

EDITORIAL

INSIDE THIS ISSUE:

LCP GP Survey

Expert Advisory Group & Member Profile

2012 LCP Training Dates

Hawkes Bay LCP Sustainability

Lucy Meldrum

A Perspective from the International LCP Conference

National Care of the Dying Audit (Hospitals) in UK

Changes at the National LCP Office NZ

The National LCP Office in NZ was established in November 2008. The Ministry of Health-funded National Office has the stated aim to “promote and coordinate the sustainable implementation of the LCP across all District Health Boards in NZ”

Since the inception of the National LCP Office, much has been achieved under the leadership and direction of its founding Lead, Theresa Mackenzie. Theresa, a registered nurse, developed the NZ National LCP Office from its very beginnings, has nurtured it through the development of its first strategic and operational plan, and seen it grow to now support over 300 sites in the implementation and maintenance of LCP. The LCP is currently being used in a range of care settings in the community, in aged care, acute care, and in Hospices. A recent publication titled “Evaluating the role and value of a national office to coordinate Liverpool Care Pathway implementation in New Zealand” concluded that: “the LCP stakeholders considered the NZ LCP Office highly important for the ongoing quality and sustainability of the LCP implementation nationally. They also saw the value in its role in the facilitation of a LCP information network and as a conduit for a strategic voice for end-of-life care issues”.



It was with sadness that we saw Theresa leave the National Office to follow a new path in Auckland. She leaves a great legacy and it is with gratitude for all she has achieved that we wish her well in her new endeavors.

It is a time of change at National LCP Office with the addition of a new Lead. Bridget Marshall commenced at the National LCP Office on November 7th 2011. Bridget is a registered nurse who has spent many years working in specialist palliative care services both in NZ and the UK. She has had roles in clinical practice and clinical education, and worked as the nurse educator for Arohanui Hospice for nine years. Her previous position as the LCP coordinator for Oceania Group (an organization with 60 aged care facilities in NZ) has set her in good stead for taking on the role of Lead, and she is looking forward to the challenges that the new role has in store for her.

One of Bridget’s first tasks at the National Office was to employ a part-time LCP facilitator to join the team and help support the aims of the National Office. The National Office is happy to announce that Liz Angus, a highly experienced senior primary care nurse from Taranaki, will fill this position commencing in the New Year. Bridget’s other initial task was to make contact with the LCP Central Team in the UK by attending the LCP International Reference Group and the LCP International Conference.

The National Office looks forward to working together with the palliative care community in 2012 to continue to build on its aims and objectives.

Website: www.lcpnz.org.nz

¹ Mackenzie T., Innes J., Boyd M., Keane B., Boxall J., Allan S. (2011) Evaluating the role and value of a national office to coordinate Liverpool Care Pathway implementation in New Zealand. *International Journal of Evidence-Based Healthcare*, 9:252-260

LCP GP Survey

The role of the general practitioner in care for the dying



The role of the general practitioner has long been considered key to palliative care provision in the primary care and aged care settings in New Zealand as well as the UK where the LCP originated. However, given the differences in general practice models between NZ and UK, it cannot be assumed that established practice in the UK practice is readily transferrable to the New Zealand setting.

This was brought into focus at the recent national palliative care conference where a speaker, a local general practitioner, suggested that he found the LCP document cumbersome to use and questioned its effectiveness in improving the quality of care of the dying in the general practice setting. In part prompted by this challenge the decision was made to carry out a national survey of GP experience and perceptions’ of the LCP. It was decided to also include some more general questions on end of life care from a GP perspective.

The goal was to contribute to the greater understanding of LCP use by general practitioners’ in the New Zealand context. This information would then be fed back to GP groups and other stakeholders with the intention of gaining insight into particular measures that could better supports the GP role in end of life care including the use to the LCP. It is hoped that the results of the survey will be ready for dissemination in the new year.

Article contribution: Barry Keane, Chair—LCP Expert Advisory Group & Director of Nursing, Central Cancer Network

Expert Advisory Group

The purpose of the National LCP Expert Advisory Group is to enable structured discussion and the provision of expert advice to assist the continuous improvement of the national implementation of the LCP programme and its role in end of life care in New Zealand.

This expertise and advice is provided through a formal national discussion forum which meets quarterly.

The role of the National LCP Expert Advisory Group is to provide the National Office with:

- expert clinical advice and recommendations on:
 - ⇒ LCP and related end of life care issues (e.g. clinical effectiveness, service improvement, service development, policy development, service standards)
 - ⇒ technology change for LCP and end of life
 - ⇒ advice on services / initiatives to inform ongoing planning and prioritisation
 - ⇒ other related areas as requested
- expert review



Expert Advisory Group Member Profile: Raewyn Jenkins

Raewyn Jenkins

Raewyn is Clinical Nurse Educator for Nurse Maude Hospice Palliative Care Service in Christchurch. She has worked in oncology, haematology and palliative care settings in New Zealand and the United Kingdom for the past 25 years, including 10 years at St Christopher's Hospice in London.

Raewyn holds a Master's degree in Advanced Clinical Practice and has been involved in developing a number of educational resources for palliative care services including the Hospice New Zealand Syringe Driver Competency Programme. She is currently one of a team implementing the LCP into aged residential care facilities across Canterbury. She has been involved with the National LCP office since 2009 when she was an inaugural member of the National LCP Governance Group.

2012 LCP TRAINING DAYS

Friday, 4 May Auckland—Crowne Plaza

Friday, 25 May Christchurch—Commodore Hotel

Friday, 1 June Wellington—West Plaza

Registrations online will be available from the 1 Feb 2012
Go to www.lcpnz.org.nz

Fee: \$180

Minimum for course to proceed: 15

LCP Sustainability in the Hawkes Bay

Wow hard to believe three years have gone by and now the Hawke's Bay LCP project is coming to an end. When we started the project implementation into hospital level ARC facilities and into the regional hospital and two smaller rural hospitals seemed an almost impossible challenge. With the benefit of hindsight now I can see

that was the easier part. Sustainability (yes, almost a 'dirty' word) is actually the tricky one. Without it all the good (and hard) work that we have done will be lost.

Sustainability looks different everywhere but this is what is happening here in Hawke's Bay. Some of the key's to sustainability I have found is time, ongoing auditing (which is a dirty word) and buy in from a site.

That is, what does the site get out of continuing with LCP?

When working with the ARC facilities emphasis has been put on the importance of ongoing reflective data cycle and the relevance of completing this to a site. For example we have had discussions that for accreditation this is a tool that is quick, easy and one the auditors will love. It magically spits out graphs and all you have to do is input the information. Obviously the graphs are lovely but it is in the interpretation of these graphs where the true gems lie. All our ARC facilities have taken on RDC audit, most of them 6 monthly. The results are fed back to staff in a variety of ways but excitingly are being used in a meaningful way to each site. Resource nurses were key and across the 12 sites we have over 40 resource nurses. They have a job description and see use of LCP, ongoing auditing, education and improving of standards within their facility as their roles. Community/rural areas of CHB and Wairoa also attend these meetings, as these areas inpatient beds are also managed by GP's.

Within the DHB we have been lucky and I fully acknowledge that. Our HPCT team has supported us from the beginning and we have worked closely with them over the course of the project. Resource nurses within the hospital have been a lot trickier, but there is a least two nurses per ward. Nurses are busy and stretched with high acuity, acute patient care. Due to budget restriction they are not given dedicated time to their resource roles as their ARC counterparts often are. Which means incorporating LCP into everyday practice and internal structures becomes essential. A clinical policy has been submitted to be added to clinical procedures/ guidelines within the hospital. LCP education has been included into the company orientation package. This does seem to be making an impact, in our last 6 monthly RDC 45% of patients were on LCP within the hospital. A 'caretaker' role has been developed where the HPCT will continue to oversee LCP use within the wards for the next year just to ensure that sustainability continues and to support the 'business as usual' philosophy.

After a year it will then be returned to hospice to caretake both in the hospital and within the community. The way this will look is currently a work in progress but will include networking, education and liaison aspects.

So now I am left packing up boxes of LCP audits, tying up loose ends and writing the final report re the LCP project (which is beginning to feel like writing War and Peace). I would like to say Thanks to everyone I have met in my LCP project journey. You have all been a great support. I have enjoyed sharing ideas and all the pearls of wisdom (and laughter) conference invariably contained. Best wishes and Merry Christmas.

Article contribution: Michelle Rodda, Cranford Hospice

Lucy Meldrum



Lucy Meldrum

Lucy Meldrum the BIG CHIEF of the LCP in the Auckland area is moving onto greener pastures. LCP has been her passion since 2001, and what a difference she has made to the implementation of the LCP in Auckland.

I have worked collaboratively with Lucy for nearly 3 years. In that time she has mentored me to be the strong LCP Facilitator that I am now. She leaves at the end of November to take time for herself and her family after the successful and daunting task of implementing the LCP throughout the ADHB.

Her strength is having the gift of good communication and being able to relate to everyone she meets, making that person feel very comfortably and at ease. She loves using reflective story telling at her education sessions, which always get positive feedback and the staff will always remember the story. I have been known some times to lead her back on track!

We have had so many good times and laughs in the time we have worked together, it has always been a pleasure to come to work. We are well known as being the "aunties" at Auckland City Hospital. I will miss her mischievous actions, and her facing me across the desk pulling faces at me to catch my attention.

She is one of the "good people" that we all need in our lives and I shall dearly miss working with her, but know that we have developed a great friendship and that will continue. She can count on me like 1, 2, 3, I'll be there, as she is my 4, 3, 2, and I can

count on her cause I know that she will always be there for me, that's what friends are for (just like the song)!!

I know that I am not alone in wishing her all the best with her future plans.

Go well my friend.

Article contribution: *Aylene Parker, Auckland DHB*

"Care of the Dying: Everyone's Business"

A Perspective from the International LCP Conference in London 1st of December 2011

Firstly It was great to have the opportunity to attend this conference and network with so many health providers with the passion and common interest in providing best practice End of Life Care.

The theme for the conference this year focused on providing an international perspective of the management of End of Life Care. The Chairpersons for the day were from Sweden, Slovenia and Buenos Aires and speakers from Italy, Argentina, The Netherlands, Germany, England, and New Zealand completed an informative and inspiring conference for those attending.

The Keynote speaker Professor Susan Block M.D. Chair of the Department of Psychosocial Oncology and Palliative Care Dana-Farber Cancer Institute, and Professor at the Department of medicine & Psychiatry, Harvard medical School, USA spoke on Dying in America, 'Lessons learnt and future visions'

Professor Block described that it can still be difficult to directly talk about and use the word dying in many areas of health care and the words 'serious illnesses' are generally used to describe care of the dying and hospices now provide 40% of care of those who die each year in the USA. Professor Block also highlighted that communication remains our most powerful tool in going forward in Palliative Care.

Other sessions covered of interest was the development of a electronic version of the LCP, LCP Research in Practice, and the current work on a randomized cluster trial on the effectiveness of the LCP in improving EOLC for dying patients in hospital in Italy.

Article contribution: *Stephanie Ash, Lead—Education and Research Unit, Arohanui Hospice*



RUNNING LOW ON LCP STATIONERY?

Download an order form online from www.lcpnz.org.nz/files/resource_order.pdf

to get more pens, lapel badges and LCP folders.

National Care of the Dying Audit- Hospitals (UK)

PATIENTS RECEIVE HIGH QUALITY CARE AT THE END OF LIFE

For the third time the Marie Curie Palliative Care Institute Liverpool (MCPICIL) in collaboration with the Royal College of Physicians, and supported by Marie Curie Cancer Care and the Department of Health End of Life Care Programme has lead an audit in end of life care. The audit is now part of the UK Department of Health Quality Accounts list of recommended national audits, and is the only national audit listed under 'End of Life Care'.

The audit measures key performance indicators in eight specific 'themes' of care provision and delivery covering both organisational and clinical areas.

The audit included clinical data from over 7,000 patients (from 127 NHS Trusts) whose care was supported by the Liverpool Care Pathway for the Dying Patient (LCP), and organisational data regarding provision of care for patients in the last hours or days of life was submitted from 131 NHS Trusts in England.

The following information is taken from the media statement released on December 1st

PATIENT LEVEL KEY FINDINGS – CLINICAL DATA

Physical Comfort of the Patient

Including

- written prescriptions available for the 5 key symptoms (pain, agitation, respiratory tract secretions, nausea and vomiting and breathing difficulties) that may develop in the last hours or days of life so that there is no delay in responding to a symptom if it occurs following an assessment. In some trusts this was achieved in 100% of all patients.
- Routine, ongoing assessments of the patient show, where assessments were recorded in the last 24 hours, patients were documented as comfortable in over 94% of cases, for those goals relating to symptom control.

Communication

- Results illustrate that, where data were available, significant conversations are happening with the relatives or carers (eg explanation of the plan of care was achieved in 94% of cases documented), even though it is not always possible to have these conversations with the patient, depending on his or her state of awareness/ability to understand
- There is wide variation in hospital performance (coded achieved) for goals relating to conversations with the patient regarding awareness of dying, and addressing cultural, spiritual or religious needs at this time. This indicates practice across different hospitals may be very different, which should be a point of discussion when interpreting these results. Some trusts are achieving 100% in these areas.

Multiprofessional Decision Making

- For those patients receiving it, clinically assisted (artificial) hydration was more likely to be continued after the multi-

disciplinary/multiprofessional team discussion than clinically assisted (artificial) nutrition, with around a sixth (16%) of patients still receiving clinically assisted (artificial) hydration after the initial assessment.

- Documentation of the multidisciplinary/multiprofessional team 3 day review has wide hospital variation. It is encouraging however, that some hospitals are achieving this on 100% of occasions, which could highlight an opportunity for lower performing hospitals to learn from other services.

NCDAAH participation

Hospital participation has increased by 13% between NCDAAH Round 2 and Round 3, with 178 hospitals (from 127 Trusts) submitting a total of 7058 individual patient data sets this time.

ORGANISATIONAL LEVEL KEY FINDINGS

1. Education & Training, Audit and Evaluation

We can see an increase between Round 2 and Round 3 in the amount of education and training offered in care of the dying for Medical staff (R2: 74%; R3: 90%). However, the majority of education and training offered is not mandatory.

Two thirds (67%) of all Hospital Trusts produce routine action plans to improve care of the dying in their organisation, to support continuous quality improvement

2. Specialist Palliative Care Service Provision:

In almost all Trusts (92%) there is an out of hours telephone service in operation. It is recommended that Trusts provide a 7 day face to face service. 20% of participating Trusts had this in place.

3. NCDAAH participation

There was a 13% increase in trust participation between NCDAAH Round 2 and Round 3, with 131 Hospital Trusts submitting data into the organisational element.

4. Compliance with document completion

Compliance with document completion should be addressed by all hospitals. Compliance in some areas is relatively high, although certain other areas are a specific point for comment, such as communication

A full copy of the Executive summary can be found on <http://www.rcplondon.ac.uk/press-releases/patients-receive-high-quality-care-end-life>



*Merry
Christmas*