Health Scrutiny and Performance Panel

Agenda
Item No. 9

24 JANUARY 2012

Liverpool Care Pathway

Ward(s) All

Portfolios: Cllr B. McCracken – Social Care and Health

Report:

- The Liverpool Care Pathway (LCP) addresses quality care provision within NICE guidance, End of Life Care Strategy, and End of Life Care Programme Routes to Success recommendations.
- The Liverpool Care Pathway (LCP) is recognised as best practice nationally and its continued use is supported within the paper
- There is a need to address the continual educational requirements of the workforce across the organisation to improve quality of care, communication and decision making in end of life care.
- Robust governance processes will be put in place in order to provide the Board with continued assurance
- This report aims to give an overview of End of Life Care drivers nationally and the Liverpool Care Pathways position within this, Additionally it will outline current Specialist Provision across the organisation and present recent audit data from the Acute Hospital setting for information.

Recommendations:

That: *Panel members note and debate the content of the report*

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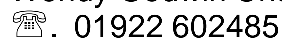
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Introduction

The Liverpool Care Pathway (LCP) was a joint venture between Liverpool University Hospital and Marie Curie Cancer care and was developed in 1990s. It is a nationally adopted integrated care pathway aimed at patients who are estimated to be in the last 48 to 72 hours of life.

The Pathway (LCP) addresses quality care provision within National Institute of Care and Excellence (NICE) guidance, End of Life Care Strategy, and the End of Life Care Programme. NICE guidelines recognise that in order to ensure best practice managed systems need to be in place. The pathway is recognised as best practice nationally

THE LCP was initially implemented at Walsall Manor Hospital in 2005, during which time a facilitator was employed for 12 months to roll out the pathway to all wards in the hospital.

The process adopted is based on the Clinical team who identify whether a patient's is no longer for any active treatment and when they have confirmed that their condition is terminal and deterioration is a natural part of dying process it is recommended that the LCP be commenced .Whilst it is identified that it is a Senior Doctor who instigates the pathway, the discussion is multi –disciplinary led allowing other professionals to contribute and ensure that families are kept informed at all times. It is important that families are provided with both verbal and written documentation regarding the pathway and what it entails.

The LCP is a robust process that ensures consistent evidence based care is given to the patient at the end of their life and support for their families both during and into the time of bereavement.

The Liverpool Care Pathway upholds the principles of best practice in palliative care in-

- Ensuring patient and family participation
- Collaborative multi-professional approach
- Use of appropriate medication for each individual patient to relieve symptoms
- Continuous regular assessment

Walsall Healthcare Trust currently uses the Liverpool Care Pathway as its framework for the care of patients at the end of their lives in both hospital and community services.

BACKGROUND

How we care for the dying is an indicator of how we care for our sick and vulnerable people and is a measure of society as a whole and a litmus test for health and social care services. The manner in which someone dies can also have a profound effect on those who are closest and impact on their health status in the future.

At the beginning of the 20th Century a majority of the deaths in the United Kingdom took place in the community. Currently we have a very different picture. Around half a million people die in England each year, of whom, almost two thirds are aged over 75. The majority of deaths at the start of the 21st Century follow a period of chronic illness such as heart disease, cancer, stroke, chronic respiratory disease, neurological disease or dementia.

The tables provide some of the most recent information on the patterns of mortality for the borough of Walsall.

Table 1**: Cause of Death by Disease Group in Walsall 2007-2009**

	Regional Figure	**Local Figure**
Cancer Deaths (underlying)	27.9%	27.4%
Cardiovascular (Deaths (underlying)	29.7%	30.5%
Respiratory Deaths	13.9%	15.4%
Other Disease	28.5%	26.7%
Total Deaths	100%	100%

N.B The Regional comparative is data relating to the West Midlands.

Table 2: **Place of Death in Walsall grouped by location 2007-2009**

	Regional Figure	**Local Figure**
Hospital	58.3%	64.2%
Own Home	20.1%	21.2%
Residential Home	6.0%	3.7%
Nursing Home	9.2%	7.2%
Hospice	4.6%	1.9%
Elsewhere	1.8%	1.8%

Total	100%	100%

Source: National End of Life Intelligence Network data 2007-2009

These figures show that the cause of death by group in Walsall is very similar to those regionally.
National figures for place of death still reflect that most deaths (58%) occur in NHS Hospitals, with around 18% occurring at home, 17% in Care Homes, 4% in hospices and 3% elsewhere (End of Life Care Strategy 2008).

As has been reported previously, the data shows that the borough of Walsall has above national and regional average percentages for the proportion of deaths taking place in hospital but a lower than average proportion of deaths in residential and nursing homes and in hospice. Some of this may be attributed to improving evidence in relation to home deaths particularly in cancer patients but there is also evidence that nursing and residential homes are admitting patients possibly at the end of life and failing to recognise and prepare for the final phase of care. The figures for Hospice deaths may also change in the forthcoming years following the opening of a 12 bedded facility for Walsall Residents in April 2011 at Goscote Palliative Care Centre.

CURRENT SERVICES

Walsall Healthcare provides a wide range of specialist palliative care services for our patients.
Walsall Healthcare Community Services have received significant investment in the last three years as part of the Walsall Palliative and End of Life Care Strategy and have a wide range of Specialist Services including:

- a Specialist Palliative Care Team
- Day Hospice Facility
- Lymphoedema Service,
- Therapies Team
- Bereavement Service
- Patient Information and Complementary Therapy Service

Within the hospital setting there is a smaller Team of Specialist Nurses with links to Physiotherapy and Occupational Therapy. Both Teams are supported by a variety of arrangements with Both Compton Hospice and St Giles for their Consultant medical cover.

The new Palliative Care Centre in Goscote provides a base for the Trust's community services as well as housing a 12 bed inpatient facility for palliative care patients operated by St Giles Hospice.
NHS Walsall has also identified palliative care services as one of the second wave of priorities for the development of integrated pathways across hospital and community services as part of the Pioneer Pathway programme of work.

TRUST APPROACH

There is however more work to do to ensure that we have a fully "whole system" approach to End of Life Care (EoLC) within the borough. In particular it is necessary to develop improved discharge arrangements and better co-ordination of care with a range of community services to enable more people to die at the place of their choice whilst crucially for those who will remain in hospital ensuring they have a "good death". Although some people do achieve all their personal wishes at the end of life many do not and still experience unnecessary pain and symptoms at this time in their life.
Delivering End of Life Care for clinicians who have not chosen it as their specialism can be difficult, particularly within an acute hospital setting that is focused around treatment and does not necessarily provide the environment that patients and family require at this time. Although Hospice and Specialist Palliative Care Services have been delivering excellent care they are small in numbers and could not possibly meet all the needs of patients that may be dying across a health economy. Given that we have an aging population and a relatively small specialist resource, it is important that all staff are equipped with end of life competency and that pathways of evidenced based care are in place to support good practice. This will then ensure that there is equity of access for all patients with end of life needs.
The overall approach to palliative and end of life care should therefore be based on:

- developing services that enable us to maximise the numbers of patients at the end of their lives able to die in the place of their choice;

- ensuring that we have available a range of specialist palliative care end of life care service in both hospital and community;

- developing integrated pathways between our hospital and community services for people at the end of their lives;

- ensuring that all relevant staff whether in specialist palliative care team or not have the competencies and tools to provide good end of life care for their patients.

THE LIVERPOOL CARE PATHWAY

The use of the Liverpool Care Pathway (LCP) in both hospital and community services should therefore be seen in the context of this overall approach to palliative and end of life care. Although it should not be seen as the sole solution in providing good end of life care, it can provide the framework to assist in decision making and clinical care at this time. In many ways the quality of a person's death and final hours is determined by the actions taken by the coordinating team prior to the dying phase. However, a fundamental element in this final phase of life is the Team's decisions, in consultation with the patient (where-ever possible) and their carer's to use a recognised final days and hours" pathway to ensure that appropriate standards of care are delivered.

The Liverpool Care Pathway was developed by the Royal Liverpool University Trust and Marie Curie Liverpool in the 1990's. It provides a comprehensive template of appropriate, evidence-based and multi-disciplinary care for the last days and hours of life, to improve the focus of care for dying patients and their families (Ellershaw, 2007).The LCP was developed to help transfer best practice in caring for the dying from hospices into other care settings such as acute hospitals and address the issues of empowering non-specialist palliative care practitioners to deliver good end of life care. The LCP promotes quality and high standards of care for patients and enables them to die a dignified death in their place of choice. It was recognised that not all patients who die in hospitals have contact with specialist palliative care teams (Kinder and Ellershaw, 2003). Therefore the LCP was developed to empower generalist healthcare professionals in hospital and community settings to care for dying patients and follow best practice. It highlights the importance of comfort measures, anticipatory prescribing of medication and discontinuation of inappropriate interventions which may be futile. The pathway has three sections; initial assessment; ongoing care and care after death. However, patients can only benefit from such pathways if clinicians are able to recognise those patients that are dying and feel confident to 'diagnose' it (Edmonds & Rogers, 2003).

Implementation of LCP Locally

Between 2005 and 2007 Walsall Acute Hospitals received Liverpool Care Pathway facilitation support from what was then the Black Country Palliative Care Network. At the time of conclusion of the project 12 wards within the hospital were fully trained and medical support had been gained to use the document. The Hospital Palliative Care Team has maintained support for pathway education alongside their busy caseload and the Trust's Palliative Care Medical Consultant has offered education sessions to medical staff. There has also been very evident commissioning intent demonstrated to both previous organisations in the last two years with different CQUIN schemes being implemented to continuously demonstrate use of the framework. Within the hospital the Trust uses version 11 of the pathway. Within the community version 12 which amongst other amendments provides for more regular

review of the decision to retain a patient on the pathway is in use in our community services.
It is recognised, however, that concerns have been raised with the Trust about the way the LCP has been used in some cases. These concerns have been raised through individual patient complaints, members of the public attending Trust Board and some members of the MyNHS Walsall Parliament. The complaints often identify issues of communication with patients and their relatives or carers in the use of the pathway.
Both Hospital and Community settings have conducted audits around the use of the LCP this year. The hospital is in its third year of participating in the Acute Care National Audit of Dying Patients and the results of this and benchmarking nationally will not be available later this year. Therefore a summary of findings and some of the methodology are presented within this paper. For the Community Service the audit was concluded at the end of August and the results are not yet available for comment.

Aims of the Audit

While it was recognised that it is not possible to anticipate every death. The audit aimed to:

- identify the deaths that were recognised by medical staff according to the information recorded in the notes
- the relevance of the use of Liverpool Care Pathway (LCP) in patients identified to be dying
- the number of patients in which the Liverpool Care Pathway was implemented
- the number of patients overall who could have been on the Liverpool Care Pathway

Method

This audit was conducted in conjunction with the national care of the dying audit. It is a retrospective audit looking at the patient deaths within the Trust from the period of the 1st April 2011 until the 30th June 2011. The audit was carried out by the Hospital Palliative Care Team. Multi-professional case notes (those that we were able to access) of all deaths on all the adult wards within this 3 month period were audited. Notes were collected by the cancer team and were screened by the Palliative Care Nurse Specialists and the Lead Cancer Nurse. Medical and nursing notes as well as drug and observation charts were also reviewed against the guidelines set out by the Liverpool Care Pathway.

Main Audit Findings

There were a total of 292 deaths within the hospital within the period of 1st April- 30th June 2011. It was only possible to audit 141 of these case notes as these were the only ones accessible during this period.

- **Recognition of dying**
  - Entries within the multi professional notes suggested that 75 patients were recognised to be dying by medical staff, using terms such as 'for best supportive care' and 'for tender loving care' (TLC).
- **Use of Liverpool Care Pathway (LCP)**
  - Of the 75 patients recognised to be in the dying phase, 70 patients were eligible to be commenced on the LCP. The remaining patient was not suitable for the LCP due to sudden deterioration in their condition and imminent death. Therefore the LCP would not have had time to have been beneficial to quality of care.
  - Out of the 141 sets of notes audited, 70 patients were suitable to be commenced on the LCP. This judgement was made by studying the documentation of the multi-professional team caring for the patient, in conjunction with the criteria suggested to help diagnose dying within the LCP
  - Out of the 75 patients identified to be dying by the multi professional staff, only 26 patients were actually commenced on the LCP.
  - Out of the 70 patients who were deemed suitable for the LCP only 26 patients were commenced on this pathway
  - 1 patient was placed on the End of Life bundle which is used in the intensive care unit (ITU)
  - Retrospectively reviewing the case notes of the 26 patients commenced on the LCP, it appears that this assessment tool was used appropriately.
    - The audit did not identify any patients who had been placed on the LCP inappropriately.
- **Areas of Concern**
    - Poor documentation in general in the notes, often written with no logical sequence
    - The LCP documentation was often not completed fully and the quality of the documentation was poor
    - A lot of notes were not filed appropriately

- The use of the LCP within the trust was poor when comparing to the number of patients that we identified who were appropriate for the LCP. This signifies a significant underuse within the trust.

The Community Study has viewed a random sample of thirty sets of notes from District Nursing Service, Nursing Home and Specialist Palliative Care Team and audited against identified standards. This does contain elements of the acute hospital audit of dying proforma but other standards within the current community policy. For example evidence of advanced care in place, do not attempt resuscitation decisions, evidence of multi-professional discussions and decisions between nursing and medical staff and frequency of reassessments. The audit is completed but no data analysis has been conducted at the time of this report.

Next Steps following the audit

The Trust's use of the LCP as part of our overall approach to providing palliative and end of life care has been considered in the light of the issues raised by some patients and members of the public, the outcome of the audit reported above and the views of the Trust's senior clinical team (at Trust Management Group).

1. Recommend the continued use of the Liverpool Care Pathway within Walsall Healthcare as it is a nationally best practice tool.
2. As agreed at the End of Life Steering Group (April 2011) the acute care setting should adopt version 12 of the Liverpool Care Pathway so that there is parity within the organisation as a whole.
3. Develop and implement an agreed organisational clinical policy for the use of the Liverpool Care Pathway. This should include a review of whether any elements of the framework of documentation should be adapted for local use.
4. Agree a monitoring and governance structure for the organisation to assure continuous audit and improvement is maintained.
5. The Trust should develop an action plan in response to the awaited National Care of the Dying Audit this year findings to ensure good compliance with the tool.
6. The organisation progresses towards core competencies for End of Life Care that are mandatory for all clinical staff and that this is monitored for compliance.
7. A separate audit is conducted of bereaved relatives who have raised concerns about end of life care across the organisation for lessons learnt and care improved.

8. Agree a plan for increasing capacity to provide education in end of life care to as many staff as possible.

9. Review the resources available to facilitate the effective use of the LCP within the Trust. This might include the appointment of an additional facilitative role for the implementation of the LCP but also other end of life frameworks such as Acute Care Gold Standard Framework. We also recognise the financial constraints currently to investing in a new role at present. If this post was made available it could be combined with the existing Palliative Care Education Facilitator post that is already in place to provide support and ensure collaboration.

CONCLUSION AND RECOMMENDATIONS

This paper is to provide an update for the Health Scrutiny and Performance Panel on the Walsall Healthcare Trust's approach to palliative and of life care and in particular on the use of the Liverpool Care Pathway within the Trust. The report has reinforced the importance of prioritising the development of an integrated approach to the provision of palliative and end of life care.

It is also important to note that the Hospital Trust has been selected as one of only four sites nationally, by the Department of Health National End of Life Care Programme, to become an early adopter of an End of Life Care modelling tool. Whilst the model is not a clinical decision making tool it should allow them to inform our Pioneer pathway development, for this group of patients, but also to re examine our workforce assumptions in delivering supportive, intermediate and intensive levels of care at End of Life in providing further assurance that the patient receives the right care at the right time and in the right place.

Recommendations

It is suggested that Members:

1. **note and debate the contents of the report.**

2. **note the current position with the development of palliative and end of life care services;**

3. **note Walsall Healthcare Trust's overall approach to palliative and end of life care as set out in the fourth section of this paper;**

4. **support the continued use of the Liverpool Care Pathway as the Trust's framework for managing end of life care in the hospital and community;**

5. **request a more detailed action plan for further improving our palliative and end of life care services (including improving the way we use the Liverpool Care Pathway) which includes a response to the awaited National Care of the Dying Audit this year findings to ensure good compliance with the tool.**

6. **request the results of the audit to be conducted with bereaved relatives who have raised concerns about end of life care across the organisation and how lessons learnt will improve care.**

Appendix 1

Walsall Healthcare NHS

NHS Trust

End of Life Care Action Plan
Lead Director: Sue Hartley- Director of Nursing
Date: 3.11.2011

Ref 1.	Detail recommendation made	**Services should be developed that enable the numbers of patients able to die in the place of their choice and "at the end of their lives" to be maximised**	**Risk rating : S x L 9**

Ref:	**Action**	**Lead**	**Completion deadline**	**Progress update**	**Evidence**	**Monitoring Arrangements**	**Date completed**
1.1 1.1.1	**Adoption of End of Life delivery tools/models across the organisation:-** Preferred place of care (PPC)	Sue Crabtree	February 2012	Ward 4 of modular block and community specialist palliative care team are implementing preferred place of care. Scope of recording PPC will be extended within the Palliative &	Specialist palliative care team audit October 2011 reveals 66% of caseload supported to remain/die in their own home.	End of Life Steering Committee	

Appendix 1

				End of Life Pathway with the transfer from District Nursing and pathway development PPC is recorded within the GSF Registers within primary care			
1.1.2	The Gold Standards Framework	Sue Crabtree/ Chris Davies/ Divisional Head of Nursing	Maintain Community Practice and develop acute Trust progress. Three more ward ward adopted practice by 2012.	GSF is well established in primary and community services. Ward 4 of the modular block has also implemented GSF. GSF roll out plan in the modular block.	GP Practices across the borough holding a Register TWICC 94% West 100% North 94% South East 95% GP Practices holding an MDT Meeting TWIcc 61% West 71% North 94% South East 79%	This is monitored by the QoF for Primary Care. Additional payments can be claimed through a locally enhanced service for GSF. End of Life Steering Committee	

1.1.3	Liverpool Care Pathway	Sue Crabtree/ Chris Kelly	Acute Trust Programme Oct 2011 to March 2012	Community pathway has been adapted for use across the organisation. Acute Trust roll out plan for LCP Education: Oct- Dec 2011 – Wards 1, 3,4 Nov 2011-Jan 2012 Wards 14-17 Dec 2011-Feb2012 Wards 5, 6, 7, 10, 11, 12 Wards ITU, HDU and A&E Alongside EOL Champion Programme.	Version 12 print planned for mid-November 2011. Mortality review group audit (quarterly) Policy ratified November 2011 Community CQIN outcome Achieved 100% of payment in March 2011 80% of total staff trained 87 district Nurses 13 Matrons 33 Specialist Nurses 49 Intermediate	Version control audit planned for December 2011.	

					Care Team Staff 12 Community Nursing Children's Staff Additionally training given to three key Nursing Homes with GSF status.		
1.2	**Discussion and recording of patient preferred place of care (including an advanced care plan) is well embedded in the organisation.**	Sindy Dhallu	Initial training completed by March 2012	In place in the modular block and community specialist palliative care team.	Audit of care plans 6 monthly Complaints, PALS analysis. In your Shoes feedback	Advanced Care Planning Sub-Group. End of Life Steering Group.	
1.3	**Produce an action plan in response to the third national audit of dying in acute care.**	Pat Bennett	Provisional date for release end of December 2011.	Results not yet released nationally.		End of Life Steering Group	

Appendix 1

Ref 2		Service provision incorporates and mobilises a range of specialist palliative and end of life care resource in both the hospital and the community.	Risk rating : S x L 6

Ref:	Action	Lead	Completion deadline	Progress update	Evidence	Monitoring Arrangements	Date completed
2.1	**Access to specialist palliative care advice and support is maximised.**						
2.1.1	Equity of access to specialist palliative care across the 7 day period is achieved.	Pat Bennet/ Mike Goodwin	February 2012	Community specialist palliative care team have operated 7 day service since October 2008 and are NICE compliant	Protocol and rota in place in the community	End of Life Steering Group	
2.1.2	Specialist palliative care operates as a single managed integrated service.	Jayne Tunstall	March 2012	Divisional directorate structures under review by COO.	Single management in place. Resources maximised.	End of Life Steering Group	

Appendix 1

Ref 3		**Integrated pathways are developed between hospital and community services in meeting the needs of people at the end of their lives**	**Risk rating : S x L** **6**

Ref:	**Action**	**Lead**	**Completion deadline**	**Progress update**	**Evidence**	**Monitoring Arrangements**	**Date completed**
3.1	**Demonstrable outcomes measured and delivered as a result of the implementation of the End of Life Pioneer Pathway:-** • **National End of Life Care Modelling Tool developed and implemented.**	Trish Skitt	January 2012	Core group developed. Baseline SUS data for one year analysed for retrospective review of end of life management 2009/10.	Model produces a report of assumptions for percentage of people who can be supported "out of hospital" to inform workforce and financial assumptions. Reduced length of stay assumptions	Sub group of the End of Life Steering Committee	

					produced.		
3.2	**Role of named key worker for palliative/end of life care patients is systematically implemented.**	Sue Hartley	Needs to be extended across all services and acute wards by September 2012	Community protocol developed.	Alignment of Specialist Community Palliative Care Team to GPs localities and specific named patients.	Pioneer Pathway Group/End of Life Steering Committee	
3.3	**Appropriate sharing of information occurs across the pathway including relevant stakeholders and partner agencies. The organisational vision is that data will be shared in electronic form**	Trish Skitt	To be confirmed	Patient alerts in place for vulnerable patients who enter hospital during the winter for response by community teams. Hand held single assessment process document in place in the community to be utilised as shared information with the hospital.	Project proforma for building electronic register in Fusion developed. Potential adaption of the GSF template already in place attached to electronic discharge template. Progressing work with	Sub-roup reports to End of Life Steering Group. Pathway Performance Dashboard captures relevant data.	

					Primary Care GSF Facilitators within practices.		
3.4	**Ensure that families are supported appropriately after death:-**						
	• **Develop integrated bereavement service between community and the hospital.**	John Hayes	March 2012	Sub-group established.	Meeting minutes, agreed work plan for group.	Progress reported through the EOL Sub-Group structure.	
	• **Collate baseline of organisational complaints surrounding end of life care.**	Dawn Kenny	December 2011		Three key priorities from action plan and benefits realisation plan.		
	• **Conduct an In Your Shoes with volunteer bereaved relatives to explore their experience/ organisational areas for implementation.**	John Hayes	January 2012				

Appendix 1

Ref 4		Relevant staff, whether in the specialist palliative care team or not, have the competencies and tools to provide good quality end of life care for their patients.	Risk rating : S x L 12

Ref:	Action	Lead	Completion deadline	Progress update	Evidence	Monitoring Arrangements	Date completed
4.1	**Education and workforce competency plan in place across the partnership.**	Sharon Yates/ Kathryn Halford	November 2011	EOL care competencies have been developed for all grades of staff and adapted. Discussion progressing with ESR department re core palliative care education that ensures benchmarking against number of staff trained in four key areas. Ambulatory 1.Syringe Driver knowledge and Competence 2.Communication	Competency Document Will be able to track progress and competency of staff through ESR system when achieved.	End of Life Care Steering Group. National End of Life Care early adopter evaluation.	

				skills and Advanced Care Planning 3.EOL Tool Training 4.Symptom Control at the End of Life			

Walsall Healthcare NHS
NHS Trust

Community Care of the Dying Audit

Palliative Care Business Unit / Professional Development Unit

Sue Crabtree – Head of Palliative & End of Life Care
Sharon Yates – Palliative Care Education Coordinator

Project start date: 8th August 2011
Final report date: 18th October 2011
Date action plan agreed:
Date of Proposed re-audit:

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Audit Project Team Membership

	Name	Job Description	Tel No	Email
Lead	Sharon Yates	Palliative Care Education Coordinator	01922 775062	Sharon.yates@walsallhealthcare.nhs.uk
Lead	Sue Crabtree	Head of Palliative & End of Life Care	01922 602608	Sue.crabtree@walsallhealthcare.nhs.uk

Background

The Royal Liverpool University Trust and Marie Curie Liverpool developed the Liverpool Care Pathway (LCP) in the 1990's. It provides a comprehensive template of appropriate, evidence-based and multi-disciplinary care for the last days and hours of life, to improve the focus of care for dying patients and their families (Ellershaw, 2007).

The LCP was developed to help transfer best practice in caring for the dying from hospices into other care settings such as acute hospitals and address the issues of empowering non-specialist palliative care practitioners to deliver good end of life care. The LCP promotes quality and high standards of care for patients and enables them to die a dignified death in their place of choice. It was recognised that not all patients who die in hospitals have contact with specialist palliative care teams (Kinder and Ellershaw, 2003). Therefore the LCP was developed to empower generalist healthcare professionals in hospital and community settings to care for dying patients and follow best practice. It highlights the importance of comfort measures, anticipatory prescribing of medication and discontinuation of inappropriate interventions which may be futile. The pathway has three sections; initial assessment; ongoing care and care after death. However, patients can only benefit from such pathways if clinicians are able to recognise those patients that are dying and feel confident to 'diagnose' it (Edmonds & Rogers, 2003).

The Liverpool Care Pathway has been rolled out across the community during 2010-2011 as part of a CQUIN. This audit plans to establish how the pathways are being completed in practice, identifying the standard and quality of patient care being delivered.

Aim

The Liverpool Care Pathway version 12 was rolled out within the community setting during April 2010 – April 2011 the purpose of this audit is to establish how the pathways are being completed in practice, give an insight into the level and quality of end of life care being delivered to patients within the community setting and bench mark against the standards within the community policy.

Objectives

A random selection of the thirty care pathways have been identified for the purpose of audit. The completed care pathways were from a range of community locations and have been reviewed and compared against identified standards. The audit hopes to clarify the standard of care pathways completed in practice, identifying good areas of practice and also identify any potential areas of practice that need to be improved on. Additionally provide

the commissioning organisation NHS Walsall that we are monitoring the pathways use and identifying areas for improvement.

Standards and Criteria

The standards and audit criteria can be viewed on Appendix A

Population and Sampling

Population & Sample

During the period of April 2010 – April 2011 a total of sixty seven LCP had been completed, from this total population a random/convenience sample of thirty care pathways were selected for audit purposes.

Method

Thirty completed pathways were selected at random. The care pathways and accompanying nursing documentation which included the single assessment process notes, nursing home notes and the Community Macmillan Team notes were then reviewed cross referenced against the identified standards outlined within appendix A. Notes were collected from District Nursing clinic bases from across the borough and jointly audited at the Walsall Palliative Care Centre, two Nursing Homes also participated in the audit they were visited, the audit of their completed care pathways and notes was conducted on site.

The information obtained was initially transcribed onto the audit standards form (Appendix A), for the purpose of data analysis the information obtained was then inputted into a Microsoft excel document.

Ethical Considerations

This audit required access to patient notes only, throughout the completion of the audit patient confidentiality has been maintained, all of the notes have been stored in a locked cupboard, the results produced do not divulge any personal identifiable information.

Findings

Following data analysis the audit findings highlighted some interesting results. In general the standard of the completed Liverpool Care Pathways reviewed were felt to be of a reasonable to high standard, the audit identified that the assessment process and the identification of symptom management was on the whole taking place but this was not always documented within the LCP, evidence supporting health care professionals actions was found in other sources of documentation such as on the evaluation sheets or within multiprofessional progress sheets.

In relation to the audit standards identified the following key findings were generated:

Key Findings

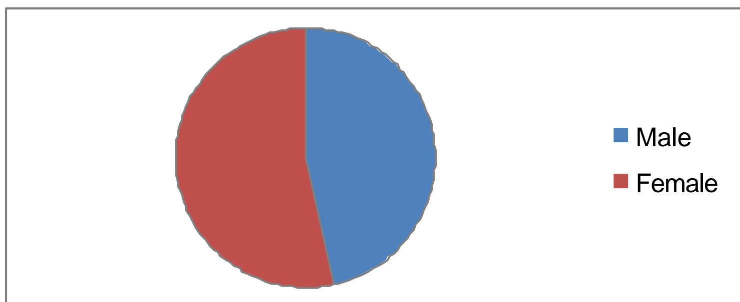
Out of a total of thirty Liverpool Care Pathways:-

- Five patients had an advanced care plan in place
- Five patients had an advanced decision in place
- Sixteen patients had their cultural and spiritual needs assessed
- Twenty five patients had pre-emptive medication in place
- Eight LCP had been signed by the GP
- Eight patients had a Do Not Attempt Resuscitation Order in place
- Fourteen patients had received an explanation of their care, with eight patients unconscious
- Twenty relatives and carers received an explanation of care, with eighteen receiving the tear off information sheet
- Only three patients had been reviewed by a community nurse twice within 24 hours
- The care after death section had only been completed on six pathways

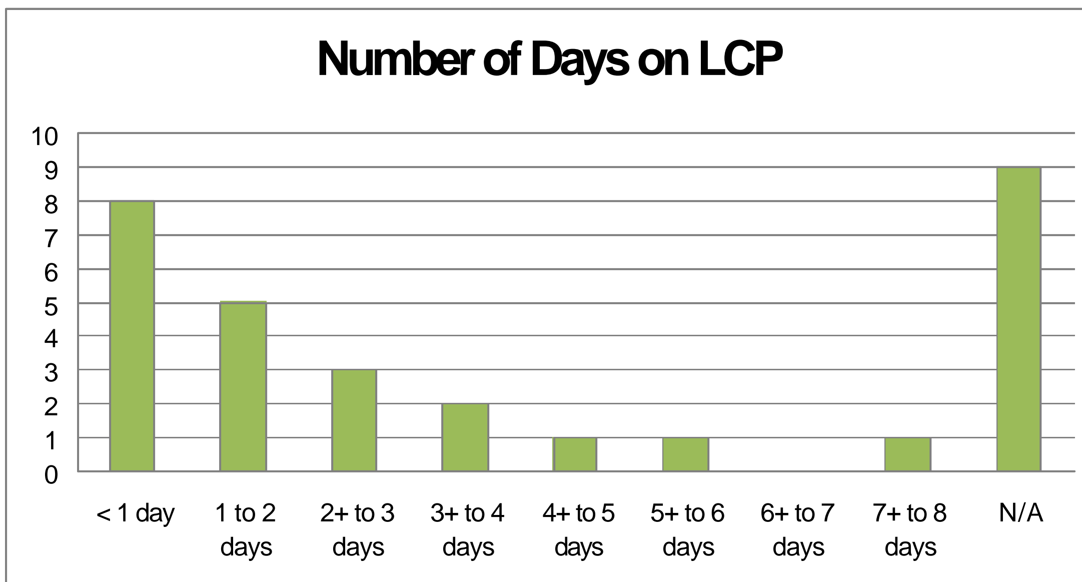
It was also apparent during the audit process that patient care had been documented in multiple places, it was noted that none of the care plans within the patient notes/Single Assessment Process File had been crossed through, this may have presented confusion for staff as it was unclear which place was the most appropriate place to document their actions.

Results

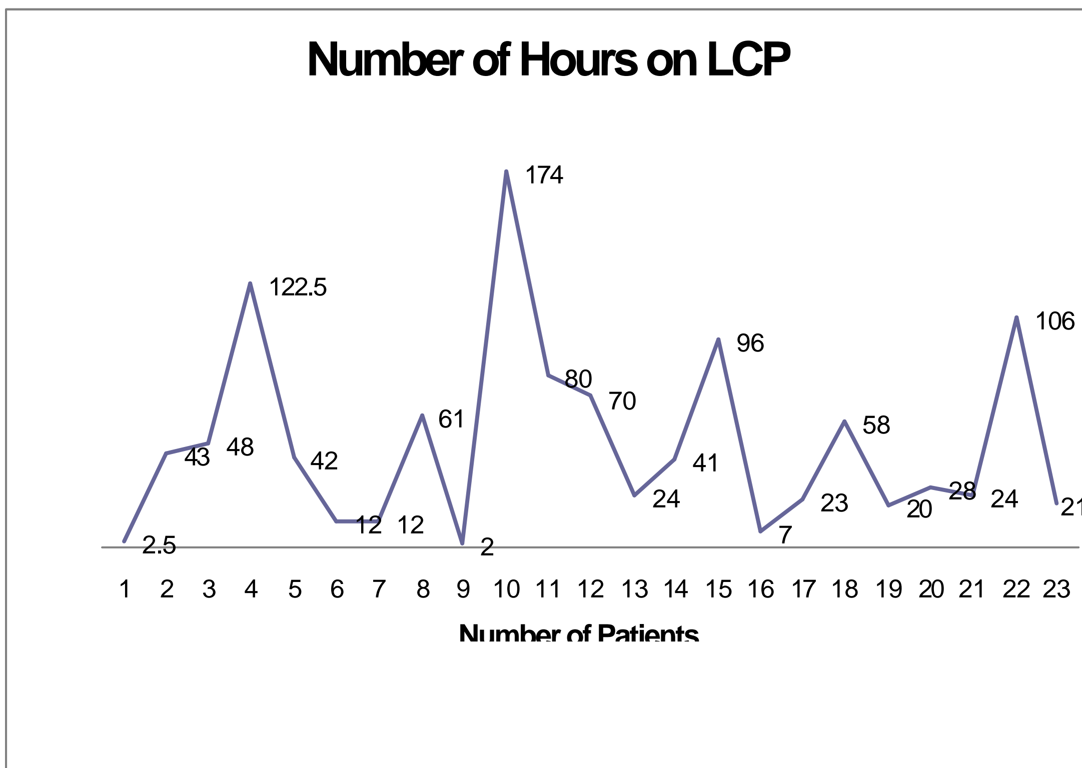
Demographic Data



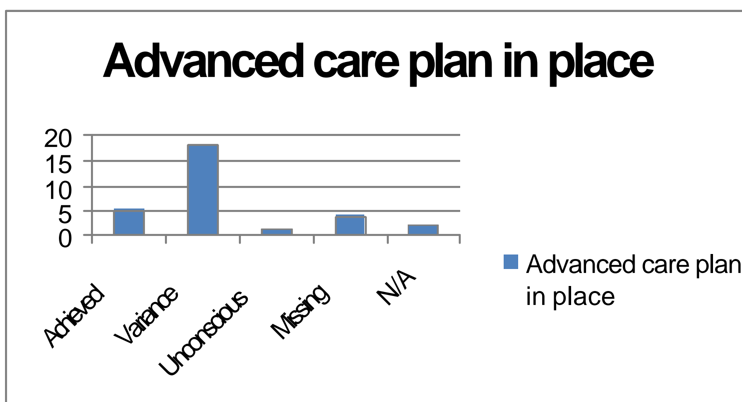
Out of the thirty Liverpool Care Pathways selected fourteen patients were male and sixteen were female, the age of those patients ranged from twenty eight to ninety years of age. The majority of patients who commenced the Liverpool Care Pathway – twenty-six had a cancer diagnosis; four patients had a non cancer diagnosis which included: stroke, heart failure and dementia.



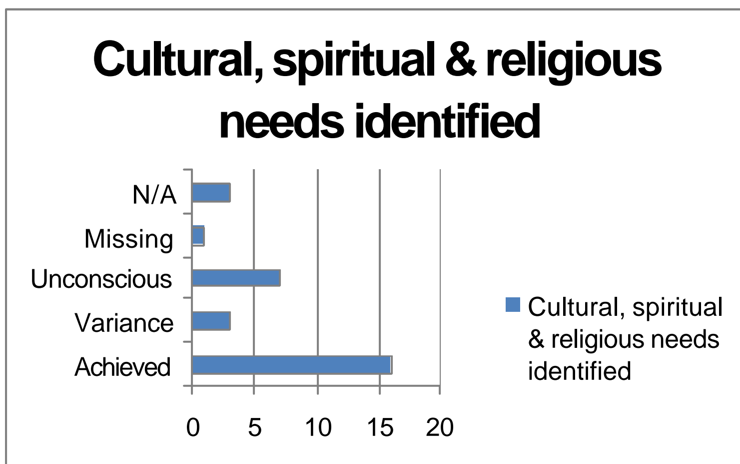
The majority of patients remained on the pathway for between one and three days. For eight patients it was difficult to establish how long they had been on the pathway, this was due to either the date of commencement or the date of death not being documented within the pathway.



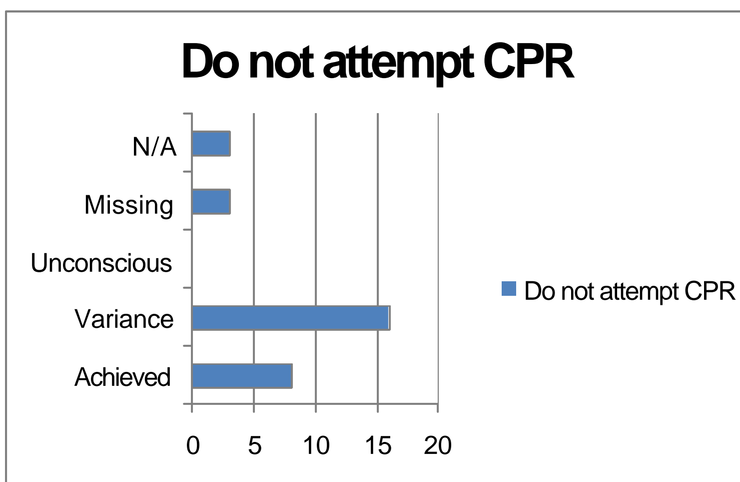
The above chart breaks down the length of time patients were on the LCP into hours.



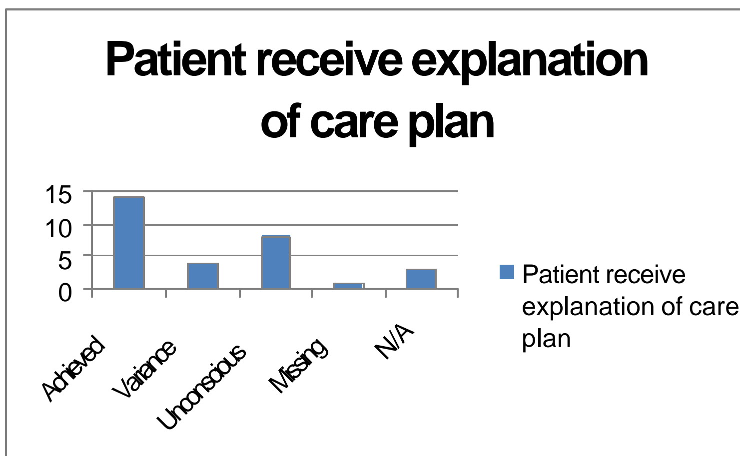
Out of the thirty Liverpool Care Pathways reviewed five patients had an advanced care plan in place. This was also the same number of patients who had an advanced decision in place to refuse medical treatment. It is important to acknowledge that the completion of advanced care plans is more established practice within Nursing Homes than in comparison to the Community setting. Work to promote and educate staff around the completion of advanced care plans is due to commence in the near future.



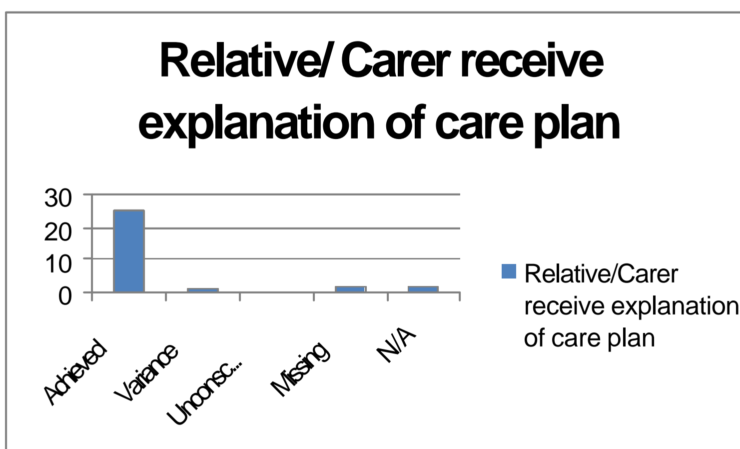
Sixteen patients had their cultural and spiritual needs identified, seven were unconscious, the remaining pathways variance, missing and not assessed had been entered. It was apparent as part of the audit process that cultural and spiritual needs had been assessed for patients within the general nursing assessment, it would appear that this information had therefore not been transferred across.



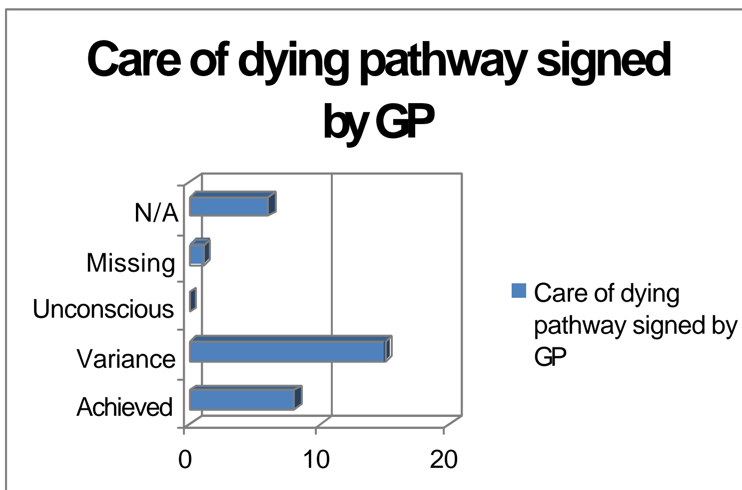
Eight patients had a Do Not Attempt Resuscitation order in place, this had been entered as variance for 16 patients, documentation within the pathway was missing for three patients and this aspect of care had not been assessed for three patients. It was also noted that on occasions there was a copy of the Acute Trust DNAR form in place, it is important to highlight that at present these DNAR forms only cover the Acute Trust and are not valid/transferrable into the Community setting. It is also recommended practice that DNAR orders are clearly documented, signed and dated.



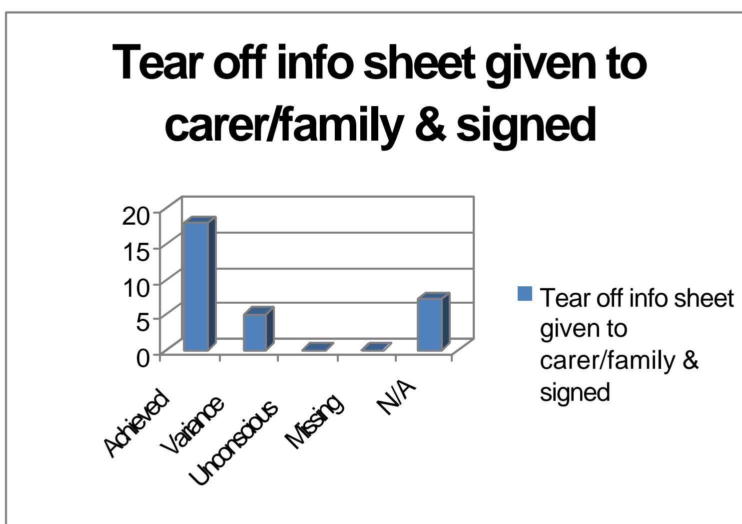
Fourteen patients had received an explanation of their care, this had been entered as a variance for four patients, eight patients were unconscious, entry within the LCP was missing for one patient and three patients had not been assessed.



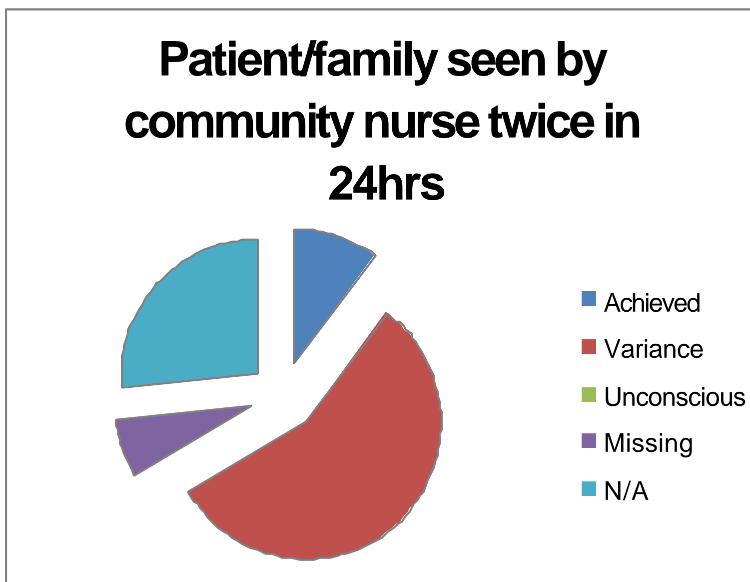
Twenty five relatives and carers received an explanation of the plan of care, this had been entered as a variance for one patient, within two pathways this had not been documented and within the remaining three pathways this had not been assessed.



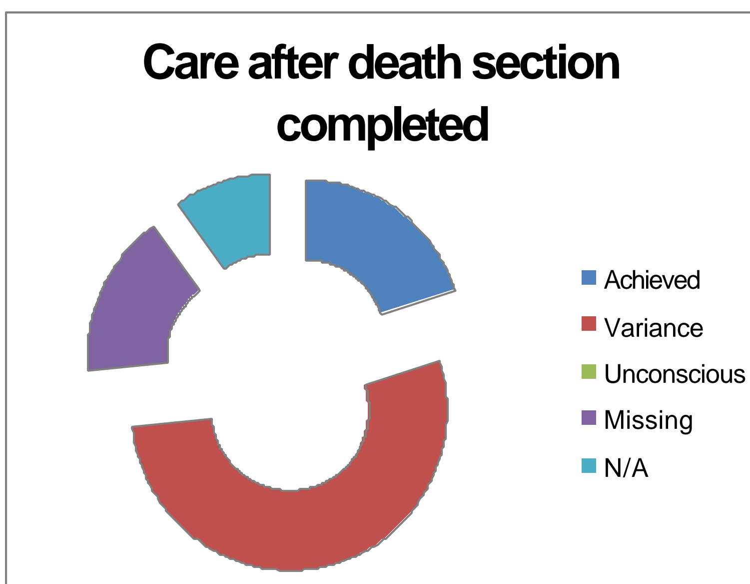
Eight pathways had been signed by the General Practitioner, it was also apparent through review of the documentation that verbal discussions regarding the patients plan of care had taken place with the GP, the care pathway was then initiated by the nurse but the GP had not signed the pathway.



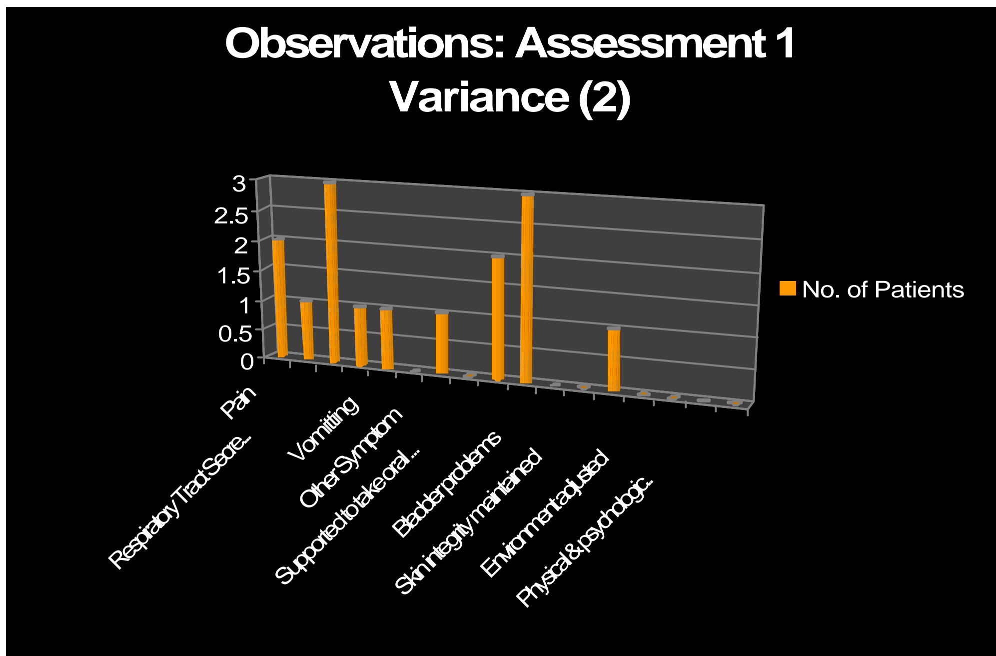
Eighteen relatives and carers had signed the pathway to confirm they had received the tear off information sheet.



Three patients had been seen by a community nurse twice within a twenty four hour period, this appeared to be due to ongoing nursing needs for example maintenance of subcutaneous fluids. Within all of the LCP's completed within the nursing home setting 4 hourly reviews had taken place.

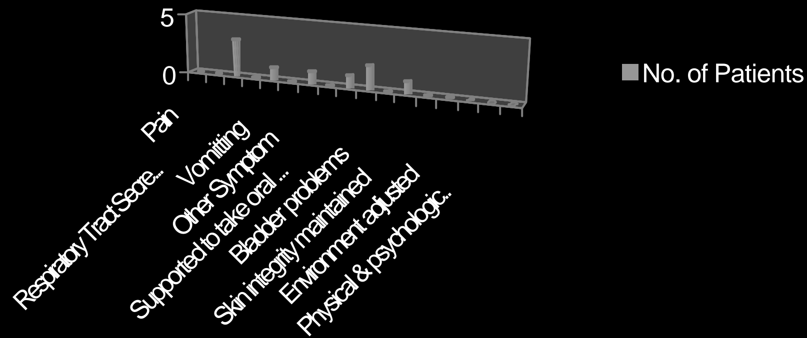


The care after death section had been completed within six pathways, documentation of the patient's death had been recorded but this was not documented within the care pathway, entries had been made either on the evaluation sheet or within the multidisciplinary sheet.



On the first assessment the most prevalent symptoms included: respiratory tract secretions and mouth care followed by Pain, nausea and vomiting, other symptoms, skin care and supported to take oral fluids. It was also apparent that in some cases the patient had been assessed in relation to certain symptoms but this had not been entered as achieved or variance within the care pathway but had been documented as part of the evaluation process.

Observations: Assessment 2 Variance (2)



The results for the second assessment were similar to those from the first assessment. The most common occurring symptom was respiratory tract secretions followed by mouth care, vomiting, other symptoms, supported to take oral fluids and bowel problems. Only three patients received two community nursing visits during 24 hours. All patients within the nursing home setting received four hourly assessments.

Action Planning

[The Action plan should also include consideration of the resources required for implementing the agreed changes (including costing) where applicable.]

Use this form to plan actions as a result of clinical audit reports. The resulting action plan should be monitored by your relevant Clinical Governance Task Group or appropriate committee

Standard	Result	Main Finding	Barrier to change	Risk	Action(s) to improve	Person(s) or Committee(s)	Progress report	Date Complete by
Patient to have Advance care plan in place	Poor use of advance care plans	Only five patients out of a sample of thirty patients had an advance care plan in place	Potential lack of staff awareness and education to support the use of advance care plans	Poor co-ordination of patient care	Develop and deliver advance care planning training programme across the organisation	Sharon Yates / Shradha Lakanhi		Ongoing over 2011/2012
Once LCP commenced all patient documentation should be recorded within the pathway	Disjointed documentation	Patient documentation recorded in multiple places, duplication in some cases	Potential lack of staff awareness around the correct place to document care	Poor record keeping and disjointed delivery of patient care	Raise staff awareness through the dissemination of audit report and reinforce this issue through LCP awareness training	Sue Crabtree / Sharon Yates		Audit report to be shared with key staff groups Nov 2011. Ongoing training Annual audit 2012

Care after death section to be completed	Poor completion of the care after death section	Only six LCP's out of a total of thirty had the care after death section completed	Potential lack of staff awareness around the correct place to document care	Poor record keeping and disjointed delivery of patient care	Raise staff awareness through the dissemination of audit report and reinforce this issue through LCP awareness training	Sue Crabtree / Sharon Yates		Audit report to be shared with key staff groups Nov 2011. Ongoing training Annual audit 2012
Spiritual needs to be assessed	Poor completion of the spirituality goal	It was recorded within sixteen pathways that the patients spiritual needs had been assessed	Potential lack of staff awareness around spiritual assessment	Two potential risks: -are staff assessing patients spiritual needs –are there issues around documentation	Raise staff awareness through the dissemination of audit report and reinforce this issue through LCP awareness training	Sue Crabtree / Sharon Yates		Audit report to be shared with key staff groups Nov 2011. Ongoing training Annual audit 2012
Liverpool Care Pathways should be signed by the general practitioner	High incidence of LCP's not signed by GP's	Only eight pathways out of a possible thirty pathways had been signed by the GP	Potential lack of awareness around signing the care pathways		Raise staff awareness through the dissemination of audit report and reinforce this issue through GSF meetings	Sue Crabtree / Sharon Yates / Community Clinical Nurse Specialists in Palliative Care		Audit report to be shared with key staff groups Nov 2011. Ongoing training Annual audit 2012

Patients on the LCP to have DNAR orders in place	High incidence of DNAR orders not in place	Eight out of thirty patients had DNAR orders in place	Potential lack of staff awareness and local guidance to support practice	Inappropriate resuscitation of patients and uncoordinated care	Progress with community DNAR procedure and disseminate recommendations once work complete	Sharon Yates		Awaiting finalisation of DNAR work

Appendix A

Walsall Healthcare NHS
NHS Trust

COMMUNITY CARE OF THE DYING AUDIT

PATIENTS NHS NUMBER:	
PATIENT AGE:	
GENDER:	
HOURS ON LCP:	
IF APPROPRIATE DID A REASSESSMENT TAKE PLACE ON THE 3rd DAY	
GENERAL PRACTITIONER:	
MONTH OF DEATH:	
YEAR OF DEATH:	
DID THE PATIENT HAVE DEMENTIA AS A CO-MORBIDITY?	
COMPLETED BY:	

PRIMARY DIAGNOSIS (Please x only one)

------------------CANCERS-----------------------

	Bone		Stomach		Bladder
	Breast		Adrenal		Kidney
	Eye		Carcinoid		Ureter
	Meninges		Neuroendocrine		Lymphoid
	Brain		Thyroid		Independent Multiple Sites
	Anus		Bronchus		Other Specified Sites
	Colon		Non Small Cell Lung		Unknown Primary
	Oesophagus		Trachea		Other Connective / Soft Tissue Disorders
	Rectum		Malignant Melanoma		Ill defined, Secondary, Unspecified Including Carcinomatosis
	Small Intestine		Non Melanoma		ENT
	Female Genital Organs		Gall Bladder		Liver
	Testis		Mesothelioma		Prostate
	Pancreas		Penis		

------------------NON CANCER--------------------

	Chronic Renal Failure		Other Heart & Circulatory Conditions
	Chronic Respiratory Disease		Chronic Vascular Disease
	Dementia including Alzheimer's		HIV/AIDS
	Motor Neurone Disease		Stroke
	Neurological Conditions		All other Non-Cancer Diagnoses
	Heart Failure		

---------------IDENTIFIED STANDARDS : - SECTION 1 & 3 --------------------

	Outcomes	**CODE: Achieved Variance Unconscious Missing**
1.	Was an advanced care plan in place?	
2.	Was an advanced decision to refuse treatment in place?	
3.	Were the patient's individual cultural, spiritual and religious needs identified?	
4.	Was any pre-emptive medication prescribed?	
5.	Was section 1 goal 7-10 completed by the General Practitioner?	
6.	Was a Do Not Attempt Cardiopulmonary Resuscitation Order in Place?	
7.	Did the patient receive an explanation of the current plan of care?	
6.	Did the relative/carer receive a full explanation of the current plan of care?	
7.	Has the care of the dying pathway been signed by the General Practitioner?	
8.	Has the tear off information sheet been given to the family/carer and signed for?	
9.	Was the patient/family seen by a community nurse twice per 24 hour period (minimum standard within Care of the Dying Policy)?	
10.	Was the care after death section completed?	

12 HOURLY ASSESSMENTS: BREAKDOWN OF OBSERVATIONS

Please enter:-
1 – For achieved
2 – For variance
3 – Patient not supported by the LCP at this time point
4 – Assessment possible but entry missing

GOAL	**ASSESSMENT 1**	**ASSESSMENT 2**
A: PAIN		
B: AGITATION		
C: RESPIRATORY TRACT SECRETIONS		
D: NAUSEA		
E: VOMITING		
F: BREATHLESSNESS		
G: OTHER SYMPTOM		
H: SAFE ADMINISTRATION OF MEDICATION		
I: SUPPORTED TO TAKE ORAL FLUIDS		
J: MOUTH MOIST & CLEAN		
K: BLADDER PROBLEMS		
L: BOWEL PROBLEMS		
M: SKIN INTEGRITY MAINTAINED		
N: PERSONAL HYGIENE NEEDS MET		
O: ENVIRONMENT ADJUSTED		
P: PATIENTS PSYCHOLOGICAL WELLBEING		
Q: PHYSICAL & PSYCHOLOGICAL WELLBEING OF THOSE ATTENDING THE PATIENT		