Liverpool Care Pathway for the Dying Patient (LCP) - FAQ

What is the LCP?
The Liverpool Care Pathway for the Dying Patient (LCP) is a model of care which enables healthcare professionals to focus on care in the last hours or days of life when a death is expected.

The LCP is tailored to the person’s individual needs and includes consideration of their physical, social, spiritual and psychological needs. It requires senior clinical decision making, communication, a management plan and regular reassessment.

The LCP is not a treatment in itself but a framework for good practice – it aims to support, but does not replace, clinical judgement.

The LCP guides and enables healthcare professionals to focus on care in the last hours or days of life, when a death is expected. However, communication, care and compassion must come from all the healthcare workers caring for an individual patient and their family.

Who is responsible for the development of the Liverpool Care Pathway?
The Marie Curie Palliative Care Institute Liverpool (MCPI) has overseen the development and dissemination of the LCP. Responsibility for day to day implementation of the LCP lies with individual hospitals, GPs and care homes. Implementation must always be underpinned by a robust education and training programme. The LCP has been reviewed regularly and a 2 year consultation exercise led to the design of the LCP generic version 12.

The use of the LCP in hospitals is audited by The National Care of the Dying Audit – Hospitals (NCDAH). The most recent audit took place in 2011.

Is the Liverpool Care Pathway a recommended model of care?
The LCP is an integrated care pathway (ICP); ICPs are used throughout the healthcare system to ensure excellence in patient care (Ellershaw J. & Wilkinson S. 2011). It has been recognised nationally and internationally and recommended as a model of good practice to support care in the last hours or days of life by successive national policy frameworks (DH, 2003 and 2006), the National End of Life Care Strategy: Quality Markers and Measures for End of Life Care (DH 2009), General Medical Council (GMC) guidance (2010) and the NICE Quality Standard (2011).

When should the LCP be used?
Recognising that someone is in the last few hours or days of life is always complex, it requires a multi-disciplinary team approach and should be led by the most senior doctor ultimately responsible for the patient’s care. The LCP should be considered when there is no appropriate reversible treatment available and the team considers that the patient is in the last hours or days of life.

Uncertainty is an integral part of dying. There are occasions when a patient who is thought to be dying lives longer than expected and vice versa. This means that good communication and support for the patient, the relatives and carers is vital.

When it is determined that the patient is dying, all care and treatment must be reviewed; some interventions will be continued, some discontinued, and others started. A referral to the specialist palliative care service or a second opinion should be sought as appropriate.
Good, comprehensive, clear communication is essential and all decisions leading to a change in care delivery should be communicated to the patient where possible and deemed appropriate, but always to the relative or carer. This is in accordance with GMC best practice guidance (GMC 2010). The views of all concerned must be listened to, considered and documented.

**Does the patient or relative need to give written consent to use the LCP?**
No, the LCP is not a treatment but a framework for good practice, therefore, written consent is not required. However, identifying that someone is in the last hours or days of life and agreeing a plan to support care in the last hours or days of life should be discussed with the patient where possible and deemed appropriate and always with the relative or carer.

**How will a relative or carer know if the LCP is being used?**
Acknowledging that a patient is dying and making the decision to use the LCP to support care in the last hours or days of life should be discussed by the clinical team, with the patient where it is possible and deemed appropriate and always with the relative or carer, in accordance with GMC best practice guidance (GMC 2010). All significant conversations should be supported by appropriate written information about the LCP.

Therefore there should never be an occasion when the relative or carer who is named as the first contact or next of kin is unaware of the diagnosis of dying or of the subsequent care plan.

**What happens if the relative or carers disagree with the use of the LCP?**
As with all clinical decisions in healthcare, the senior doctor and the multi-disciplinary team should reach consensus about what care is appropriate at this time. If disagreements occur between the members of the healthcare team or between the healthcare team and those close to the patient, then the clinical team should involve an independent advocate, and/or should seek advice from another senior colleague, and should also seek a second opinion and/or use local mediation services. (GMC 2010)

Good, comprehensive, clear communication is crucial and all decisions leading to a change in care delivery should be communicated to the patient where possible and deemed appropriate but always to the relative or carer. The views of all concerned must be listened to, considered and documented.

**Does the LCP recommend continuous deep sedation?**
No, the LCP recommends a full review of all medication currently prescribed. Medications for the most common symptoms including pain are prescribed, should they be required. However, medicines for symptom control will only be given when needed in response to a symptom, at the right time and just enough and no more than is needed to help with the symptom.

National Care of the Dying Audit – Hospitals Round 2 Generic Report (2008/2009) reviewed the prescription and administration of medication for agitation and restlessness in the last 24 hours of life. The results demonstrated that where medication was prescribed or administered the dosages and frequency of use were low and there was no evidence of continuous deep sedation. (Gambles et all 2011)
Does the LCP recommend stopping or not commencing clinically assisted (artificial) nutrition or hydration?

**No**, the LCP does not preclude the use of clinically assisted nutrition or hydration (CANH). Indeed the LCP prompts clinicians to consider the need for CANH. All clinical decisions must be made in the patient’s best interest and tailored to the patient’s individual needs. The GMC guidance provides specific information regarding this issue. (GMC 2010)

Each patient is an individual with individual needs. Some patients will have a drip continued, some will have a drip discontinued or indeed commenced. These best interest clinical decisions should be made by the senior doctor ultimately responsible for the patient’s care at that moment in time supported by the multi-disciplinary team, and reviewed regularly.

All decisions leading to a change in care delivery should be communicated to the patient where possible and deemed appropriate but **always** to the relative or carer. The views of all concerned must be listened to, considered and documented and all significant conversations should be supported by an appropriate written information leaflet.

Is the LCP a form of euthanasia?

**No**, the LCP guides and enables healthcare professionals to focus on the best possible care in the last hours or days of life. This includes consideration of the individual patient’s physical, social, spiritual and psychological needs. This requires assessment, senior clinical decision making, communication, a management plan and regular reassessment.

The LCP exists to support good decision making in the last hours or days of life which will focus on ensuring good quality of care. The provision or withdrawal of interventions with the direct aim of hastening death is contrary to the rationale of the LCP, contrary to GMC guidance, and illegal.

The LCP aims to support, but does not replace, clinical judgement. Clinical decision making is the responsibility of the clinical team looking after the patient. All decisions must be made in the patient’s best interest, tailored to their individual needs. The LCP is in accordance with the decision making processes as outlined in the GMC Guidance (2010).

How often should the patient be reviewed when supported by the LCP?

The patient should be reviewed as often as needed as each patient and their relatives and carers have individual needs. However, irrespective of clinical need, the patient in an in-patient unit (e.g. a hospital) should be reviewed at least 4 hourly, and at home each time the doctor or nurse visits.

In addition to these regular 4 hourly assessments as outlined above, a full multi-disciplinary team review of the plan of care should occur

**When**

- the patient appears to have an improved conscious level, functional ability, oral intake, mobility, or ability to perform self-care
- concerns are expressed regarding the management plan by either the patient, the relative or carer or healthcare worker

**or**

- It is 3 days since the last full multi-disciplinary assessment

As above, this assessment and the subsequent outcome should be communicated to the patient where possible and deemed appropriate but **always** to the relative or carer.
What if the patient improves can the LCP be discontinued?
Yes, the LCP can be discontinued following a review of the patient’s condition by the multi-disciplinary team and in consultation with the patient, where possible and always with the relative or carer. The views of all concerned must be listened to, considered and documented. (GMC 2010)

How is the LCP monitored?
Any organisation that cares for dying people should be able to demonstrate best practice in care of the dying including the last hours or days of life. End of Life Strategy (2008), GMC (2010), CQC (2010), NICE (2011).

Each Organisation should ensure;
- it has an End of Life Strategy including the use of a best practice model for care in the last hours or days of life, which is monitored at executive board level;
- a named person is employed and responsible for driving up quality for care of the dying in the organisation;
- the Specialist Palliative Care Team offers a 7/7 face to face service with an out of hours support line;
- the organisation audits care of the dying against the best national benchmark; and
- all those who care for dying patients are trained to do so.

The responsibility for use of the LCP lies with the organisation which is using it. It should be used as part of a continuous quality improvement programme within the governance of the organisation and it must be underpinned by a robust education and training programme.

The LCP, like any other end of life care tool, or an escalation of care tool, is itself the product of a review of good practice and is in place to enable the delivery of safe, standardised, effective patient-related outcome measures. The monitoring and governance of any best practice tool or technology is the responsibility of the organisation using it.

Where can I find out more information?

http://www.liv.ac.uk/mcpcil/liverpool-care-pathway/

The LCP guides and enables healthcare professionals to focus on care in the last hours or days of life, when a death is expected. However, communication, care and compassion come from all the healthcare workers caring for an individual patient and their family. Care must be delivered, communicated and assessed within the organisational governance framework.

This FAQ has been prepared by the National End of Life Programme, Marie Curie Cancer Care, and the Marie Curie Palliative Care Institute Liverpool.
REFERENCES


Royal College of Physicians http://www.rcplondon.ac.uk/resources/clinical/audits