

## Te Omanga Hospice LCP Update

2008 is going to be a busy year at Te Omanga and Hutt Valley Health. The LCP was launched in the inpatient unit at Te Omanga last month with all staff educated in the use of the document. There were some excellent suggestions from staff for cues under each goal which has ensured smooth transition from old to new.

Hutt Valley DHB, in their strategic plan, are committed to introducing the LCP across all care settings over the next 2-3 years.

Meetings with aged residential care facility managers have shown increased interest to become involved in introducing this quality documentation of end-of-life care.

**Kate Gellatly**  
TE OMANGA HOSPICE

## LCP Information Day at Arohanui Hospice

The 'LCP Information Day' is a forum designed to enable health professionals to get an overview of the LCP implementation process in its entirety from others with hands-on experience of implementing the LCP in several NZ care settings. These included hospice, hospital and aged residential care.

A variety of topics were presented at the first of these days held on April 1, 2008. Including establishing an LCP Pilot Project, the Project Plan, and the role of the LCP Facilitator, through to sustainability

measures like identifying LCP Resource Nurses to champion the pathway post-implementation, and the use of the 'Reflective Data Cycle'. The feedback from the fifteen people who attended was very positive. Attendees appreciated the identification of multiple issues, including the challenges that can occur when implementing the LCP.

If you are interested in attending an 'LCP Information Day' at Arohanui Hospice, please contact: joanne.g@arohanuihospice.org.nz

## Commonly asked questions...

### 1. Can the LCP be adapted to commence earlier?

In a nutshell – no. The LCP has been specifically designed to guide the delivery of quality evidence-based end-of-life care, focusing on the last 24-48 hours of life. Maintaining the integrity of the LCP document is the commitment sought from international collaborating centres by the LCP Central Team in the UK when they release the LCP documentation.

It is important that health care professionals using the LCP are aware of the difference between 'palliative care' and 'terminal care', even though sometimes the transition to the last 24-48 hours of life is not always clear. The LCP was not designed with the intention of guiding the entire delivery of palliative care for people with life-limiting illness or old age.

### 2. Do we need a project team?

The purpose of the LCP Project Team is to establish a group of people from the specialist team aiming for an interdisciplinary approach. The prime purpose is the guardian of the vision. We want to ensure that the project plan is delivered with integrity. This requires a strategic approach with inter-professional collaboration

because we are moving across sectors and multi-disciplinary teams in a process of education and service delivery impacting people who are already using many other pathways.

For pathways to be established many people and several systems need to be influenced. This is why the characteristics of the team are very important, influencing culture change in fairly rigid and busy environments. Then we move to sustainability so the project team needs to continue to assert influence to maintain the integrity of the pathway and the culture changes made.

The foundation of the LCP is founded on the tool itself, the LCP Facilitator and the Project Team. The LCP Project Team at Arohanui meets fortnightly.

### Marie Curie Palliative Care Institute Liverpool Conference October 9, 2008:

- "Care of the Dying: Meeting the Challenge: A European Perspective".
- **Arena & Convention Centre – Liverpool, UK. Details on the website: [www.mcpcil.org.uk](http://www.mcpcil.org.uk)**

## Recent Publications

1. Ellershaw, J.E. (2007). Care of the dying: what a difference an LCP makes! *Palliative medicine*, 21: 365-368.
2. Specialist Palliative Care Tier Two Service Specification. Final draft released February 2008 (developed by a sub-group of the Palliative Care Working Party between Nov2006-Feb2008). For more information contact Nancy\_Harp@moh.govt.nz
3. UK National Care of the Dying Audit – Hospitals. Summary report 2006/2007. The Marie Curie Palliative Care Institute Liverpool (MCPCIL) in collaboration with the Royal College of Physicians. You can request a copy via the website: [www.mcpcil.org.uk](http://www.mcpcil.org.uk)
4. Veerbeek, L., van Zuylen, L., Swart, S.J., et al. (2008). The effect of the Liverpool Care Pathway for the dying: a multi-centre study. *Palliative medicine*, 22: 145-151.



Arohanui Hospice Service Trust • 1 Heretaunga Street • PO Box 5349 • Palmerston North • New Zealand  
Ph + 64 6 356 6606 • Fax +64 6 355 0453 • [theresam@arohanuihospice.org.nz](mailto:theresam@arohanuihospice.org.nz) • [www.arohanuihospice.org.nz](http://www.arohanuihospice.org.nz)



# LIVERPOOL Care Pathway

Promoting best practice for care of the dying

## NEW ZEALAND NEWSLETTER

## EDITORIAL

### International LCP Collaboration in New Zealand!

European Union Grant and New Zealand involvement

The Liverpool Marie Curie Palliative Care Institute has been successful in organising a consortium for a European union grant around optimising research for the care of cancer patients in the last days of life. The consortium is mainly European union countries but also includes Argentina and New Zealand as partners. This is a three year project to identify existing research areas and direction for further research in 5 work packages. At the end of three years, the project will define the relevant streamlining of ongoing research for these areas.

The work packages are signs and symptoms of approaching death, end of life decisions, complementary comfort care, physiological and psycho-social support to patients, families and caregivers and voluntary service. These will be considered in relation to the intersecting themes of needs assessment, quality indicators, technologies and methodologies. The Delphi process will be utilised within and outside the collaboration to supplement findings of the systematic review by establishing expert opinion regarding knowledge in each of the work packages. Engaging with palliative care colleagues regarding expert opinion in New Zealand will be our main role.

Having a partnership link into this European collaborative project provides an important international link for the New Zealand Palliative Care community. It is anticipated that opportunities will arise which will stimulate research interest and be beneficial for developments nationally and internationally.

We are excited by this opportunity and hope to share the progress and information gathered from this project as the three years unfold.



Photo of LCP National Facilitators Group who met in Nelson, May 2008

L to R Front Row: Elizabeth McKenzie (Invercargill); Jan Clarke (Waikato); Carron Roberts (Wanganui); Theresa Mackenzie (Arohanui Hospice); Yvonne Gibb (Cranford); Bobby Davidson (West Coast); Karen Campbell (Golden Bay); Jacqui Bowden-Tucker (Marlborough); Joanne Giesen (Arohanui Hospice).

L to R Back Row: Dianne Boon (Arohanui Hospice); Faye Gillies (Timaru); Lucy Meldrum (Auckland); Kate Gellatly (Te Omanga); Jane Heather (Nelson).

To join the LCP National Facilitators Group, you must be in a dedicated LCP Facilitator role or have a mandate to implement the LCP as part of your role. For more information contact [theresam@arohanuihospice.org.nz](mailto:theresam@arohanuihospice.org.nz)

It will be important to form a network of people who are happy to assist with this process of information and opinion gathering. Jean Clark RN, PhD, and Simon Allan, MD will be the two main contact points for the international work in progress and will be seeking help from around the country as the projects unfold.

**Dr Simon Allan**  
Director of Palliative Care  
AROHANUI HOSPICE

# “Making a difference to families”

## - using the LCP in real time practice

I work in a non-malignant care setting in an acute care hospital where we recently introduced the Liverpool Care Pathway (LCP). Often because of age, multiple co-morbidities, advances in medical and surgical interventions and multiple similar admissions, predicting the dying phase in patients with end-stage non-malignant disease is difficult.

One Sunday afternoon my nursing colleague was caring for a patient entering the terminal phase after years of hospital admissions with non-malignant disease. The patient, his wife, doctors and the nurse agreed that he was dying and active treatment was withdrawn. The doctor commenced the LCP and prescribed medications for the management of end-of-life symptoms to ensure the patients physical comfort.

Rather than complete the LCP initial assessment with the patient and his wife, my nursing colleague thought it would be less intrusive to copy this information from the nursing assessment that had been completed during the patient's previous admissions. I pointed out to my colleague that the focus of the nursing assessment on admission is on best health outcomes and discharge planning, whereas the religious beliefs, cultural beliefs, social history and psychological needs of a dying patient have a completely different focus.

On seeing this distinction, my colleague completed the initial assessment in the LCP with the patient and his wife. My colleague discovered that this was the patient's second marriage, and that he had children from his previous marriage that he had not seen for a year. He had been in hospital many times and had only ever identified his current wife as next-of-kin. My colleague asked if he and his wife would like her to contact his children, to which they readily agreed.

The patient's children were able to spend four precious hours with their father before he passed away. The prompts in the LCP initial assessment enabled my colleague to identify who the patient wanted contacted regarding his impending death and enabled him to be surrounded by those he loved and those who loved him. We only have 'one chance to get it right' (Lloyd-Williams, Shah & Baker, 2007) for our dying patients.

**Debi Gregory**  
Registered Nurse  
MidCentral Health

### References:

Ellershaw, J., & Ward, C. (2003) - Care of the dying patient: the last hours or days of life. *BMJ*, 326, pp.30-34. Lloyd-Williams, M., Shah, S., & Baker, I. (2007) - Only one chance to get it right: End of life care. *BMJ*.

# Feel the fear and do it anyway!

## Reflective Data Cycle - Cranford Hospice

**After some considerable procrastination the LCP team at Cranford Hospice completed our first Reflective Data Cycle, including a presentation to staff.**

We are happy to report that the whole process was a lot less painful and a lot more enlightening than we had first anticipated. The hard yards of entering all the data onto spreadsheets were rewarded by the ease with which we were able to tabulate the figures, and explore any query that took our fancy. The presentation of results was an interactive session, including feedback regarding practical issues and the exploration of areas of interest as we 'crunched the numbers'. A case presentation was included to remind us all of the real people behind data.

Some insights we gained included quantifying the increase in the percentage of patients who died using the LCP since the previous year (77% v. 71% respectively); less patients on the LCP with non-cancer diagnoses compared to overall hospice referral with a cancer diagnosis; staff interpretation of differences between the 'not applicable' and 'comatose' options; and identification of the most

frequently missed goals; the 'Medication given' and 'Bereavement leaflet given' goals. The later generated a discussion about the complexity of caring for families during the bereavement period.

Another area of interest for our hospice was 'not for resuscitation' (NFR) and advance directives, discussions/documentation. We noted a reluctance to include dyspnoea as an additional symptom, so a case study was used to illustrate this issue. We identified several areas for education and project work such as new prompts in the 'Initial Nursing Assessment' and the 'Medical Assessment' to remind us about NFR and advance directives and the need for more education opportunities to develop communication skills.

The contributions from staff during the feedback session were a highlight of the process and the ensuing discussions have generated a number of changes to our practice.

**Dr Lynn Twigley**  
Cranford Hospice  
HASTINGS

## Working Alongside Aged Residential Care Facilities to Implement the LCP

Many opportunities to work alongside aged residential care (ARC) facilities to implement the LCP are beginning to emerge. One such opportunity has arisen with Ryman Healthcare Ltd who have taken the initiative in planning a nationwide roll-out of the LCP in all eighteen of their ARC facilities in NZ.

Ryman Healthcare Ltd have responded to the New Zealand Palliative Care Strategy finding that "people already in a residential care setting who either develop a terminal illness or become terminal... are likely to stay in residential care and will need access to palliative care services" (Minister of Health, 2001, p.38).

The recent situation, publicized widely, about a resident's death in a Taumarunui ARC has highlighted the high level of need for specialist palliative care providers and ARC facilities to support each other and work collaboratively to ensure the delivery of best practice end-of-life care. The LCP is one of the tools that can be adapted in consultation with key stakeholders to meet the specific needs of residents dying in ARC facilities.

In the Waikato, following a discussion with Susan Bowness (Northern Regional Manager, Ryman Healthcare Ltd) at the end of May 2008, a review of the Ryman LCP document revealed several aspects requiring further consideration and attention to process, in particular the frequency of administration of medications and the recommended use of an antiemetic that reflects usual palliative care practice in NZ. In adapting the LCP as a national document, consideration of how the LCP interfaces with local and regional services is an important consideration. Ryman Healthcare Ltd are to be congratulated for recognizing the merit in the LCP to support the delivery of end of life care informed by palliative care best practice.

Their openness towards fostering closer working relationships with local generalist and specialist palliative care providers across NZ to ensure a systematic approach to the implementation of the LCP in a way that will ensure success and sustainability sets the bar for LCP in ARC facilities in NZ.

Key points to consider before attempting to use the LCP in practice are to establish a Project team and links with other organizations with experience implementing the LCP in NZ (so you are not re-inventing the wheel!), have a dedicated LCP Facilitator (part or full time), register your LCP Project with the LCP Central Team in the UK, establish support for the LCP from generalist and specialist palliative care providers and negotiate symptom management guidelines with them to ensure these reflect local practice. These are the building blocks that will ensure best use of your resources and the success and sustainability of your LCP Project.

If your generalist or specialist palliative care service is working alongside ARC facilities, the National LCP Facilitators Group is happy to provide information, advice and support. Contact can be made by emailing [theresam@arohanuihospice.org.nz](mailto:theresam@arohanuihospice.org.nz)

**Theresa Mackenzie**  
LCP Lead Facilitator  
AROHANUI HOSPICE, PALMERSTON NORTH

## Update of LCP progress in New Zealand.

