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Issue 5



LIVERPOOL

Care Pathway

Promoting best practice for care of the dying

## New Zealand NEWSLETTER

### Inside this issue:

International Leaders in Driving up Quality for Care of the Dying	1
NZ National LCP Facilitators Group is Growing!	2
Variance Reporting	3
Do IV antibiotics and the commencement of the LCP go together?	4
MCPCIL Conference 25 November 2009	4
Valuing Care Assistants in Caring for Dying in Residential	5
NZ LCP Site Distribution Map	5
Common Questions	6

## International Leaders in Driving Up Quality for Care of the Dying

The Liverpool Care Pathway for the Dying Patient (LCP) is an integrated care pathway that empowers and enables health care professionals to deliver evidence-based, best practice care to dying patients and their families/whanau in the last days and hours of life. The LCP is internationally recognized as a tool capable of driving up quality for care of the dying, irrespective of place of care or diagnosis, with 17 countries including New Zealand (NZ) now registered international collaborators.

NZ are leaders on the LCP world stage. In collaboration with the LCP Central Team (UK), we are the first country in the world (outside of the UK) to develop a National LCP Office to coordinate the sustainable implementation of the LCP across all care settings in our own country. This exciting new initiative began in earnest November 2008 with the appointment of a full time National LCP Lead and National LCP Office Administrator, a governance group and the host organization Arohanui Hospice (Palmerston North). Funding for the development of the National LCP Office was provided by the Ministry of Health (MoH). Feedback following submission of the first MoH quarterly report on this development has been positive: "Overall, the Ministry commends you on providing a fantastic service that has already made significant improvements in the quality and consistency of LCP provision in New Zealand". The latest NZ LCP Status Report compiled by the National LCP Office lists 17 hospice, 8 hospital, 63 residential care and 11 community care settings at various stages of LCP implementation. The most significant area of LCP uptake has been in residential care, with an 80% increase in registered LCP sites between July 2008 and March 2009.

In April 2009, Deborah Murphy (pictured on the left) Associate Director, Marie Curie Palliative Care Institute Liverpool; National Lead Nurse – LCP, UK accepted an invitation to co-facilitate the inaugural NZ Foundation and Advanced LCP Training days in Palmerston North and to meet with LCP Facilitators from across NZ, the National LCP Office Governance Group and Deborah Woodley (Manager–Cancer Services, MoH). Ms Murphy was extremely impressed by the enthusiasm and commitment to driving up quality for care of the dying in NZ from bedside to policy and fully endorsed the ongoing development of the NZ National LCP Office.

To learn more about the role and functions of the NZ National LCP Office and governance group: [www.arohanuihospice.org.nz](http://www.arohanuihospice.org.nz) >> Liverpool Care Pathway >> National Office, or contact Theresa Mackenzie, National LCP Lead [theresam@arohanuihospice.org.nz](mailto:theresam@arohanuihospice.org.nz).

Theresa Mackenzie RN, MN. National LCP Lead – NZ.



"Ode to Deborah"

*"There was a great lady from Liverpool  
Who's trip to NZ was a whirlpool  
But the knowledge she brought  
Gave us food for thought  
To ensure the LCP tool  
Goes with the best evidence rule"*

## NZ National LCP Facilitators Group is Growing!

On Wednesday 1<sup>st</sup> of April 2009 the New Zealand National LCP Facilitators Group bi-annual meeting was held at Arohanui Hospice. The purpose of the group is to promote a consistent approach to the LCP implementation in NZ and to ensure that LCP Facilitators have support and a chance to network with each other. Twenty four facilitators from different parts of NZ attended the meeting hosted by Steph Ash and Dianne Boon.

The meeting was very successful and coincided with Deborah Murphy's visit from LCP Central UK to attend the National Office LCP Advanced Training Day and Foundation Day held in Palmerston North on the 2<sup>nd</sup> and 3<sup>rd</sup> of April 2009.

The agenda for the National Facilitators Day was arranged to take advantage of Deborah's expertise and her position as Associate Director of the Marie Curie Palliative Care Institute Liverpool and National Lead Nurse LCP UK.

Deborah shared her LCP expertise and reminded us that 'success is a journey and not a destination'.

Deborah discussed the five key elements that provide a framework to the LCP. If problems arise it is often because of a problem in one of the areas. Understanding these key elements can help to clarify which area needs attention.

1. Clinical Decision Making
2. Management and Leadership
3. Learning and Teaching
4. Research and Development
5. Governance and Risk (data protection, ethical/legal decisions)



*NZ National LCP Facilitators Group with guest Deborah Murphy (centre front)*

In the afternoon we discussed current issues about the LCP identified by facilitators prior to the meeting. The broad themes included: barriers and challenges to the LCP; scope of practice; cultural safety; sustainability and document compliance.

Deborah's experience helped to clarify these issues. The group came up with strategies to address the issues and challenges.

Feedback from the facilitators has been very positive, everyone enjoyed meeting and listening to Deborah and gained valuable knowledge and support for their role.

The next meeting for the National LCP Facilitators group has been set for **12<sup>th</sup> November 2009**, West Plaza Hotel, Wellington. For more information, please contact National LCP Office.

*Di Boon & Steph Ash, LCP Facilitators, Arohanui Hospice*

## Variance Reporting

I recently attended the New Zealand National LCP Facilitators Group day at Arohanui Hospice. The guest speaker Deborah Murphy was an inspiration. She reinforced the aim of the pathway - to improve the care of the dying in the last hours/days of life. And explained it as a complex intervention rather than just a document or structure.

Then there were discussions about the 'VARIANCES'. Deborah reinforced that the 'Variance Sheet' tells the true story of the patient journey. A 'Variance' is not negative but highlights a clinical judgement for a moment in time that allows you to make an intervention and record an outcome. This promotes individualised patient care. We all understood that if you have written a NO against ANY GOAL this must be recorded on the 'Variance Sheet'. But the enlightening moment happened when she explained that in addition to the 'Variance' being recorded for 'that moment in time' at the 4 & 12 hourly assessment, other variances can be recorded at **ANY TIME** you notice: a **CHANGE**, any **ALTERATION**, and any **CONCERN**.

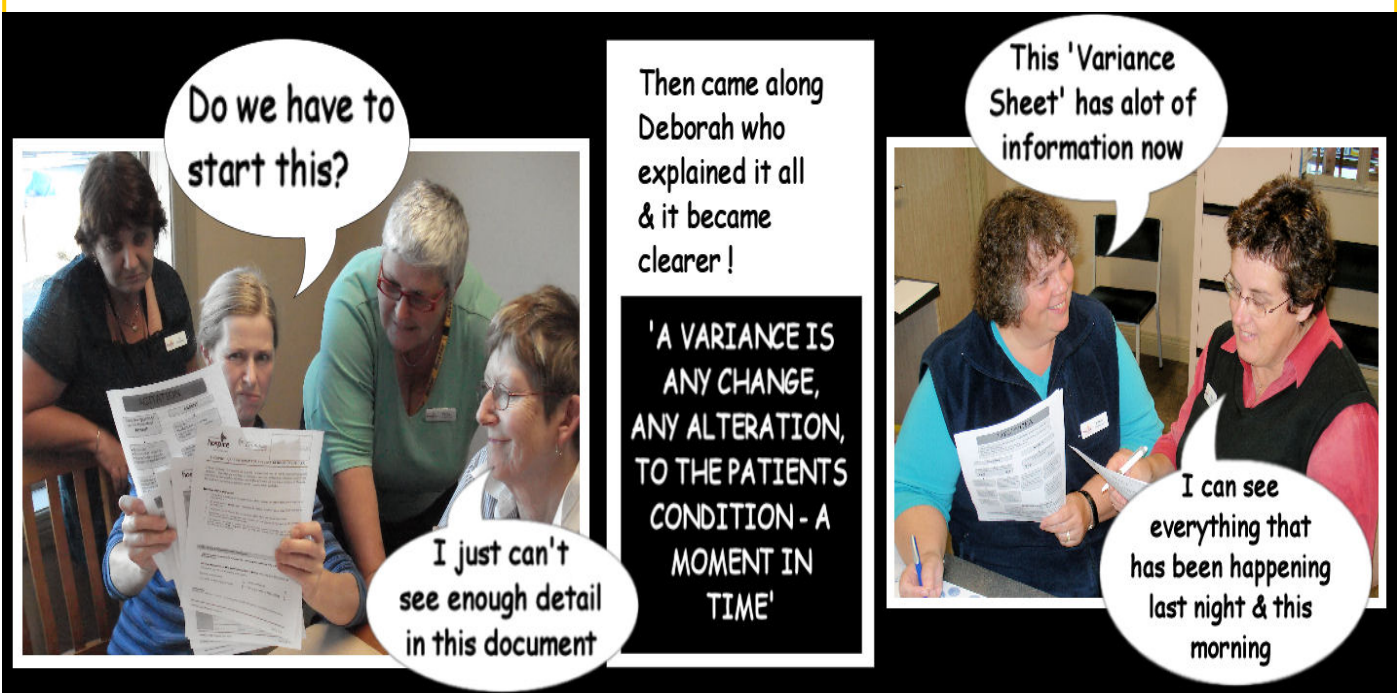
I returned to work and began explaining these revelations. Now the 'Variance Sheet' tells the true story of the patient journey because we are documenting more clearly:

- What variance occurred and why?
- The Action taken
- The Outcome

We are able to follow the patient's journey from the 'Initial Assessment' which includes the different aspects of their condition plus their psychological, spiritual and cultural care, and their family support. We are all feeling more positive about using the document. Sometimes there was a not so positive feeling about beginning the pathway and then trying to follow what has been happening with the patient and their family.

Thank you Deborah for helping us through this. I believe this can be another step we use in palliative care towards improving the quality of care in the last hours/days of life.

*Faye Gillies, LCP Facilitator, Hospice South Canterbury*



## Do IV antibiotics and the commencement of the LCP go together?

I went with a Palliative Care Consultant to one of the residential care facilities to see a Hospice patient who was in the facility for respite care, it was a Monday morning! We were informed by the clinical manager that Mrs M. had been up to the hospital's emergency department (ED) on Saturday as she had severe cellulitis in her right arm and she needed intravenous (IV) antibiotics. Whilst in the ED she was commenced on the IV antibiotics and also the Liverpool Care Pathway! This at first sounded a bit of a conundrum. Mrs M had a glioblastoma multi-forme as her primary diagnosis and she was in the care facility as it was becoming increasingly difficult for her family to care for her. She had developed the cellulitis on the Friday and the GP was asked to come to the facility on the Friday to see his patient which did not occur. On the Saturday the pain in Mrs M's arm was extreme and she needed to be seen by a doctor and as there is no GP cover over the weekend she needed to be seen in ED, and the necessary treatment to relieve that pain was IV antibiotics.

The medical personnel in the emergency department had obviously used the LCP on the wards; it has not currently been taken into the ED! He felt that Mrs M was beginning the dying process and it was very appropriate to begin the LCP, and the fact that she needed the IV antibiotics to reduce the pain in her arm, it was totally appropriate to commence the antibiotics, as the LCP is a framework to maintain someone's comfort at the end of life. The doctor completed goals 1-3 and then photocopied the pathway and sent it back to the facility with Mrs M. All the anticipatory prescribing was also completed.

When we saw Mrs M on the Monday was looking very comfortable and the District Nurses were continuing the IV antibiotics for the 5 day course that she was charted, as the nurses in the facility were not IV certificated. The staff in the facility were very comfortable that Mrs M was on the pathway and her family were with her also. She died 5 days after commencing the pathway.

There was a great deal of discussion as to whether it was appropriate to start IV antibiotics and the pathway at the same time. I feel that it was totally appropriate as the antibiotics assisted with her comfort and that everything was put in place for Mrs M, her family and the staff.

*Jan Clark, Waikato DHB*

## MCPCIL Conference- 25th November 2009



The MCPCIL Conference 2009 is on

**Wednesday 25th November 2009**

at Royal Society of Medicine, London UK

For more information click on the link below:

<http://www.mcpcil.org.uk/education/conferences>

## Valuing Care Assistants in caring for the dying in residential care

There has been much discussion among LCP Facilitators and Residential Care Facility staff in NZ about the role of healthcare assistants when caring for a dying resident who has been diagnosed as dying and commenced on an LCP. In NZ it would appear that the majority of the workforce in the Residential Care sector are unregulated healthcare assistants. Ensuring that the contribution of healthcare assistants in the care of dying residents and their families/whanau is recognized, valued and visible when the LCP has been initiated to guide the delivery of evidence-based care in the last days and hours of life is essential. A clear aim of the LCP is to improve communication and team working.

The Nursing Council of NZ “Guideline: direction and delegation” (June, 2008) were written to regulate nursing practice and protect public safety. In the guideline, an unregulated healthcare worker is described as someone who “works under the delegation and direction of an RN in the performance of health care activities... (and)... contributes to the delivery and reporting on of health care and personal care” (p. 26). Healthcare assistants must be included in multidisciplinary team discussions when diagnosing dying and planning the care of a dying resident, and the Registered Nurse (RN) in charge is encouraged to ask the healthcare assistant what care they have provided, and how they have found the dying resident and their family/whanau each shift prior to the RN documenting the ongoing assessment in the LCP. Care assistants are able to document in the ‘multidisciplinary notes’ section in the LCP if they wish.

The “Guideline: direction and delegation” (June, 2008) states: “A RN must be involved with the client when the client’s responses are less predictable or changing, and/or the client needs frequent assessment, care planning and evaluation” (p. 18). When a resident has been diagnosed as dying and commenced on an LCP – this is a change, the resident’s responses may be less predictable and they will require frequent assessment, care planning and evaluation. However, this does not preclude healthcare assistants from remaining involved in the care of dying residents and their families/whanau.

We must remember that the LCP is not the answer to the challenge of care for the dying in residential care in NZ, but a step in the right direction and that we must ensure that we value the contribution of healthcare assistants, whilst not expecting them to function beyond their education or competence.

*Theresa Mackenzie RN, MN. National LCP Lead – NZ.*

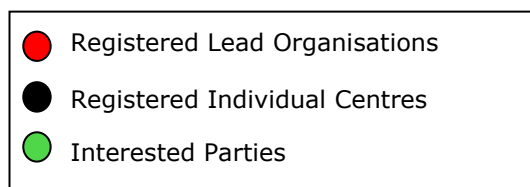
## NZ LCP Site Distribution (as of May 2009)

This map indicates the dissemination of the LCP across care settings in New Zealand as of May 2009.

‘Registered Lead Organisations’ (red dots) are where there is an organisation with associated other facilities/sites listed as “additional sites” under their LCP project. Currently the number of additional sites for Registered Lead Organisations in NZ ranges from 3 to 26.

‘Registered Individual Centres’ (black dots) indicate stand-alone sites.

‘Interested Parties’ (green dots) indicate organisations who have contacted the National LCP Office - NZ requesting LCP project advice, but have yet to formally register an LCP project.



## Common Questions

### Is the term 'LCP' another euphemism for dying?

Those using the LCP must take care that the term 'LCP' does not become another euphemism for dying. Reporting that a patient is "on the LCP" and has had "two variances" does not tell the patient story. Using 'LCP' language has reportedly provided some staff with a safe way to articulate their thoughts that a change in the plan of care may be appropriate, but it doesn't let members of the multidisciplinary team know what has changed for this patient that may indicate they are now in the last days or hours of life. Neither will using the term 'LCP' with families/whanau let them know what has changed for the patient that may indicate they are now in the last days or hours of life.

Equally, reporting that a dying patient on the LCP has had "two variances" does not relay which end-of-life symptom(s) have required an intervention and why, or whether the intervention made a difference to the patients physical, emotional, spiritual and/or cultural comfort. Language is important. As health care professionals, we need to encourage the use of open, clear, honest communication about dying and death, and avoid using the term 'LCP' as a euphemism for the dying patient's reality.

### Does the LCP 'dumb down' specialist palliative care?

There is a debate surfacing that use of the LCP 'dumbs down' specialist palliative care and that the LCP is akin to tick-box medicine. These concerns need to be made explicit to encourage discussion. Although the LCP is a standardized tool, practitioners are free to exercise their own professional judgment regardless of whether they are a specialist or generalist palliative care provider.

Every 'Goal of Care' in the LCP requires the health care professional to make a considered decision before indicating whether the 'goal of care' has been met. The health care professional then has the opportunity to document the rationale for any decision that differs from the evidence-based recommended best practice that underpins the document. Indicating a 'no' or a 'variance' should never be interpreted as a failure to provide best care. Rather, these should be viewed as they were initially intended by the authors of the LCP document i.e. a way of utilizing the LCP framework to make explicit the individualisation of every dying patient's plan of care and journey in the last days and hours of life.

The 'dumbing down' of specialist palliative care by using the LCP is an interesting debate. In my experience of auditing LCPs from all care settings, specialist and generalist palliative care knowledge and skill are visible in the language that health care professionals use to document what variance occurred and why, the action taken and the outcome of the care or intervention. The documentation of important events not captured in the 'Goals of Care' and/or conversations that occur in the last days and hours of life are able to be documented on the 'multidisciplinary notes' page of the LCP.

The value of the LCP as an 'aide-memoir' to ensure consistency and its use as a teaching tool for new staff in specialist palliative care settings have been recognized (Ellershaw, 2007), alongside the measurable outcomes of care that facilitate audit and benchmarking that enable specialist palliative care settings to demonstrate they are delivering the care they claim to be. We must remember that as a tool, the LCP is only as good as those using it and that first and foremost the documented care should reflect the journey of the dying patient and their family/whanau.

Ellershaw, J.E. (2007). Care of the dying: what a difference an LCP makes! *Palliative medicine*, 21: 365-368.

Theresa Mackenzie RN MN, National LCP Lead – NZ.