163-167.
5. Ellershaw J (2007) - *"Care of the dying: what a difference an LCP makes."* Palliative Medicine 21: 365-368.

Arohanui Hospice Service Trust • 1 Heretaunga Street • PO Box 5349 • Palmerston North • New Zealand
Ph + 64 6 356 6606 • Fax +64 6 355 0453 • lcp@arohanuihospice.org.nz • www.arohanuihospice.org.nz

Homecare LCP implementation in the Waikato

A home-based community LCP pilot is to commence in the Waikato this month. Believed to be a 'first' for New Zealand, the project represents a collaboration between general practice (via the MSO 'Pinnacle') and Hospice Waikato's home-care nursing team as a way to facilitate equitable access to quality, evidence-based end-of-life care for patients who choose to die at home. Pinnacle nominated GP's from Cambridge and Ngaruawahia to pilot the community LCP.

In preparation a base audit of the notes of patients known to the Hospice Waikato home-care team has been completed. In addition, Cambridge GP's were keen to have access to the LCP for their patients for whom "home" is an aged residential care facility. Consequently, three rest homes in Cambridge have completed LCP education and begun to use the 'rest home' version of the LCP.

Health Waikato's 2006-2010 regional LCP implementation plan forms the basis for LCP development in the DHB. It is a multi-tiered, semi-concurrent approach to dissemination that began in Waikato Hospital, followed by collaboration with GP's to support home-based care of the dying, and finally linking with rest homes and rural hospitals.

With two LCP facilitators, we are still finding that demand for the LCP is greater than the resource of our time. However, successfully engaging key stakeholders, securing the buy-in of senior medical and nursing staff and educating at least 80% of nursing staff/carers prior to implementation have been central to the success and sustainability of the LCP. The delivery of the Hospice NZ "carer package" and "sub-cut pump education" training modules has augmented LCP education.

Progress to date sees six inpatient wards in Waikato Hospital, covering 50% of the overall deaths in the hospital, now use the LCP. Of the 100 hospital LCP's used to-date, seven patients were taken off the LCP when discharged home or to a rest home facility at the request of family, most of who subsequently died within 2-4 days, and one at 21 days post-discharge. The success of the LCP has been evidenced by our pre- and post-implementation audits showing a marked improvement in the documentation of care; consultants from the pilot wards unanimously agreeing to continue using the LCP; doctors writing 'start on Liverpool Care Pathway' in the patient's clinical notes; doctors wanting to use the LCP for their 'outliers' (patients under their care who are in another ward); house surgeons asking to use the LCP when rotating wards; LCP's being used without the knowledge of the SPCT; LCP 'language' now embedded in the nursing culture of the wards using it; sustained monthly LCP Network Nurse Group meetings; and requests to be 'next in line' from other wards.

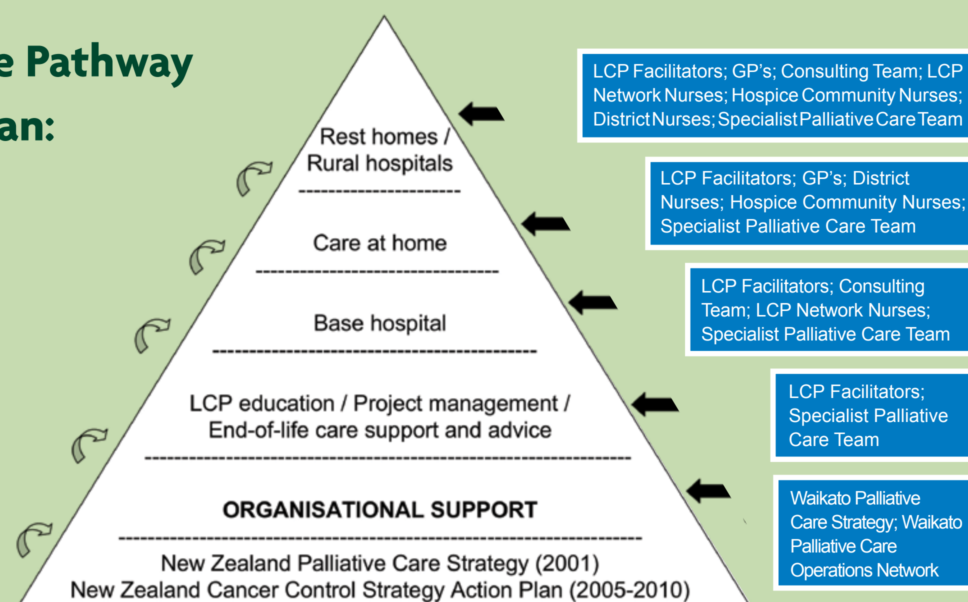
Thames Hospital is one of Health Waikato's four rural hospitals. We have gained the support of Thames hospital's senior medical and nursing staff to begin implementing the LCP in their hospital, with a base review audit due to be completed in the next few weeks and roll-out planned for late September. We believe this will be another 'first' for New Zealand.

Health Waikato are hosting the next National LCP Facilitators meeting on October 30, 2007 here in Hamilton. We would like to take this opportunity to congratulate and welcome Dianne Boon from Arohanui Hospice and look forward to meeting up with the group again.

Theresa Mackenzie
LCP Project Coordinator
Health Waikato

Jan Clark
LCP Community Liaison
Health Waikato

Waikato End of Life Pathway Implementation Plan: 2006 - 2010



The LCP: from a Charge Nurse perspective...

The LCP has changed the way we provide and meet the end of life needs for patients and their families. Staff feel more comfortable and empowered when nursing patients who are dying, using the LCP.

Ward 23 at Palmerston North Hospital is an 18 bed Oncology/Haematology Ward. When the LCP Facilitator and I began discussing the implementation of this initiative, it seemed a daunting task.

As any Charge Nurse will know, the thought of having to organise all your staff to attend two ½ hour education sessions is quite an undertaking. My initial fears however were soon alleviated by two factors. Firstly, the LCP Facilitator was extremely flexible, able to undertake the education sessions during the day, evening or night shifts.

This provided staff with the flexibility to attend the education sessions which suited them. Secondly, once the staff had attended the first education session, they could see the benefits of the LCP, and were keen to learn more about using and working with the pathway. Staff did not require encouragement to attend the second session.

> *The team as a whole understand the concepts behind the LCP therefore the patient and their family benefit.*

A positive part of the implementation was all of the ward team were included in the education. This encompassed the Ward Clerical Staff, Cleaner and Care Assistants. This has meant that patients on the LCP encounter a team approach.

As a Charge Nurse it is very encouraging to see the team working together, understanding each other's roles and valuing each team members role in providing end of life care for patients. At the time of implementation, Ward 23 had permanent night staff. In the past night staff have often found themselves in difficult situations, especially when in the middle of the night a dying patient's condition deteriorates.

In this situation there have often been times when issues have been left unaddressed by the medical team during the day. Some of these issues and questions are extremely difficult to answer in the middle of the night, especially when the medical staff are unfamiliar with the patient.

When a patient is on the LCP the night staff are confident that all these issues have been addressed. They are then able to concentrate on keeping the patient comfortable. This provides security for staff as they can focus on the patient and the family's needs.

As a Charge Nurse, it is reassuring to know that staff have the tools to provide quality patient centred end of life care. The LCP has been and continues to be a positive, empowering tool for staff.

Stephanie Parsons
Charge Nurse, Ward 23 (Oncology/Haematology)
Palmerston North Hospital

The LCP: from a Medical Registrar perspective...

Jenny Fernando
Medical Oncology Registrar
Palmerston North Hospital

As a Medical Oncology Registrar, I have found the LCP an invaluable tool for the management of our dying patients. It was often the case that in their last days our patients were still receiving medications or treatments which would not alter their outcome.

The LCP has allowed us to focus the care of these patients to palliative care, and helped to facilitate discussions between families and staff as to the appropriate time for such a change. This has given us the opportunity to address end of life issues more effectively with patients and their families, giving both the chances to accept the inevitable outcome.

From a medical point of view I have found that the information in the pathway aids decision making in the choice of drugs in the syringe driver.

This has allowed me to feel more confident that I have considered all aspects of symptom control. It has also ensured that all relevant PRN medications have been prescribed. Before the introduction of the pathway this was frequently not done and as a result, patients could be waiting unnecessarily for these to be prescribed out of hours.

Looking at all the patients I have been involved in on the LCP I now have confidence that they have received optimal symptom control. I have found the LCP easy to use and of great assistance to both nursing and medical staff. Families involved also seemed to have greater peace of mind as they know their loved one is not suffering unnecessarily.

Overall the introduction of the LCP has provided a powerful new tool in the management of palliative care patients.