

A pilot study of the use of the Liverpool Care Pathway in Western Australia.

Final report

**WA Cancer & Palliative
Care Network**

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Executive Summary

The Palliative Care Pathways and Protocols Working Group was established in order to address recommendations regarding protocols and pathways in palliative care. The priority for the Working Group was the implementation of a pathway for the last days of life. Best practice pathways utilized nationally and overseas were identified and compared. The Liverpool Care Pathway was selected for use in WA. The LCP was identified as an ideal quality framework due to its ongoing international use, adaptability, and the support provided by the Marie Curie Palliative Care Institute Liverpool.

The Palliative Care Pathways and Protocols Working Group worked collaboratively to modify the LCP to suit the needs of service providers in WA. The modified LCP was then piloted in four palliative care services in WA during 2007 and 2008. The aim of this pilot was to determine the suitability of the LCP in the WA setting and to inform the potential future implementation strategy of the pathway in WA. This involved a pre and post intervention audit of medical records of deceased patients at each site. The intervention included education of staff members at each trial site regarding palliative care and the use of the LCP, as well as implementation of the LCP.

The pilot study highlighted the need for a systematic approach to implementation with support from a centralised group of experts, such as the WA Palliative Care Network. This approach will ensure a smooth transition from previous work procedures to application of the LCP, up to date and ongoing education of providers, support and guidance in regard to addressing problem areas identified during the audit process, and will strengthen relationships between services and providers. A quality improvement approach to implementation of the LCP and further research regarding its clinical impact are recommended.

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Background

The Palliative Care Pathways and Protocols Working Group was established in 2007 with representatives from 12 WA Palliative Care Services and the WA Palliative Care Network. This working group was formed to address recommendations regarding protocols and pathways identified from the 2005 Review of Palliative Care Services in WA.¹ The initial focus for this group was to ensure the implementation of an evidence-based integrated care pathway to guide care of the dying across the WA health system, regardless of the illness, location and area of expertise of the service provider. This priority arose from the notion that expertise in the care of the dying is a fundamental element of a palliative approach to care.²

Care during the last days of life remains problematic. Much of the difficulty lies in diagnosing dying and communicating about the end of life.³ The need to withdraw unnecessary treatment is often a challenge in hospital and health care settings as traditional medical models focus on curative treatment.^{4, 5} Making a diagnosis of dying may be seen as medical failure rather than an inevitable and final phase of life.⁶ This emphasis on cure and digression from end of life care can result in a lack of awareness or recognition that the patient has entered the dying phase and a lack of knowledge on the part of the health professionals of what to do once the dying process has begun.⁷ This means many patients and their families continue to suffer physical, psychological and social symptoms during the last days of life.⁸ Additionally this can lead to the inappropriate use of life-sustaining interventions right up until the time of death.⁹⁻¹² These interventions can prove costly to the health system and burdensome to patients and their families.

The review of palliative care services in Western Australia identified that by the year 2016 there will be significant increases in the burden of disease the population increases in the size and age.¹ This highlights the growing need to extend the availability of palliative care in WA and a need to improve skills and efficiencies encompassing the management of terminally ill patients. Ongoing education of service providers regarding palliative care is an essential component of improving the quality of care in the last days of life. Similarly, the introduction and routine use of integrated care pathways (ICPs) are another component of improving care of the dying.

ICPs are a popular, powerful tool in guiding the provision of care for the dying. The National Pathways Association of the United Kingdom (UK) developed the following definition:

*“An integrated care pathway determines locally agreed, multidisciplinary practice based on guidelines and evidence where available, for a specific patient/client group. It forms all or part of the clinical record, documents the care given and facilitates the evaluation of outcomes for continuous quality improvement”.*¹³

These pathways provide a best practice template outlining essential goals and elements of care for the patient and their family to provide quality care.⁷ ICPs

were developed in the United States in 1985 to improve efficiencies surrounding the use of resources, implement evidence based practice and to find better ways to involve patients and their families in health care.¹⁴ The introduction and routine use of ICPs globally has continued since.¹⁴ ICPs' have been used to standardise care across a range of services and for a wide range of illnesses.¹⁵ The use of ICPs however has attracted some controversy as there is a paucity of evidence in support of some of the declared benefits. In palliative care the difficulty in measuring the clinical benefit of such tools is due to the fact that patients are terminally ill and that measurements could be deemed intrusive at this time of life. There is still a need for more research into the clinical impact of ICPs. Despite this need, ICPs have crossed professional, geographical and cultural boundaries.¹⁴

The Palliative Care for Advanced Disease (PCAD) pathway is an ICP developed by the Beth Israel Medical Centre in the United States during the early 2000s. The aim of the development of this pathway was to improve palliative care for inpatients with advanced disease.¹⁵ The PCAD was considered to offer an approach to change within the organisation that focused on collaboration, encouraged utilization of resources for patients, and repaired inadequacies in care. The PCAD focussed on symptom control, the needs of the family/caregiver, advance directives and communication.¹⁵ A nine month before and after study of the use of the pathway at five inpatient hospital units in the states indicated improvements in levels of clinician knowledge and documentation of care with the use of the PCAD. The authors highlighted the need for further research regarding the use of the PCAD, particularly the impact on patient outcomes and its use in a variety of settings.¹⁵ However there is no evidence to indicate continued use or research of the PCAD, nor its transference to other health care settings.

The Liverpool Care Pathway (LCP) is another ICP that is widely recognised to guide management during the last days of life. The LCP was developed in the late 1990s by the Marie Curie Hospice Liverpool and the Royal Liverpool University Hospitals.¹⁶ The concept behind the development of the LCP was to enhance educational programmes regarding identifying and articulating the dying phase and to transfer the hospice model of care to other health care settings.¹⁶ The LCP has continued to be governed and administered by the Marie Curie Palliative Care Institute Liverpool (MCPCIL) which comprises the University of Liverpool, the Royal Liverpool University Hospital and Marie Curie Cancer Care. The LCP prompts the health care team to implement 18 goals of care to ensure optimal patient comfort and family member support during the last days of life. These goals relate to initial assessment and care, ongoing care and care after death.¹⁷ The LCP provides a best practice template for health professionals, and is a valuable audit tool promoting reflective practice and benchmarking.

The LCP has been implemented in hospices and hospitals globally.^{16, 18} A recent study investigated the use of the LCP in a number of services in Rotterdam. The results of this study showed that the LCP can improve the quality of documentation of care and symptom management of terminally ill patients.¹⁸ In Australia, the LCP or modified versions of the tool have been

used in at least 12 organisations, particularly in New South Wales and Queensland. A recent audit (2007) of eight of these organisations, based on the goals of care outlined in the Liverpool Care Pathway, identified several aspects of care that could be improved.⁶ The audit indicated that the LCP was suitable for improving care of the dying in Australia by educating practitioners and prompting changes within these organisations.⁶

The use of the LCP and research into its clinical impact continues, with recent data indicating implementation in 17 countries, and more than 1400 services in palliative care and other health care settings. The National Health Service UK recommends the use of pathways and identifies the LCP as one which delivers high quality care.² The LCP is used as a national audit tool of care of the dying in the UK.¹⁹ Research is currently in progress investigating the use of the LCP in optimising clinical care for cancer patients in nine palliative care services in Europe, South America and New Zealand.²⁰

Several other ICPs used in palliative care were identified in the literature²¹⁻²³ however the majority were found to have similarities with, or were modified from, the LCP or extended beyond the last days of life. The Pathways and Protocols Working Group selected the LCP as the most ideal pathway for use in WA. The LCP was selected for piloting over the PCAD or alternative pathways due to its ongoing international use, adaptability, and the support provided by the MCPCIL. The aim of implementation of the LCP for care of the dying in WA is to improve equity of access to services and support consistency of care across the state. All WA Health services have a responsibility to provide quality care to the dying which meets Palliative Care Australia Standards.²⁴ The implementation of the LCP into health services in WA, rather than an alternative ICP would reflect international and national trends.

The Pathways and Protocols Working Group worked collaboratively to modify the LCP to suit the needs of service providers in WA. This involved amalgamating the four different LCPs' (hospital, hospice, community and care home) into one universal document and incorporating local systems. The modified LCP was approved by the MCPCIL and then piloted in WA.

The aim of this pilot was to determine the suitability of the LCP in the WA setting and to inform the potential future implementation strategy of the pathway in WA. This pilot project was conducted under the guidance of the MCPCIL.

The specific objectives of this pilot project were to:

- determine whether the LCP corresponds with local palliative care practice,
- assess the education and support requirements for implementation of the pathway, and
- identify potential barriers or problems relating to implementation of the pathway.

Methods

Project Design

This project involved a pre and post evaluation of the documentation involved in the implementation of the LCP in four health care facilities in Western Australia. Medical records were audited prior to, and after implementing the LCP. The objective of this approach was to capture the current state of practice regarding care of the dying in order to compare with the use of the LCP. This method facilitates comparisons with future practice. Details of the project tasks are found in Appendix 1.

A formative assessment of an educational session and use of the LCP were also conducted. This involved an exploration of ways in which the overall pathway package could be improved through questionnaires and feedback.

Ethics

Ethics approval was granted for this project by the respective ethics committees for each trial site.

Trial Sites

The Palliative Care Network called for expressions of interest regarding this pilot study. Four sites volunteered to participate and reflect three care settings, in-patient hospice, tertiary hospital (oncology and renal units) and community palliative care. Endorsement from management at each site was received prior to commencing the study. A minimum of twenty patients were required for the pre and post intervention audit, as per the LCP protocol stipulated by the MCPCIL.

Procedure

1. Pre-Intervention Audit

The pre-intervention audit conducted at each trial site incorporated a pro forma developed by the MCPCIL which reflected the goals of the LCP. The records of twenty consecutive patients who had deceased at each site in the previous six months were reviewed. Criteria for inclusion in the audit were patients who had been admitted to the facility at least 72 hours prior to death. The audit involved assessing the documentation in relation to each of the goals outlined in the LCP to determine how well care during the last days of life was documented. Goals were recorded as achieved, not achieved or not addressed, as indicated by documentation in the notes. From this, a baseline of the level of documentation was established.

Documentation during the pre-intervention audit could be categorized as either 'yes', 'no', 'missing', 'comatose' or not applicable. These were defined as:

- Yes: Goal met
- No: Goal not met
- Missing: Goal not documented

- Not applicable: Not required to be reported on (for example symptom not occurring or intervention not being carried out)
- Comatose: The patient was unable to communicate due to coma.

'Missing' meant that no information was provided for a particular goal. 'No' indicated that assessment or treatment was recorded against a particular care goal, however the goal was not met.

Data collected from the audit of trial sites were forwarded to the MCPCIL and entered into SPSS.

Trial sites were provided with the results prior to the introduction of the LCP. This allowed some reflection on the part of the trial sites, in order to recognize and consider areas for improvement.

2. Intervention

- Educational package
Following the collection of pre-intervention data, staff members at each trial site were requested to attend an educational session regarding the LCP. A train the trainer approach was used to deliver the material. Educational sessions were arranged at each trial site and were facilitated by the on-site clinical educator. These 'facilitators' were provided with materials for the session. The educational material entitled '*Care pathway for the dying patient (LCP)*' was developed by staff at the Palliative Care Network and other experts in the field and was based on evidence-based best practice. The content comprised care of the dying, particularly holistic care, and the use and completion of the LCP. The educational session involved two modules, each approximately 60 minutes in duration. Each facilitator was supported by staff at the Palliative Care Network to ensure familiarity with the material prior to the educational sessions.

At the end of each educational session attendees were asked to complete an evaluation form. This evaluation encompassed the learning outcomes, delivery, structure, and content of the session. Facilitators were also invited to provide feedback on the educational material.

- Pathway
On completion of the educational sessions the LCP was introduced at each trial site. Each trial site was asked to complete the LCP for twenty patients. As per the LCP protocols, completion of the document was commenced when there was agreement from the health care team that the patient was dying. The LCP is configured to prompt the health care team regarding 18 goals of care to ensure optimal patient comfort and family member support. The patient was then assessed regularly and any variations in care were recorded.
- Post-Intervention Audit
The completed LCPs were collected by a member of staff at the Palliative Care Network and were forwarded to the MCPCIL for review, data entry into SPSS and feedback.

Post-intervention documentation could be categorized as either 'achieved', 'variance', 'missing', 'comatose' or 'not applicable'. These were defined as:

- Achieved: documented
- Variance: symptom or issue identified as present and/or problematic
- Missing: No recorded information
- Not applicable: Not required to be reported on (eg. symptom not occurring or intervention not used at this service)
- Comatose: The patient was unable to communicate due to coma

Any variances recorded in the LCP required additional information with regard to why the symptom or issue was present and the action taken or planned to reduce or eliminate it.

Staff members at each trial site were also asked to complete an evaluation form regarding the use of the LCP.

Results

Audit of documentation

Three of the four trial sites completed the pre and post-intervention audit of medical records. The Project Officer conducted the pre-intervention audit at all but one trial site, where two members of staff performed the audit. A total of 80 notes were reviewed during the pre-intervention audit (January – September 2007), and 52 completed LCPs were collected across three sites (January – May 2008). The number of patients per site is shown in Table 1.

The majority of patients in the pre-intervention audit were male, and the median age was 73 years across the four sites. Patients exposed to the intervention were an average age of 68.7 years. Patient characteristics are shown in Table 2. Patients involved in the intervention were on the pathway for an average of 34.3 hours.

Data collected during the audits were analysed descriptively and the pre and post intervention data compared for each domain of care. The domains of care comprised groups of goals present in the LCP and include: Physical comfort of the patient, psychosocial (insight) and spiritual aspects of care (patient and carer), communication (patient, carer and other health care professionals), information (giving and receiving) and following appropriate procedures.

The intent of this pilot study was not to determine which services were performing better than others in terms of documentation of care, but to ascertain any differences seen between standard documentation of care and the use of the LCP. A summary of the findings are outlined below. See Tables 3 for the complete data set.

Domain 1: Physical comfort of the patient

The percentage 'achieved' for anticipatory prescribing for dyspnoea was remarkably low for the pre-intervention audit across the four sites (5-40% achieved: 60-95% not achieved). There were considerable improvements for this symptom at all sites for the post-intervention audit (74-80% achieved). The care goal of discontinuation of inappropriate interventions had substantial numbers across all sites documented as 'not applicable'. These interventions include blood tests, antibiotics, IV fluids/drugs and cardiac defibrillators. The documentation of 'Not for CPR' however resulted in high percentages of 'not achieved' (pre-intervention) or 'variance' (post-intervention). Three sites had 100% 'not achieved' for this intervention during the pre-intervention audit, and two sites had 80% and 100% variance for the post-intervention audit. Documentation of assessment of pain, agitation, nausea and vomiting were achieved for at least 75% of cases at three sites for the pre-intervention audit, and for at least 80% for all sites for the post-intervention audit.

In terms of ongoing assessment and care, documentation of pain was achieved for at least 74% of patients across all sites for both the pre and post-intervention audit. The percentage 'not achieved' for the ongoing care goal of dyspnoea was high across three of the four sites for the pre-intervention audit

(70-89%). A considerable increase in the percentage 'achieved' for the post-intervention audit was noted. Noted is that documentation surrounding the management of syringe drivers was only reviewed for the pre-intervention audit. No separate care goal for management of syringe drivers exists in the LCP which impairs the ability to compare pre and post-intervention data.

Domain 2: Psychosocial (Insight) and Spiritual aspects of care (patient and carer)

The percentage 'achieved' for insight into the condition assessed and the family/caregiver made aware of the diagnosis was high for all sites during both the pre-intervention (75-100%) and post-intervention audits (95-100%). Ensuring the patient is made aware of the diagnosis resulted in lower percentages of 'achieved', due to a number of patients being comatose. This occurred in both the pre and post-intervention audits.

The assessment of religious/spiritual needs of both the patient and their family/caregiver showed reductions in the percentage 'variance' during the post-intervention audit (5-16%) compared with the 'not achieved' during the pre-intervention audit (40-89%).

Domain 3: Communication (Patient, Carer and other Health Care Professionals)

Communication with the patient regarding the plan of care was documented as 'achieved' in almost 50% of cases in both the pre and post-intervention audits, where the patient was not comatose. Explanation of the plan of care to carers was documented as 'achieved' in 89-100% of cases in the pre-intervention audit and 100% in the post-intervention audit across all the sites. The family/caregivers understanding of the plan of care showed improvements during the post-intervention audit with all sites scoring 100% 'achieved' compared to 60-100% for the pre-intervention audit. Notifying the primary care practitioner of the patients deteriorating condition was documented as occurring in the majority of sites in each audit. Notification of the primary care practitioner of the patients' death however indicates that all sites performed better in the pre-intervention audit (100%) compared to the post-intervention audit (55-92%).

Domain 4: Information (giving and receiving)

The majority of sites documented the provision of information, documentation and advice on procedures to the appropriate person following death during the pre-intervention audit (100%). In the post-intervention audit however two of the three sites did not achieve this in 65-90% of cases. Documentation of a bereavement leaflet having been given to the family/caregiver was 100% not achieved during the pre-intervention audit for three out of four sites. Similarly the post-intervention audit shows this was 'not achieved' at two of the three sites.

Domain 5: Following Appropriate Procedures

Each site achieved documentation of following procedures for laying out in 100% of cases during the pre-intervention audit. During the post-intervention audit however these scores decreased to 85-90% across the three sites. The

documentation of after death procedures being discussed or carried out showed variation across the three sites. Three of the four sites achieved this in 95-100% of cases during the pre-intervention audit, where as 20-85% were achieved across all sites during the post-intervention audit.

Missing data

A small amount of documentation for all care goals was missing across all sites for the post-intervention audit regarding physical comfort of the patient. There was also a small amount of 'not achieved' for the majority of care goals across all sites for the post-intervention audit regarding physical comfort of the patient. This lack of documentation was apparent in the pre-intervention audit however varied across the sites and for certain care goals.

Small amounts of missing data were shown for each care goal during the post intervention audit which was not seen in the pre-intervention audit regarding information giving and receiving. Small amounts of missing data were also shown for each care goal in the post-intervention audit, which were not seen in the pre-intervention audit regarding following appropriate procedures.

Educational package

The educational sessions regarding the use of the LCP were compulsory for staff at only one trial site. Forty-two responses regarding feedback on the educational sessions were received. This feedback related to the content of the session, the delivery and presentation of the session and the venue. Responses were immensely positive; with scores of 86% and above of 'agree' or 'strongly agree' for all aspects under review. See Appendix 1 for the responses.

Facilitators described difficulties in getting all staff to attend the session and the need to hold a number of sessions in order to capture the majority of staff.

Liverpool Care Pathway document

Eighteen responses regarding feedback on the LCP document were received. This feedback related to the layout of the document, ease of use and possible improvements. The responses indicated that the LCP was relatively easy to use, however it became easier to use once the health professional became more familiar with it. Some respondents found the LCP to be time consuming to complete, at least initially. It was highlighted that there wasn't enough room in places to record information, and the layout of the document would be better with some adjustments (for example the variance sheet would be more functional in landscape view as opposed to portrait view). See Appendix 2 for the responses.

Discussion

Implementation of the pathway

The results of the pilot indicate that one trial site did not complete the study. Feedback from the site as to why this occurred indicated the predominant reason for not completing the trial was due to reduced staffing because of leave arrangements and turn-over of staff during the study period. This trial site also did not have a clear facilitator for the LCP due to staff changes which impacted on completing the study. Despite the inconvenient timing of such occurrences this feedback indicates that more information and support may be required from services regarding the use of the LCP. A lack of guidance and support has previously been identified as a barrier to implementation of the LCP.²⁵ The LCP is intended to guide routine care. Although there will be an adjustment period during the early introduction of the pathway with staff being unfamiliar with the requirements or contents of the document, continued use and a systematic, supported implementation has been shown to reduce the burden of the change in practice.

Additionally the implementation of the pathway during the pilot was the responsibility of each trial site. This meant strict instructions were not given as to how to implement the pathway into trial sites. This enabled flexibility for services to incorporate the pathway into their own environment in the best possible manner, due to their familiarity with their own systems. It was also a way to encourage sustainability and compliance with the use of the LCP, which have been highlighted as important in other care pathway studies.^{23, 26} The project team frequently contacted the facilitator at each site via telephone during the pilot period to monitor progress. Anecdotal evidence indicated that trial sites were in fact contacting each other for advice and information. Further ongoing support from the project team incorporating a quality improvement approach is likely to help reduce the seemingly burdensome task of implementation. Staff involved in implementing the pathway would have the opportunity to openly discuss challenges with colleagues from other organisations in a structured, constructive manner. Utilising a quality improvement approach has been shown to improve support for the LCP as a whole framework rather than just a written document.²⁷ The approach has shown to enhance commitment, and encourage interdisciplinary relationships and communication.²⁷

Documentation of care

The audit of medical records involved determining the documentation of care in regard to goals outlined in the LCP. Consequently if the care was not documented it was marked as “no”, or “not achieved”. This means the results do not necessarily reflect the standard of care provided by each service, rather the documentation of such care. However, specific areas for improvement were identified by reviewing the documentation for each trial site. It should be noted however that some results may reflect differences in the type of service. For example, community hospice results would have expected differences in areas such as resuscitation compared to the tertiary hospital. Anecdotal findings from the audit process suggest that difficulties arose regarding how to address such areas for improvement in a systematic,

constructive manner. The audit process used during this pilot did not follow a rigorous quality improvement approach therefore support was not provided regarding methods to enhance service delivery. Future implementation of the LCP would benefit from a more thorough quality improvement approach to ensure the full potential of the LCP package is reached, rather than using the LCP purely as an alternative method of documentation.

The results show that in some cases documentation of care did not improve with the use of the LCP. For some goals, the documentation of care actually deteriorated. This may have been due to lack of familiarity with the use of the pathway which would improve with practice. Anecdotal findings and feedback regarding the use of the LCP suggest that familiarity with the pathway due to continued use improved recognition of when to start a patient on the pathway. The documentation of the incidence of patients being comatose for some care goals could indicate that the LCP may have been started too late. It is anticipated that with continued use the incidence of this occurring would reduce. Further research in this area is required to confirm this suggestion. Anecdotal evidence also indicated reluctance on behalf of some services to use the LCP. It is apparent that some services already have excellent practice in terms of documentation of care therefore felt the LCP was not necessary. It is important to remember that the aim of implementation of the pathway in WA is to ensure consistency of practice. An organisational culture that instils high standards of documentation of care should ascend the particular document that is used to record such data. Additionally some trial sites continued with normal practice in that the LCP was used in addition to routine documentation. This meant that although the LCP had not been completed, it is likely that other site documentation had been completed. There is a need to ensure definitive change over during implementation so that the LCP captures the documentation of all care provided.

Domain 1: Physical comfort of the patient

The high percentages of 'not achieved' for determining whether patients are not for CPR during both the pre and post-intervention audits required further consideration and a review of the variance records. The variance records individualise care to the needs of the patient and their families and offer insight into why goals are not met. They also can identify areas where change in practice may be required. The variance sheet for this care goal indicated that this intervention was not part of the organisations policy. Despite this organisational policy it is important that discussion with patients and their family still takes place as questions or concerns will still continue. There is a need to keep the patient and their family informed of such organisational policies or procedures. Staff members are in a position to provide support for the family and caregivers by discussing these and other related issues.

The increased incidence of missing data for ongoing assessments during the post-intervention data reflects the increased frequency of assessments introduced by the LCP as opposed to standard practice at some of the services. For some services, such as a community based service the frequency of assessments provided by the LCP is unattainable. The frequency

of assessments should be made at the discretion of the organisation and will be based on the patient and family need.

The collection of specific information regarding syringe drivers during the pre-intervention audit and the collection of this data in combination another care goal during the pilot of the LCP indicates differences in the audit proforma and the LCP. It is important for future audits that modifications made to the LCP for WA practice should be reflected in the audit document. Difficulties in comparing and analysing results, and drawing conclusions can arise if such intricacies are not addressed.

Domain 2: Psychosocial (Insight) and Spiritual aspects of care (patient and carer)

Considerable improvements were noted in the assessment of the patient and their family's religious or spiritual needs with the use of the LCP. This indicates that the LCP prompted the health professional to address and document these issues. It is in this manner that the LCP has the potential to improve care for the dying.

Domain 3: Communication (Patient, Carer and other Health Care Professionals)

The results indicate that the LCP was also responsible for improvements in discussing and documenting the plan of care with the patient's family or carer during the pilot. The LCP has prompted the health professional to involve the family in the patients care.

The substantially poor performance in notifying the General Practitioner of the death of the patient during the post-intervention audit compared to the pre-intervention audit could be explained by organisational procedures. That is, the trial sites have other documentation that staff are required to complete rather than recording details of such conversations on the LCP. The implementation of the LCP should include education surrounding the discontinuation of separate documentation. A systematic approach to implementation would ensure that documentation of all aspects of care occurs on the one document. Ensuring the primary care practitioner is kept informed of the changes in the patients' condition can mean additional support for family during and after the death of the patient.

Domain 4: Information (giving and receiving)

The retention of verbal information can be difficult for the patient and their families during end stage illness. Therefore it is recommended that written information is provided to support any discussions that take place. (eg. practical advice relating to steps required after the death of the patient; grief and bereavement advice including how and where to access help and support). The poor scores in these areas during both the pre and post-intervention audit indicate a lack of appropriate literature.

Domain 5: Following appropriate procedures

The poor results for goals in this domain require further research to determine the cause (Care goals: Following procedures for laying out, and After death procedures being discussed or carried out).

Missing data

The small amounts of missing data for each goal in the information (giving and receiving) domain for the post-intervention audit suggests that the occurrence of discussions with the appropriate people may have been recorded elsewhere. It is important that staff are educated regarding the use of the LCP, and to discourage documentation of care on a variety of different documents. The decrease in achieving the provision of information, documentation and advice on procedures during the post-intervention audit compared to the pre-intervention audit however suggests that this was not occurring. Further research in this area would help determine the cause of such occurrences.

Similarly, the small amounts of missing data for each goal in the following appropriate procedures domain for the post-intervention audit suggests that the after death procedures were being recorded elsewhere.

Education package

The results indicate the education package was well received. Trial site facilitators would benefit from support whilst planning educational sessions in order to determine the best methods for capturing the maximum number of staff.

Liverpool Care Pathway document

The WA LCP document is an amalgamation of the four available LCPs, these being hospital, hospice, community and care home versions. The Palliative Care Pathways and Protocols Working Group made the decision to establish one uniform LCP for use in WA for simplicity and for standardisation across services. The suggested modifications to the LCP document from the feedback from the trial sites require careful consideration and approval from the MCPCIL. Further approval for the final WA LCP document should also be sought from the WA LCP Implementation Reference Group.

Limitations of study

This pilot study involved a pre and post-intervention audit of medical records. This meant that the documentation of care was measured rather than the impact of the LCP on care itself. There are therefore limitations with regard to what can be said about the performance of each trial site. Additionally only auditing the records of twenty patients during the pre and post intervention audit means that the generalisability of the results is somewhat limited. A larger study which includes measures of clinical outcomes such as symptom management would be beneficial in determining the impact of the LCP in guiding clinical care.

The pilot study only involved palliative care facilities as trial sites. These facilities are already well informed and familiar with end-stage care of the

terminally ill. The results are therefore not indicative of how other services may perform with the use of the LCP. An evaluation of the impact of the LCP on clinical outcomes during the roll out of the LCP to other services in WA would be valuable in determining the effect of the LCP in guiding care.

The requirement of consent from the patient or family at one site caused difficulties. Health care providers were uncomfortable in asking the patient or their family to participate in the study. Once this difficulty was acknowledged by the organisation arrangements were made to obtain consent on admission to the service rather than trying to obtain once the patient had entered the dying phase. It is important to ensure that such difficulties are avoided in future studies.

Conclusion

The pilot of the LCP in four services in WA highlighted the potential to promote change in practice with the use of the LCP. A rigorous quality improvement approach to implementation with support from a centralised group of experts, such as the WA Palliative Care Network would reduce the seemingly burdensome task of implementation. Widespread implementation of the LCP would benefit from such a systematic approach due to the need for ongoing education and support. Further evaluation of the use of the pathway is essential with particular focus on the impact of the pathway on clinical outcomes.

Recommendations

The following recommendations surrounding the use of the LCP have been made as a result of this pilot study.

Recommendations for LCP Document

- Final modifications to the WA LCP document should be approved by the MCPCIL and WA LCP Implementation Reference Group prior to implementation of the LCP.
- The audit proforma should be modified to reflect the final approved version of the WA LCP document so that pre and post intervention documentation can be directly measured.
- Written documentation such as generic manuals that includes protocols guiding use of the LCP should be developed, in accompaniment to the educational package.
- Policies surrounding the inability of services to change the LCP document should be developed.
- Policies surrounding the process of updating the LCP document should be developed.

Recommendations for LCP implementation

- A formal arrangement with the MCPCIL regarding the use of the pathway and future projects should be established.
- The WA Palliative Care Network and Palliative Care Services should provide ongoing support during the implementation of the LCP.
- Implementation of the LCP should follow a systematic approach with support from a centralised group of experts.
- Services implementing the LCP should be informed that each site retains responsibility for the implementation of the LCP. This includes providing ongoing education for staff regarding palliative care and clinical support for the use of the LCP.
- Implementation of the LCP at sites should involve a site facilitator who will be trained by the WA Palliative Care Network to train other staff.
- Implementation of the LCP should occur across all services in WA, rather than being restricted to palliative care services.
- The LCP should be promoted as a quality improvement initiative with specific links to EQUiP 4²⁸ for the Australian context.

Recommendations for further research into the use of the LCP

- Further research regarding the clinical impact of the use of the LCP should be conducted.
- WA should collaborative with international researchers regarding the use of the LCP.

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Tables

Table 1: Number of patients per site

Site	Baseline (n)	Post pathway (n)	Total
1	20	20	40
2	20	13	33
3	20	19	39
4	20	0	20
			132

Table 2: Patient Characteristics

Characteristic		Frequency			
		Site 1	Site 2	Site 3	Site 4
Baseline					
Gender	Male	12 (60%)	10 (50%)	10 (50%)	11 (58%)
	Female	8 (40%)	9 (45%)	10 (50%)	7 (37%)
	Missing	-	1 (5%)		1(5%)
		20 (100%)	20 (100%)	20 (100%)	
Age	Median	75	73	66	78
	Range	(40–87)	(15–90)	(43–83)	(49–92)
Post pilot					
Gender	Male	6 (30%)	8 (62%)	11 (58%)	N/A
	Female	14 (70%)	5 (38%)	8 (42%)	
	Missing				
		20 (100%)	13 (100%)	19 (100%)	
Age	Median	67	70	69	N/A
	Range	(38–90)	(49–99)	(14–93)	
Number of Hours on Pathway	Median	34	48	21	N/A
	Range	(2–183)	(10–294)	(1–152)	

Table 3. Achievement of goals in Liverpool Care Pathway

Section 1: Initial Assessment and Care		Baseline				Post-pilot					
		Site 1 (%)	Site 2 (%)	Site 3 (%)	Site 4 (%)	Site 1 (%)	Site 2 (%)	Site 3 (%)			
1.	Current medication assessed and non-essentials discontinued	achieved	(100)	(95)	(30)	(79)	achieved	(85)	(92)	(95)	
		not achieved		(5)	(65)	(21)	variance	(15)	(8)		
		missing			(5)		missing			(5)	
2.	Subcutaneous drugs written up according to protocol	▪ Pain	achieved	(100)	(100)	(95)	(95)	achieved	(90)	(100)	(95)
			not achieved				(5)	variance	(10)		(5)
			missing			(5)		missing			
	▪ Agitation	achieved	(100)	(75)	(80)	(26)	achieved	(95)	(92)	(95)	
		not achieved		(25)	(10)	(74)	variance	(5)	(8)	(5)	
		missing			(10)		missing				
	▪ Respiratory tract secretions	achieved	(80)	(70)	(65)	(53)	achieved	(75)	(62)	(74)	
		not achieved	(20)	(30)	(30)	(47)	variance	(20)	(38)	(26)	
		missing			(5)		missing	(5)			
	▪ Nausea and vomiting	achieved	(80)	(80)	(90)	(58)	achieved	(80)	(100)	(89)	
		not achieved	(20)	(20)	(5)	(42)	variance	(20)		(11)	
		missing			(5)		missing				
▪ Dyspnoea	achieved	(40)	(30)	(15)	(5)	achieved	(80)	(77)	(74)		
	not achieved	(60)	(70)	(75)	(95)	variance	(20)	(23)	(26)		
	missing			(10)		missing					
3.	Discontinue inappropriate interventions	▪ Blood tests	achieved	(45)			(63)	achieved	(60)	(15)	(21)
			not achieved				(37)	Variance			
			missing					missing			
	▪ Antibiotics	achieved	(5)		(5)	(53)	achieved	(50)		(21)	
		not achieved			(5)	(21)	Variance	(15)			
		missing					missing	(5)			
	▪ IV fluids/drugs	achieved	(95)	(100)	(90)	(26)	N/A	(30)	(100)	(79)	
		not achieved	(30)	(5)		(53)	achieved	(25)	(5)	(16)	
		missing				(16)	variance				
			(70)	(95)	(100)	(32)	missing				
							N/A	(75)	(95)	(84)	

Section 1: Initial Assessment and Care			Baseline				Post-pilot		
Care Goal			Site 1 (%)	Site 2 (%)	Site 3 (%)	Site 4 (%)	Site 1 (%)	Site 2 (%)	Site 3 (%)
	▪ Not for CPR	achieved					achieved	(15)	(79)
		not achieved	(100)	(100)	(100)	(11)	variance	(80)	(100)
	▪ Deactivate cardiac defibrillators	missing					missing	(5)	(16)
		N/A					N/A		
3a	Discontinue inappropriate nursing interventions	achieved	(95)	(90)	(25)	(68)	achieved	(95)	(90)
		not achieved	(5)	(10)	(75)	(32)	variance		(10)
3b	Syringe driver set up within 4 hours of Doctors order	missing					missing	(5)	
		N/A					N/A		
4	Ability to communicate in English assessed as adequate	achieved	(85)	(95)	(95)	(100)	achieved	(60)	(77)
		not achieved			(5)		variance		(15)
	▪ Patient	missing					missing		(5)
		comatose	(15)	(5)			comatose	(40)	(8)
	▪ Family/Other	achieved	(100)	(100)	(85)	(100)	achieved	(100)	(100)
		not achieved			(15)		variance		
5	Insight into condition assessed	missing					missing		
		comatose	(20)	(10)	(5)	(11)	comatose	(40)	(8)
	▪ Awareness of diagnosis Family/Other	achieved	(100)	(100)	(75)	(95)	achieved	(95)	(100)
		not achieved			(20)	(5)	variance		
		missing			(5)	missing	(5)		
		comatose				comatose			

Section 1: Initial Assessment and Care			Baseline				Post-pilot				
Care Goal			Site 1 (%)	Site 2 (%)	Site 3 (%)	Site 4 (%)	Site 1 (%)	Site 2 (%)	Site 3 (%)		
	Recognition of Dying: Patient	achieved	(60)	(75)	(60)	(42)	achieved	(50)	(85)	(63)	
		not achieved	(15)	(5)	(25)	(32)	variance	(10)	(8)		
		missing			(5)		missing				
		comatose	(25)	(20)	(10)	(26)	comatose	(40)	(8)	(37)	
	Recognition of Dying: Family/Other	achieved	(100)	(100)	(80)	(79)	achieved	(90)	(100)	(100)	
		not achieved			(15)	(21)	variance	(5)			
		missing			(5)		missing				
		comatose					comatose	(5)			
6	Religious/spiritual needs assessed with:	Patient	achieved	(80)	(95)	(45)	(16)	achieved	(65)	(69)	(47)
			not achieved			(40)	(79)	variance	(5)	(8)	
			missing			(5)		missing	(5)		
			comatose	(20)	(5)	(10)	(5)	comatose	(25)	(23)	(53)
		Family/Other	achieved	(95)	(100)	(25)	(11)	achieved	(95)	(100)	(63)
			not achieved	(5)		(65)	(89)	variance	(5)		(16)
			missing			(10)		missing			(21)
			comatose					comatose			
9	General Practitioner is aware of patients condition	achieved	(90)	(100)	(85)	(11)	achieved	(5)	(100)	(95)	
		not achieved	(10)		(10)	(89)	variance	(95)		(5)	
		missing			(5)		missing				
		comatose					comatose				
10	Plan of care explained to:	Patient	achieved	(50)	(70)	(75)	(47)	achieved	(55)	(62)	(42)
			not achieved	(5)	(5)	(20)	(16)	variance	(10)	(15)	(5)
			missing					missing			
			comatose	(45)	(25)	(5)	(37)	comatose	(35)	(23)	(53)
		Family/Other	achieved	(100)	(95)	(85)	(89)	achieved	(100)	(100)	(100)
			not achieved		(5)	(15)	(11)	variance			
			missing					missing			
			comatose					comatose			
11	Family/Other understanding of plan of care	achieved	(100)	(95)	(60)	(89)	achieved	(100)	(100)	(100)	
		not achieved		(5)	(40)	(11)	variance				
		missing					missing				
		comatose					comatose				

Section 2: Assessment and Ongoing Care		Baseline				Post-pilot			
		Site 1 (%)	Site 2 (%)	Site 3 (%)	Site 4 (%)	Site 1 (%)	Site 2 (%)	Site 3 (%)	
Pain	achieved	(90)	(90)	(100)	(84)	achieved	(81)	(74)	(81)
	not achieved	(10)	(10)		(16)	variance	(7)	(20)	(7)
	missing					missing	(12)	(6)	(12)
Agitation	achieved	(100)	(80)	(45)	(32)	achieved	(83)	(77)	(83)
	not achieved		(20)	(50)	(68)	variance	(4)	(17)	(4)
	missing			(5)		missing	(13)	(6)	(13)
Respiratory tract secretions	achieved	(75)	(75)	(40)	(37)	achieved	(83)	(88)	(83)
	not achieved	(25)	(25)	(55)	(63)	variance	(5)	(6)	(5)
	missing			(5)		missing	(12)	(6)	(12)
Nausea and vomiting	achieved	(65)	(65)	(95)	(11)	achieved	(84)	(88)	(84)
	not achieved	(35)	(35)	(5)	(89)	variance	(4)	(6)	(4)
	missing					missing	(12)	(6)	(12)
Dyspnoea	achieved	(30)	(25)	(100)	(11)	achieved	(81)	(80)	(81)
	not achieved	(70)	(75)		(89)	variance	(4)	(14)	(4)
	missing					missing	(15)	(6)	(15)
Mouth care	achieved	(100)	(70)	(15)	(68)	achieved	(76)	(80)	(76)
	not achieved		(30)	(85)	(32)	variance	(12)	(14)	(12)
	missing					missing	(12)	(6)	(12)
Micturition	achieved	(100)	(75)	(50)	(79)	achieved	(87)	(94)	(87)
	not achieved		(25)	(50)	(21)	variance	(1)		(1)
	missing					missing	(12)	(6)	(12)
Medication	achieved	(100)	(95)	(95)	(95)	achieved	(85)		(85)
	not achieved					variance		(48)	
	missing					missing	(15)	(52)	(15)
Syringe Driver	N/A		(5)	(5)	(5)	N/A			
	achieved	(65)	(80)	(75)	(32)	achieved			
	not achieved					variance			
Bowel	missing					missing			
	N/A	(35)	(20)	(25)	(68)	N/A			
	achieved	(100)	(65)	(95)	(32)	achieved	(78)	(2)	(78)
	not achieved		(35)	(5)	(68)	variance	(4)	(44)	(4)
	missing					missing	(19)	(54)	(19)

Section 3: Care after Death			Baseline				Post-pilot		
Care Goal		Site 1 (%)	Site 2 (%)	Site 3 (%)	Site 4 (%)	Site 1 (%)	Site 2 (%)	Site 3 (%)	
12 GP practice contacted re: patients death	achieved	(100)	(100)	(100)	(100)	achieved	(55)	(55)	
	not achieved					variance	(25)	(25)	
	missing					missing	(20)	(20)	
13 Procedure for laying out followed	achieved	(100)	(100)	(100)	(100)	achieved	(90)	(90)	
	not achieved					variance	(8)		
	missing					missing	(10)	(10)	
14 Procedure following death discussed or carried out	achieved	(95)	(100)	(95)		achieved	(20)	(20)	
	not achieved	(5)		(5)	(100)	variance	(65)	(65)	
	missing					missing	(15)	(15)	
15 Family/Other given information on procedures	achieved	(100)	(100)	(100)		achieved		(85)	
	not achieved				(100)	variance	(90)	(90)	
	missing					missing	(10)	(10)	
17 Necessary documentation and advice is given to the appropriate person	achieved	(100)	(100)	(100)		achieved	(25)	(25)	
	not achieved				(100)	variance	(65)	(65)	
	missing					missing	(10)	(10)	
18 Bereavement leaflet given	achieved		(100)			achieved		(77)	
	not achieved	(100)		(100)	(100)	variance	(90)	(90)	
	missing					missing	(10)	(10)	

Appendices

Appendix 1: The Project Tasks.

The MCPCIL International Pack was used to guide the project. The following tasks were completed:

1. The project plan was developed.
2. The pilot sites were identified.
3. A one page Protocol outlining the project aims was submitted to the MCPCIL LCP Central Team to receive the International Registration Pack.
4. Endorsement for the project was obtained from management of the parent organisation for each pilot site.
5. The international registration was completed and submitted to the MCPCIL LCP Central Team.
6. Ethics Committee applications were made to each organisation.
7. The LCP document was reviewed.
8. Approval to modify the pathway document was obtained from the MCPCIL LCP Central Team.
9. Documentation to support the various goals of care was developed.
10. Legal opinion was sought from the Department of Health (DoH) Legal Office relating to the pathway and its use in the public health system.
11. The DoH's Office of Safety and Quality was consulted.
12. A local Teaching Package was developed.
13. All information and documentation related to the pilot project was assembled.
14. A pre-intervention audit of each service's existing documentation (minimum of twenty deceased patient's files at each site) was conducted.
15. The pre-intervention audits were analysed by MCPCIL LCP Central Team and reports were distributed to participating services.
16. "Champions" and health care staff within each service were trained.
17. The pilot study was commenced – with the aim of obtaining twenty completed pathways (within a six month timeframe).
18. A post-intervention audit was conducted on the completed pathways from each site.
19. The post-intervention audit results were analysed by MCPCIL LCP Central Team and reports were distributed to participating sites
20. Final project report with recommendations was written.

Appendix 1: Education Package Feedback

1. CONTENT

- 1.1 The information presented was clear to me.
57% Strongly Agree
43% Agree
- 1.2 I found the content easy to understand
38% Strongly Agree
62% Agree
- 1.3 What I have learned in this session would help me to use the LCP in my everyday work.
33% Strongly Agree
64% Agree
3% Did not answer question
- 1.4 I feel the learning outcomes of the session were met.
38% Strongly Agree
58% Agree
2% N/A
2% Did not answer question
- 1.5 The education session content was pitched at a suitable level.
59% Strongly Agree
49% Agree
1% Did not answer question

Comments on Content:

- Feel more appropriate for use in hospitals as we already have a good protocol
- Great for eliminating other forms
- A great deal to take in
- Need to address "falls risk" on LCP form
- Can see the benefits of the LCP, to enable effective communication between hospital and Silver Chain
- Good session, information and interesting
- Explanation clear and precise
- The content of the teaching session was clear but the 'tool' was not completely [clear].
- Presentation of content clear but did not find the actual content flowed well.
- I feel the tool is cumbersome in that it is difficult to reference the patient problem/focus and the Variance analysis. Also there needs to be one page 5 per day.

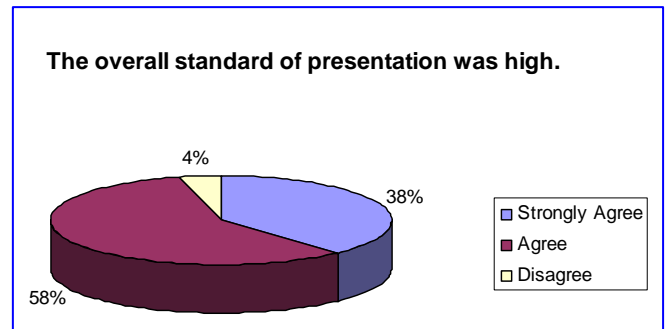
2. PRESENTATION

2.1 The overall standard of presentation was high.

38% Strongly Agree

58% Agree

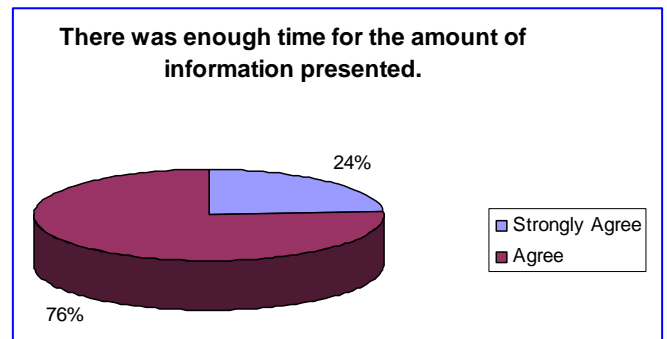
4% Disagree



2.2 There was enough time for the amount of information presented.

24% Strongly Agree

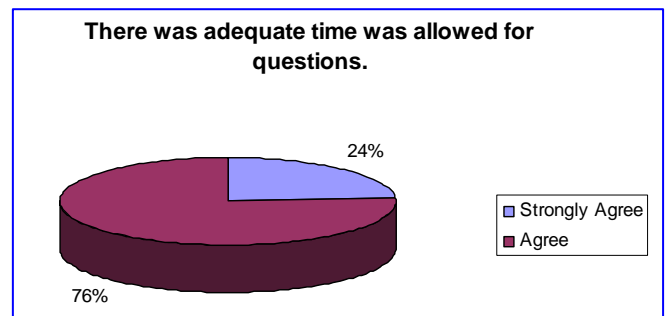
76% Agree



2.3 There was adequate time was allowed for questions.

24% Strongly Agree

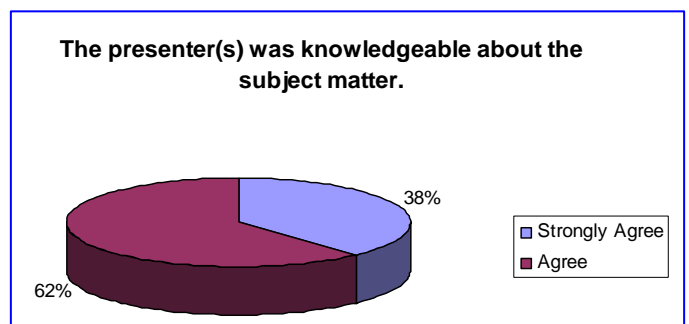
76% Agree



2.4 The presenter(s) was knowledgeable about the subject matter.

38% Strongly Agree

62% Agree



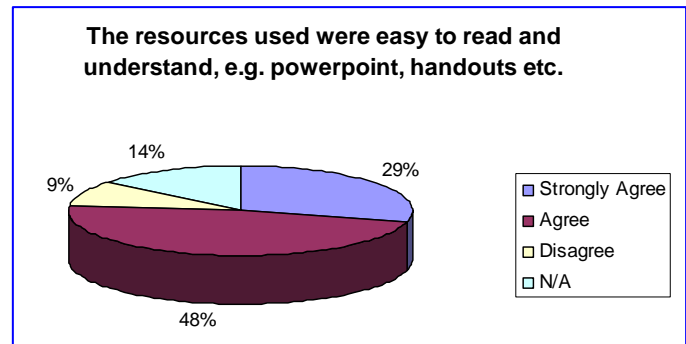
2.5 The resources used were easy to read and understand, e.g. powerpoint, handouts etc.

29% Strongly Agree

48% Agree

9% Disagree

14% N/A

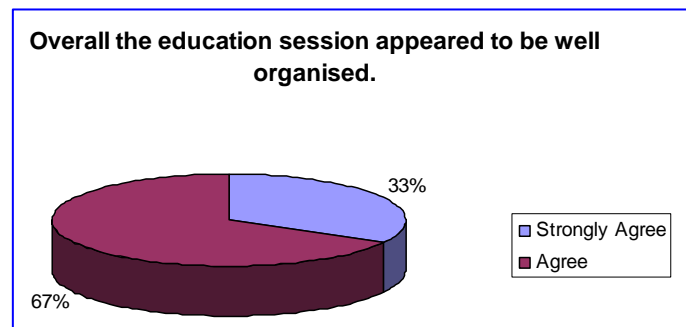


3. ORGANISATION

3.1 Overall the education session appeared to be well organised.

33% Strongly Agree

67% Agree

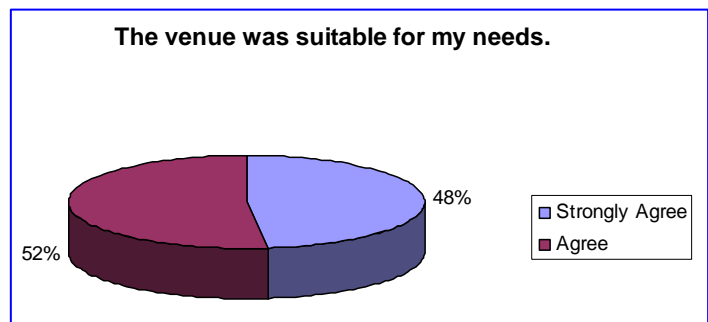


4. VENUE

4.1 The venue was suitable for my needs.

48% Strongly Agree

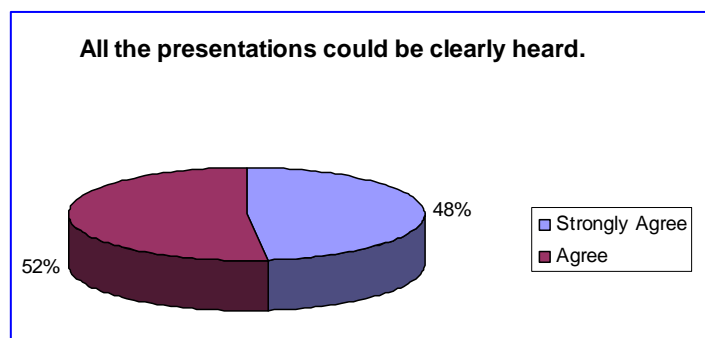
52% Agree



4.2 All the presentations could be clearly heard.

48% Strongly Agree

52% Agree

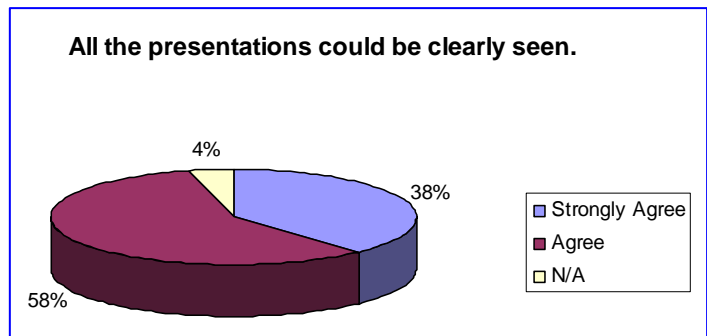


4.3 All the presentations could be clearly seen.

38% Strongly Agree

58% Agree

4% N/A



Other comments

- Well done
- I have strong concern about patient and family right to keep diagnosis confidential.
- It was a shame staff brought other issues to the teaching sessions; it got a bit side tracked.
- Too much information on PowerPoint, hard to take it all in.
- The continuity of pages and their interaction with each other could do with re-evaluating.
- Page 5 - Do we get one for each day. Tool does not seem to 'flow' - using it will be difficult ie. page 8 should follow 5 & 6.

We would appreciate your suggestions for topics which would interest you for future education programs.

- Anything to increase my knowledge and update in Palliative Care.
- Would like follow up in conjunction with PCOC - also further education on PCOC
- Updates - new trends in Pharmacology would be good
- Pharmacology
- Much of the tool is not appropriate for HCS in the community

Appendix 2: LCP Document Feedback

Layout of information:

1.	Gets a bit untidy when lots of pages need to be added. Would prefer variance page attached rather than on back – flow through would be better.
2.	Geared to inpatient facility. Too complicated – having to keep moving from plan to variance and back to plan to find out what was done/implemented. Why need to date/time/sign each box horizontally – surely only need to do one to cover “what variance occurred” and “why” and “goal name” and “action taken” and “outcome”. Too task orientated – what about discussion/family meeting/outcomes of SW/counsellor input.
3.	It is set out logically but is very much written for inpatient use. As a palliative care service we would not for example be documenting “not for resus” orders as this is made clear at the time the client signs the agreement to service. On Goal 2: in comfort measures it is not necessary to have an anti-cholinergic available for every client – while the order is a benefit For Goal 5: clearly these issues need to be addressed well before the last 72 hours of life. If a family needs wills/enduring power of attorney sorting out, this needs to be done before the client is comatose/semi-comatose.
4.	Found layout frustrating jumping to and from pages.
5.	Not a problem.
6.	Time consuming at start but easier as days go on.
7.	Seemed to flow well. May have been better single sheets not all attached.
8.	Fine
9.	Easy to follow
10.	Clear, some questions not relevant, especially on the back page.
11.	Easy to read and use – most were tick boxes information flowed well.

Variance analysis pages:

1.	See Point 1 above
2.	Incorporate variance into care plan separate sheet problematic (not as easy to marry up, time consuming, possibility of getting lost) Leave specific times out (keep night – am – pm) Void dotted lines make way for documentation of variance. Useful as education tool – greater potential with non-pall care services (ie. nursing homes)
3.	No problem in size. It takes time having to sign 4 columns if a couple of variances at one time and very busy.
4.	Very scattered and not often in sequence.
5.	Would have been better separate to document.
6.	Fine
7.	Signature, date/time for ‘what variance occurred, goal name and action taken’ will be the same – so do we have to sign it 3 times.
8.	Patient continues deterioration so many days these pages become too many and a

	bit messy.
9.	Could be a better format times/date repetitive.
10.	Lots of paperwork!! Found it difficult to variance everything as this led to more paperwork needing to be completed. Perhaps the boxes could be made smaller so that we could fit more information on a page instead of having to use several sheets.

Space for writing:

1.	Would like area for client/carer to put name as we have no care plan as such. We use ongoing report in home notes which client/carer signs at each visit.
2.	Insufficient room to individualise care No allowance made for wound or incontinence on any client/carer specifics No prompting/guidance on education of family or what to expect/how to help with care
3.	Not enough space sometimes in variance pages.
4.	OK
5.	Sometimes not enough space but depends on situation.
6.	Some areas – variances – boxes could have been bigger but other areas could have been smaller. (The variance page where you document Achieved or Variance didn't need to be so big and could have put more than one day on it.)
7.	Manageable
8.	Sufficient
9.	Enough.
10.	See above for variance pages. Would like more space in the clinical writing section as if you have 2 shifts (am and pm) and a registrar/consultant writing – it uses up a lot of space.

Ease of use:

1.	Any new paper work is always challenging. The more we used it the 'easier' it became.
2.	A lot of time wasted flipping from plan to variance to plan Frustrating as it does not meet or address all concerns
3.	It is not any improvement on the palliative care assessment and management plan that we are already using.
4.	Yes
5.	Once one becomes more familiar with it.
6.	Yes – slow at start but once we get used to it, it will be easy.
7.	Yes but I heard understandable grumbles about the 4 hours timeframe, which seems short given the amount of care required for a group of people and the patient.
8.	Yes, once you know how.
9.	It was very difficult to find the time to fill in the pathway when patient starts to be terminal care.
10.	Yes
11.	Yes, but then I have had previous experience using them.

Suggested improvements:

1.	Variance sheet as follow on would be better. Some wording eg “unable to swallow” change to “swallowing”
2.	Yes – as identified also space for page no. at top so record can be kept chronological
3.	It would have value as a prompt for services that do not normally provide palliative care but it is of little value to a service that has palliative care as its primary concern.
4.	? box in micturition/bowels. Also elimination chart if using LCP for last 24-48 hours not a problem but if we start and stop or using for a week we need to know about elimination in case cause of agitation. We do not want to be interfering if don't have to again.
5.	By introducing earlier as some are in their last stages at commencement
6.	Adding Braden Scale/Fall Risk Assessment to it.
7.	Section at end labelled “Evaluation and Problem solving” to enable team to consider strategies to overcome particular problems which may arise given the opportunity to consider variances and overall care adequacy.
8.	A separate variance page for section 2. Section 2 goals numbered instead of having to write it out each time under ‘Goal name’.
9.	“Goal” may need to have number so we don't repeat same thing in the variance page.
10.	Have not used it enough yet to comment.
11.	We could look at changing small things to personalise it to our unit, but then we would need to think about benchmarking problems which may occur as a result of this.

Comments

1.	Not sure times fit in for us as community service. Some repetition of name on pages. Goals to be numbered.
2.	Nothing to show that it improves outcomes Needs supportive documentation to prove clinical (client) care outcomes Oxford textbook states for use in services that have palliative clients not specialist services Should target population that this is meant for ie. one hospital – two wards would have given better indication of usefulness
3.	Goal 5. What if SW/Counsellor identified as required but refused by client/carers? Some goals require a N/A as an option ie. Goal 9 – client may not have a current GP or may not wish GP to be involved. No option to document change to care on plan ie. what if a client who was comatose – becomes more conscious and alert? Should this not prompt discussion?
4.	The consent form was a barrier to the use of the care plan because in a tense family situation it was difficult to explain that it did not indicate that we were implementing a different type of care to what we would normally provide. In many cases the nurses did not use the plan for this reason which is partly why it took so long for the plans to be completed.
5.	Generally found that this pathway was not of great use to community. We gained some useful hints as to what extras we could add to our care plans but in the whole we cover most areas

Group Comments

The following are comments made from two group meetings

1.	<ul style="list-style-type: none">• Goals to be numbered 1, 2, 3, etc. for ease of referencing on Variance Record Sheet (ie. on Sect: 2 Form)• Phone calls? Record of these (other than PALCIS)• Wording: 'Unable to Swallow' – should read 'Swallowing' Y N• Name/Unit No/Date: repeated on side 2 of Section 2 Patient/problem focus form• 21/1/08 If we don't document in our note covers don't sign anywhere / care plan• Times perhaps should be blank space for us to complete as we do not visit those times specified 2400 0400 0800 1200 etc.• Lots more trees! Condense• Amount of times you write patient name and MRN and sign and date your name is unnecessary especially front and back of all pages!
2.	<p>Difficulties encountered:</p> <ul style="list-style-type: none">• Obtaining consent from client/carer to commence the pathway during their terminal phase which is classed as the last 72 hours for the purpose of using the LCP. Difficulties have arisen where nurses are not comfortable requesting clients/carers signing a consent form or carers have declined to sign even though they are aware that the care that will be provided is no different to 'usual' terminal care. Action: Discussed with Ethics committee who has advised that we can collect consent to use the pathway at anytime ie. do not have to wait until the client becomes terminal. Information sheet amended to provide more information regarding trial.• Completing two sets of documentation. The majority of the aspects on the LCP are included in the HCS palliative care and management plan – the main area of difference is care after death where the HCS palliative care and management plan includes giving bereavement brochure but not other details. Notification of the GP is recorded electronically by the administration staff. When reviewing the LCP and then the HCS documentation several areas 'missing' from the LCP are documented on the HCS palliative care and management plan or in the HCS progress notes. Action: HCS staff requested to complete both sets of documentation until completion of trial.• Client commenced on LCP but overall condition improved – able to eat drink etc. Advised RN to cease LCP. Action: Recommence LCP if/when condition becomes terminal.• Client commenced on LCP meets 3 out of 4 criteria and is able to discuss his care needs. Requested euthanasia as 'wants dying process to be over'. All goals on LCP are identified as A. Client request transfer to an inpatient facility. Action: Client transferred to inpatient hospice.• Client carer refused to allow the use of the care plan as would not accept that her husband was dying – she believed that her husband would return and therefore not 'die' so use of a care of the dying pathway was not relevant to her husbands care. Action: Use of HCS pathway.• Communication is the primary component of care provision to palliative care clients and their families this care plan does not promote discussion. Within the care plan there is no concept of empathy from a health professional viewpoint for what the clients/family members are experiencing. Action: Use of HCS pathway

	<p>and progress notes to document discussion of factors involved in providing care.</p> <ul style="list-style-type: none"> Development of care plan should be collaboration between client, their carer(s) and the healthcare team. The LCP does not prompt or guide this, nor does it allow space to document its occurrence. Action: Use HCS Assessment and Management Care plan to document and guide.
3.	<p>I thought this form cut out ADL chart but we are still using – why? As this covers all care only thing not covered is Fentanyl Patch. If a problem can a box be put in under medication to tick?</p> <p>Some of the goals not relevant to us can these be left out? Are we allowed to make changes to Pathway Form. To be more relevant to us.</p>
4.	<p>I feel it is more appropriate for hospitals as we are already giving people peaceful deaths here.</p>
5.	<p>There are no sections recording culture specific care needs and the demographics section does not indicate ethnicity or spoken language. These are noteworthy.</p>
6.	<p>Be a good idea to number the pages of variance analysis once commenced. Easier to track progress/deterioration of patient after night staff's days off or if patient is new to the staff. Needs some fine tuning for our own hospice use.</p>
7.	<p>Very useful tool which has made us review some of our practices (always a positive thing) and certainly assists in the smooth transition of patients' end of life care.</p>



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Delivering a **Healthy WA**

