

EDITORIAL

6th National LCP Conference – 25th November 2009 'Care of the Dying: Time to make a Difference'

In November I attended the International LCP Leads meeting and 6th National LCP Conference in London.

At the "International LCP Lead's" meeting held the day before conference I met with other invited participants from Norway, Argentina, Germany, India, Italy, Netherlands, Switzerland, Sweden and the UK. Participants' involvement with LCP ranged from Phase 1 (i.e. in the early stages of implementation) through to Phase 5 where only NZ, UK and the Netherlands have achieved having LCP recognised as a continuous quality improvement programme at a national level. There were high-level discussions in relation to the ongoing development of an international LCP model of support based at LCP Central, and contracts and licensing.



Participants who attended the 'International LCP Leads' meeting - 24th November 2009

The conference was opened by Professor John Ellershaw who credited recent UK LCP media attention with ensuring that improving end-of-life care remained a priority on the UK national governance agenda. One of the key conference themes set by Prof. Ellershaw was the need to ensure that LCP implementation and dissemination is underpinned by robust education and training programmes, and that these are ongoing.

The results of the second UK National Care of the Dying Audit in Hospitals was a highlight for many delegates who had participated in this. The audit showed that 21% of hospital deaths occurred on an LCP and 11% of patients who died on an LCP received artificial hydration. Of particular relevance for NZ were the results that show having a dedicated LCP Facilitator correlates with less missing data and greater LCP success and sustainability.

Presentations on diagnosing dying and end of life care for neurological and renal conditions further raised awareness of the larger proportion of deaths from non-malignant compared to malignant disease, and highlighted the need for more education and training in palliative care and end of life care for non-malignant disease groups.

Having attended a comprehensive explanatory session and discussion group on Version 12 (V12) where I represented the concerns about V12 expressed by NZ LCP Facilitators, I have returned feeling far more positive about the reviewed document and how our consultations were considered in drafting the final V12.



Delegates attending the 6th National LCP Conference at the Royal Society of Medicine in London - 25th November 2009

The ethos of the LCP generic document has remained unchanged. V12 offers greater clarity in key areas particularly communication, nutrition and hydration. One generic V12 document now replaces the previous four V11 documents. In its final form V12 is no longer than its predecessor, V11. The launch of V12 at the conference was greeted enthusiastically by the majority of delegates.

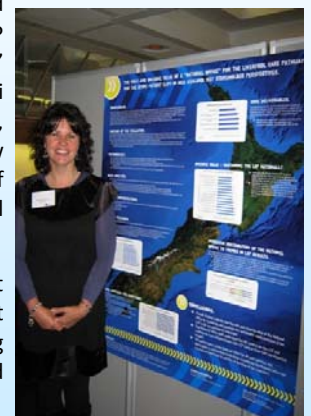
It is important to note that care of the dying patient and their family/whānau can be supported effectively by either version of the LCP. The National LCP Office will develop a generic NZ V12 document and have this available early in the new year for your consideration at which time I will be available to support you in making an informed decision about whether you will continue to use V11, or change to V12 at a time that best suits your organization/care setting in the future.

I felt incredibly proud and humbled that NZ's LCP success, including the development of the National LCP Office, was acknowledged by Prof Ellershaw and other international LCP colleagues throughout both days. This success belongs to you - the LCP Facilitators of NZ who have worked with passion and commitment toward improving the care of dying patients and their families/whānau across all care settings in NZ. You are leaders on the LCP world stage and your efforts are internationally recognized. Well done!

I presented a poster on 'The role and value of a National Office for the LCP in NZ: Key stakeholder perspectives' and also displayed the poster by Di Boon & Steph Ash (LCP Facilitators, Arohanui Hospice) on 'A New Zealand model for sustainability of the LCP' which were both well received.

Thank you all for all your support and encouragement over the past year. I look forward to supporting you in your LCP development and dissemination in 2010.

Have a safe and Happy Christmas.



Theresa Mackenzie, RN MN
National LCP Lead, NZ

National LCP Facilitators Meeting Report 2009

Held in Wellington on November 12th 2009

Twice a year the LCP Facilitators throughout New Zealand meet together in a forum which fosters collaboration, networking and the opportunity to learn from each others experience and also to ensure a consistent approach to the LCP implementation in NZ is maintained.

Currently there are 32 LCP Facilitators in New Zealand (22 were in attendance at this meeting) which was hosted by Irene O'Connell & Michelle Rodda who are based in the Hawke's Bay (pictured right).

Key themes of the day from the Irene and Michelle's perspective:

- There are challenges with engaging and educating GP's
- Sustaining ongoing education with Hospital medical staff is a challenge
- On going training and education of staff is an issue everywhere but there are some really creative ways to get around this;
- Issues for the future maybe - what about facilities that have not embraced the LCP?

Overall it was great to be able to throw these issues open to the group for discussion – many gems shared about how to address some of these issues – also acknowledging that change process can take time!

There was much discussion re the importance of nurturing relationships between health professionals and LCP facilitators and how this is key to success and highlighted the importance of relationships between LCP facilitators nationwide. It can be a somewhat lonely existence and every area is doing something ingenious to solve an issue – we need to share these more and support each other.

LCP Version 12 Document:

Liverpool has put out a draft Version 12 LCP Document which incorporates many changes. There was however, much discussion around the implications of these changes within the NZ context. The consensus among the group was that NZ continue with version 11 with some modifications. Theresa will present the NZ recommendations to the LCP Conference which she is attending in the UK next week.

Poster - Sustainability Model of the LCP in New Zealand:



Steph Ash and Di Boon (from Arohanui Hospice, pictured left) presented an excellent poster around the sustainability of the LCP in NZ.

They have drawn upon their experience within the Mid Central region and outlined many innovative actions and ways of aiding the ongoing sustainability of the LCP in each of the sites they have implemented in.

*Irene O'Connell & Michelle Rodda
LCP Facilitators, Hawkes Bay*

Syringe Drivers & the LCP: A consideration, not an expectation

In a letter to the editor of the Daily Telegraph (UK) a statement was made that 'syringe drivers are being used to give continuous terminal sedation, without regard to the fact that the diagnosis could be wrong.' As a Rest Home Liaison Nurse with a Specialist Palliative Care Team, and as an experienced LCP Facilitator, this caused me to reflect on how nurses frequently ask me about the appropriateness of commencing syringe drivers at the time a patient/resident is diagnosed as dying and commenced on the LCP.

The first 'goal of care' in the LCP prompts the doctor to assess the imminently dying patient/residents current medications and discontinue any that are no longer appropriate. The medical and nursing education and training I deliver that underpin this goal includes the need to consider an alternative route of delivery for any currently prescribed oral medications required for continued symptom management - such as long acting opioids for pain - for patients/residents who are unable to swallow.

The second 'goal of care' in the LCP prompts doctors to prescribe subcutaneous 'prn' (as required) medications for each of the five symptoms that may occur at the end of life. Again, the education and training I deliver that underpins this goal involves ensuring that doctors and nurses understand that prescribing 'prn' anticipatory medications is not synonymous with prescribing a syringe driver. Not everyone will require a syringe driver at the end of life even when they have symptoms. Often two or three subcutaneous boluses of medication are all that are required to control a symptom and ensure the patient/residents comfort in the last days/hours of their life.

Unless previously being used, medications required for the management of end of life symptoms such as pain, agitation, secretions, dyspnoea and nausea should be administered 'prn' as prescribed, their effectiveness assessed and then the medication titrated accordingly before a 24 hour continuous infusion of that medication(s) is considered via a syringe driver. It is important that staff are taught about the anticipatory medications in the LCP recommended by the specialist palliative care team, and that these are in doses that aim to neither hasten nor postpone death. The point is to have appropriate medications available, in appropriate doses, to prevent delays in managing symptoms at the end of life should they occur. This is particularly so in residential care and community care settings where often 24/7 access to a community pharmacy and medications is difficult and risks causing delays in symptom management and suffering for patients/residents.

As an LCP Facilitator, it is clear to me that the LCP does not now, nor has it ever advocated syringe drivers to deliver continuous terminal sedation of all dying patients. What the LCP does recommend is review of current medications, availability of 'prn' medications and ongoing assessment and reassessment of the patient/resident in the last days and hours of their life.

*Jan Clark, Resthome Liaison/LCP Facilitator
Waikato Palliative Care Service*

Successful ICU & District Nursing Collaboration

Mrs X, an elderly Maori lady, was referred to the district nurses (DN) from ICU shortly after she was diagnosed as dying. Mrs X's husband and whanau requested that she be transferred home to die in her small rural community.

With time of the essence, the DN team leader liaised with the ICU charge nurse to plan Mrs X's discharge. The DN team leader raised the appropriateness of commencing the Liverpool Care Pathway (LCP), and although ICU staff were not familiar with the LCP, the ICU charge nurse supported the commencement of the 'Community LCP' prior to Mrs X's discharge home.

ICU arranged for Mrs X to be accompanied home by two ICU nurses where she was extubated. Although she had a syringe driver with morphine for pain management, the ICU doctor had been reluctant to prescribe anticipatory medications as per LCP protocol, and therefore only PRN medications for pain management were available.

Soon after Mrs X's arrival at home she became unsettled and was groaning. The DN administered what PRN breakthrough analgesia medication was available. The DN then explained the plan of care to the whanau with the assistance of the night care assistant who was able to translate in Te Reo, their preferred language. Mrs X settled and the whanau were reassured and made aware they could contact the DN if they had any concerns overnight.

At 0600hrs the following morning whanau called the DN, upset and concerned that Mrs X was in pain and restless. The DN promptly visited and administered further PRN analgesia and changed Mrs X's position with assistance from whanau and noted Mrs X's audible respiratory secretions but had no PRN anti-cholinergic medication available to administer.

The DN explained the symptom to reassure the whanau and contacted the GP to prescribe an anti-cholinergic and to arrange to visit Mrs X. However, before this could be attained, at 1000hrs the whanau called the DN to say Mrs X had died peacefully. The DN visited and was assisted by the whanau to care for the tūpāpaku.

It should be acknowledged that discharge home of terminal patients from ICU has happened before and terminal care has been successfully managed with appropriate PRN medications. However, with the implementation of the LCP the DNs anticipate discharges of patients home from ICU to die may become a more likely scenario, highlighting a need for LCP education of ICU staff.

Although there were some issues with availability of medication to manage respiratory tract secretions, the true measure of LCP success was that Mrs X was supported to die with peace and dignity in her preferred place of care, home, with 24/7 access to DN support and surrounded by her whanau.

*Marie Jackson (Link Nurse) & Libby Taylor (LCP Resource Nurse for DN)
MidCentral Health, Palmerston North*

Deactivating Cardiac Defibrillators

In May of this year Hospice Wanganui implemented the LCP into the community for those Hospice patients who were dying at home. In mid July, a 53yr old woman, under the care of Hospice was commenced on the LCP in consultation with her GP.

The patient had an internal cardiac defibrillator in situ, which initially was not a concern, but as the patients' condition deteriorated and her heart rate slowed, the defibrillator began "firing" at regular intervals. This was distressing for both the patient and her family and they asked that the defibrillator be "turned off".

A staff member at Hospice, who had worked previously in Cardiology, informed us that a magnet would effectively deactivate a defibrillator. The GP contacted the Cardiologist in Wellington who confirmed this but advised that a "fridge magnet" would not be powerful enough. He then asked why we would want to deactivate it as this would "save her life". After further discussion around this, the cardiologist agreed that deactivation would be appropriate. A phone call was made to one of the Physicians at our local hospital requesting use of their magnet. He informed us that the hospital did not have a magnet and suggested we call Mitre 10. At this point staff started calling the local hardware stores asking if they had a magnet that was donut-shaped and approximately 5-6cm in diameter. After several phone calls and many questions around what we wanted the magnet for, two circular magnets were purchased.

Staff returned to the patient and her family and gained informed consent for application of the magnets.

The magnets were placed on top of each other and then taped to the patients' chest over the defibrillator. We were concerned initially that the weight of the magnets may be uncomfortable for the patient, but she assured us that this was not the case. Once the magnets were in place, the defibrillator did not fire again. The patient died peacefully 5 days later.

We requested the magnets back from the funeral director and they were appropriately cleansed. Should this situation occur again, we are now fully prepared. We have also been informed that our local hospital has also purchased a magnet in anticipation of needing one in a similar situation.



*Carron Roberts, LCP Facilitator,
Hospice Wanganui*

The role of a Project Team approach when implementing the LCP

We would like share with you our experience of site specific project teams as a key tool for implementing the LCP in the Hawke's Bay. As LCP Facilitators this model worked well for us and we now see it is ideal for supporting/ facilitating the implementation process irrespective of the setting. The project itself was initiated by the DHB and supported by the Palliative Care Network Group. From a practical point of view the starting point for the 'project team approach' was the guidance and support from someone with project planning expertise in the form of Peggy Kersley from the Hawke's Bay DHB Project support office.

As part of the team Peggy worked with us to develop Terms of Reference and then implementation plan for the hospital wards in which the LCP was to be implemented. The terms of reference outlined the background to, as well as the goals and outcomes for the project, both from the national and regional perspective. It also outlined roles and responsibilities, timeframes and reporting requirements for the project. Arising from this a hospital project team was established to provide strategic support and guidance for the implementation in the hospital setting. This team included the LCP project sponsor; hospital project sponsor; representation from both senior medical and nursing clinicians; pharmacy; HPCT representatives; chaplaincy and Maori representation; Clinical Nurse Managers of the pilot wards and of course the LCP Facilitators.

This team met monthly which provided the opportunity to work collaboratively together with the sole goal of successfully implementing the LCP and to ensure its sustainability. We found working together as a team aided communication throughout the hospital sectors; these members of the team appeared to take "ownership" of the LCP and became enthusiastic advocates. It enabled us to "trouble-shoot" and address any issues on the spot and also view these issues from the different perspectives. It ensured that everyone had a voice within the appropriate forum to be heard. The input and support from the different sectors within the hospital was valued and appreciated as LCP Facilitators. Now that the initial "pilot" project is nearing completion these monthly meetings will discontinue and possibly next year we will gather only three monthly.

Building on what we had learned in the hospital setting, Peggy also worked with us to adapt the hospital implementation plan to the Aged Care (ARC) setting. It evolved into a brief three page document again outlining the purpose of the LCP project; milestones and timeframes; roles and responsibilities of all the key players; reporting processes and the identification of possible risks. At each site we complete this plan with the ARC Manager which they then signed along with the LCP Facilitator and the LCP Project sponsor. Obtaining a "signature" gives the authorization for the implementation to proceed and formalizes the commitment to the success of the LCP implementation. In the two ARC facilities that we also established LCP project teams encompassing aged care and primary care staff which reaped similar benefits to the hospital experience.

*Irene O'Connell & Michelle Rodda
LCP Facilitators, Hawke's Bay*

OPCARE9 Update

OPCARE9 is an international collaboration based around the last days and hours of life and is linked to the Liverpool Care Pathway for the Dying Patient. The project officially started in March 2007 after the Liverpool Marie Curie Palliative Care Institute successfully led an international group to obtain three years of funding from the European Union. The project focuses on optimising collaboration for the care of cancer patients in the last days of life.

The consortium is comprised of 9 countries— seven from the European union (United Kingdom, Sweden, Switzerland, Netherlands, Germany, Slovenia and Italy) and includes Argentina and New Zealand as partners.

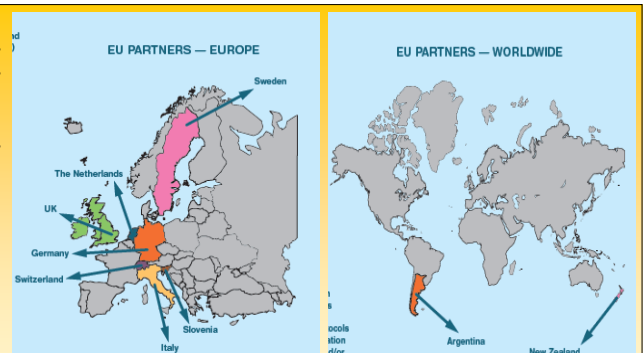
The project comprises seven work packages, two of which are related to management and evaluation. The five work packages which New Zealanders working in palliative care can contribute directly to address **signs and symptoms of approaching death; end of life decisions; complementary comfort care; physiological and psycho-social support to patients; families and caregivers** and **voluntary service**. At the end of three years, the project will define the relevant streamlining of ongoing research for these areas considered in relation to the intersecting themes of needs assessment, quality indicators, technologies and methodologies.

The project utilises systematic reviews of the literature and Delphi rounds to supplement findings of the systematic review by establishing expert opinion regarding knowledge in each of the work packages. seeking expert opinion to identify what is known and significant gaps that may be addressed through future research. A partnership link into this European collaborative project provides an important international link for the New Zealand Palliative Care community. It is anticipated that future opportunities will arise for New Zealand to contribute to projects, including research.

Engaging with palliative care colleagues regarding expert opinion in New Zealand is our main role at this time. If you are working in palliative care and interested in contributing to the Delphi process rounds associated with any of the above work packages or generally please email jean.c@arohanuihospice.org.nz

The opportunity for NZ to strengthen our international links is very exciting and we will continue to share progress and information gathered. EARLY NOTICE: The project will culminate with a conference early in 2011 – look for further details in your next LCP newsletter.

*Jean Clark (RN, PhD) & Dr Simon Allan (MD)
Arohanui Hospice*



NATIONAL LCP OFFICE - NZ

Liverpool Care Pathway for the Dying Patient (LCP)

TRAINING WORKSHOPS 2010

LCP ADVANCED TRAINING DAY

The LCP Advanced Training Day is aimed at experienced LCP Facilitators and all health care professionals using the LCP. The study day is an opportunity to network with other implementers to discuss LCP implementation/dissemination issues/strategies, education issues and pathway analysis to facilitate ongoing learning. Delegates are encouraged to attend a Foundation Day before they attend an Advanced Training Day.

WELLINGTON: **12th February 2010** **West Plaza Hotel, Wellington**

HAMILTON: **19th February 2010** **Waikato Stadium, Hamilton**

LCP FOUNDATION DAY

The LCP Foundation Day is for beginning LCP Facilitators, and health care professionals in clinical, management and funding streams of hospices, hospitals, District Health Boards and residential care organizations who are interested in the LCP as a tool for driving up quality care for dying patients and their families/whānau in the last days and hours of life. In this one day introductory programme, delegates are walked through the LCP document and are given an overview of the LCP '10 Step Continuous Quality Improvement Programme' which includes resourcing a pilot project, audit and benchmarking, and the implementation process while putting the LCP into the context of the national health care agenda in NZ.

CHRISTCHURCH: **26th March 2010** **Copthorne Hotel Commodore, Christchurch Airport**

AUCKLAND: **23rd April 2010** **Crowne Plaza, Auckland**

WORKSHOP DETAILS:

Time: 9.00am - 4.00pm

Cost: \$150.00 (incl GST) Morning tea & lunch provided

Closing Date: One week prior to workshop commencing

For more information contact:

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To register - go to our website:

www.lcpnz.org.nz