The Pennine Acute Hospitals NHS Trust

Liverpool Care Pathway (LCP) for Care of the Dying Patient Version 12

Adapted for use in Pennine Acute Hospitals NHS Trust

This document is to be used in conjunction with the Prescribing Guidance for the Liverpool Care Pathway (LCP) for Care of the Dying Patient (CPDI076)

Key Words: Care of the Dying; ICP; Pathway; Palliative Care

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Pennine Acute Hospital NHS Trust

Liverpool Care Pathway (LCP) for Care of the Dying Patient Version 12

Main Revisions from previous issue	
Name of Previous Document:	Liverpool Care Pathway (LCP) for Care of the Dying Patient Version 12
Previous Document Number:	CPME146
Previous Version Number:	1.2
Chapters, sections and pages which have been changed	'Yes No' tick box added for 'Organ/tissue donation' at Goal 11 on page 32

Contents

1. Introduction/Purpose

1.1 The Liverpool Care Pathway for the Dying Patient (LCP) has been recommended for use as a template of best practice in the last hours and days of life in : End of Life Care Strategy: Quality Markers and Measures for End of Life Care (2009) & Route to success in end of life care – achieving quality in acute hospitals (2010). This care pathway is intended as a guide to treatment and an aid to documenting patient progress in the dying stage. Practitioners are free to exercise their own judgement, however any alteration to the practice identified within this care pathway (LCP) must be recorded as a variance.

2. Scope

2.1 This document is intended to be used by Health Care Professionals across the North East Sector including Pennine Acute Hospitals NHS Trust (PAHNT), for patients that have been identified as being in the dying phase.

3. The LCP

3.1 The full LCP document can be found in Appendix 3. Instructions regarding completion and use are on the LCP itself.

3.2 It should be used in conjunction with the Trusts 'Prescribing Guidance for the Liverpool Care Pathway for Care of the Dying Patient' (CPDI076). This can be found via the 'Documents' page of the Trust Intranet.

NB: Any adverse incidents, such as equipment failure, adverse drug reactions should be recorded and reported as per the Trusts Accident & Incident Reporting Policy EDQ008.

4. Implementation

4.1 Dissemination

This document will be uploaded onto the Trusts intranet and will be listed under the Clinical Integrated Care Pathways section of the 'Documents' page. Dissemination will also be via;

- An article will be placed in the Pennine News to notify clinical teams that the document has been revised via the End of Life Care Facilitator team
- It will be announced in the Medical Director/ Nursing Director Bulletin and Core Brief via the End of Life Care Facilitator team
- IT screen saver will be used for the week of release via the End of Life Care Facilitator team

- Paper documents will be provided to all members of Specialist Palliative Care Teams via the End of Life Care Facilitator team
- Paper copies will be handed out to all relevant ward managers with policy confirmation slips via the End of Life Care Facilitator team/Specialist Palliative Care team

4.2 Training Arrangements

Training will continue to be delivered to medical and nursing staff by the Pennine End of Life Care Facilitator & Specialist Palliative Care Teams. Training will be conducted formally and informally. Attendance sheets will be completed for formal training sessions & forwarded to the Pennine Acute End of Life Care Facilitators for monitoring purposes.

Training will be advertised the Trust Training Bulletin. Should ad hoc sessions be required please contact the End of Life Care Facilitator team on: 778 5918 or 656 1253

4.3 Financial Impact

There are resource implications associated with the LCP. However resources are already in place within the Trust to support this clinical practice.

5. Monitoring Arrangements

- The Palliative Care Governance meeting is held bi-monthly, any clinical incidents are reviewed and action plan agreed.
- The Trust complies with the LCP National Audit Programme.
- The arrangements for monitoring compliance of this policy are summarised in Appendix 1.

6. Review Arrangements

6.1 This document will be reviewed in 3 years time by members of the North East Sector Specialist Palliative Care Team. Ad Hoc reviews may be necessary if new national guidelines are issued or if the outcome of a clinical incident dictates the need for change.

7. References and Bibliography

7.1 Associated Documents

- CPDI076 Prescribing Guidance for the Liverpool Care Pathway for Care of the Dying Patient
- EDG004 Complaints Handling Policy
- EDN004 Record Keeping Policy
- EDN007 Privacy & Dignity
- EDC018 Medicines Policy

- EDC039 Do Not attempt Cardio-Pulmonary Resuscitation
- EDC047 Organ Donation & Required Referral Policy
- EDQ008 Accident & Incident Reporting Policy

7.2 Supporting References

- Department of Health (2009). *End of Life Care Strategy: Quality Markers and Measures for End of Life Care*. Crown Copyright. London
- National End of Life Care Programme (2010). *Route to success in end of life care – achieving quality in acute hospitals*. Crown Copyright, London.
- Marie Curie Palliative Care Institute Liverpool (MCPIL) (2009). *LCP Generic Version 12*. Liverpool.

7.3 Bibliography

- Ellershaw JE, Wilkinson S. *Care of the Dying: A pathway to excellence*. Oxford University Press. Oxford.2003
- Department of Health (2009). *Living well with dementia: a National Dementia Strategy*. Crown Copyright, London
- National End of Life Care Programme (2010). *Mental Capacity Act (2005) support sheet 12.* London.

8. Abbreviations & Definitions of terms used

ADRT	Advance decision to refuse treatment
CSCI	Continuous Subcutaneous Infusion
ICD	Implantable Cardioverter Defibrillator
IMCA	Independent Mental Capacity Advocate
IV	Intravenous
LCP	Liverpool Care Pathway
LPA	Lasting Power of Attorney
MDT	Multidisciplinary Team
NG	Nasogastric
NJ	Nasojejunostomy
PEG	Percutaneous endoscopic gastrostomy
PEJ	Percutaneous endoscopic jejunostomy
SC	Subcutaneous
TPN	Total Parenteral Nutrition

Appendix 1 - Arrangements for Monitoring Compliance with this document

Standard/ criterion	Minimum requirement to be monitored	Process for Monitoring	Responsible Individual/ Group/ Committee for Monitoring	Frequency of Monitoring	Responsible Individual/ Group/ Committee for Review of Results	Responsible Individual/ Group/ Committee for Development of Action Plan	Responsible Individual/ Group/ Committee for Monitoring of Action Plan
Staff responsible for initiating this pathway of care will be aware of this reviewed/ revised version and change of title to being The Liverpool Care Pathway for Care Of the Dying Patient (LCP)	Ward managers for all wards will be made aware of this revised pathway of care. Ward managers will be asked to confirm that they are aware of the pathway and cascade this to their staff using a sign off sheet	Review of the sign off sheet	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team	Once reviewed version is disseminated	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team	Specialist Palliative Care Clinical Governance group
The LCP to be used in practice to ensure patients in the dying phase receive care based on best evidenced based practice	There will be evidence of use of this LCP within clinical practice across the trust	Will be audited 2 yearly as part of the LCP Care of the Dying in Hospitals National Audit.	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team	2 yearly	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team.	Specialist Palliative Care Clinical Governance group

There will be a variety of opportunities where education regarding the LCP can be accessed	Education will be provided through a variety of different sessions and programmes across the trust.	Comprehensive record of education will be provided and attendance sheets forwarded to Pennine Acute End of Life Care Facilitators	Pennine Acute End of Life Care Facilitators	6 monthly	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team	Pennine Acute End of Life Care Facilitators Pennine Acute Specialist Palliative Care team NE Sector Education subgroup	Specialist Palliative Care Clinical Governance group
There is an agreed process for reporting all incidents/ near misses relating to end of life symptom control issues for patients being managed on the LCP	All clinical incidents are reviewed and discussed as per Accident & Incident Reporting Policy (EDQ008). Any feedback from the Clinical Group Governance Group for medicine is discussed at the bi-monthly Specialist Palliative Care Clinical Governance group						

Appendix 2 – Completed Equality Impact Assessment Pro-forma

The Pennine Acute Hospitals NHS Trust

Equality Impact Assessment Pro-forma (Policy*)
Part One

Name of Policy	Liverpool Care Pathway Version 12	Date of assessment	31/01/2010	Is the policy new or for review?	For review
Area	Pennine Acute NHS Trust	Name of Author(s)	NE Sector End Of Life Care Subgroup		
1.1 Briefly describe the aims and objectives and the purpose policy		Aim: To provide an evidenced based framework that will empower ward staff in the acute hospital setting to deliver high quality appropriate care for the dying and their relatives and carers. Objective: Encourage a multi-professional approach to the delivery of end of life care that focuses on the physical, psychological and spiritual comfort of patients and their relatives/carers.			
1.2 Are there any associated objectives or directives of the policy? i.e. Care Quality Commission (CQC), NHS Litigation Authority (NHSLA)		Cancer Quality Improvement Network (CQuINS) End of Life Measures			
1.3 Who is the policy intended to benefit, and what are the expected outcomes?		The Liverpool Care Pathway involves regular assessment and continuous reflection, challenge, decision making and clinical skill. The pathway will improve staff knowledge in relation to the process of dying and thereby improve the quality of care in the last hours/days of life of the patient, relative and carer.			
1.4 What factors could influence the intended outcomes either positively or negatively?		Lack of resources within the End of Life Facilitator & Specialist Palliative Care Team to sustain the Integrated Care of The Dying Pathway. Lack of organisational recognition that all staff that Care for the Dying require education and training. The pathway needs to be firmly embedded in the organisation and be supported by a continuous learning programme. Needs to be established within the organisational governance framework & post analysis competencies maintained & improved where necessary.			
1.5 Who are the main stakeholders in relation to the policy		Staff √ Service Users √ Public √ Other (Carers) √			

1.6 Who implements and is responsible for the policy?	Pennine Acute NHS Trust End of Life Care Facilitators & Specialist Palliative Care Team

Part One (cont)

For each of the nine Equality Categories ask the question below:	Human Rights	Age	Disability	Ethnicity (Race)	Religion	Gender	Sexual orientation	Carers	Social Deprivation
1.7 From the evidence, does the policy affect or have the potential to affect individuals or communities differently or disproportionately, either positively or negatively (including discrimination)?	No	This pathway has been developed by adult palliative care services for adult patients	No	No	No	No	No	No	No
1.8 Is there potential for, or evidence that, the proposed policy will promote equality of opportunity for all and promote good relations with different groups?	Yes	This pathway has been developed by adult palliative care services for adult patients	Yes	Yes	Yes	Yes	Yes	Yes	Yes
1.9 Is there public concern (including media, academic, voluntary or sector specific interest) in the policy area about actual, perceived or potential discrimination about a particular community?	In 2009, there was adverse media coverage regarding the Liverpool Care Pathway.In response to the media coverage the Liverpool Care Pathway Central Team at the Marie Curie Palliative Care Institute Liverpool (MCPCIL) issued a statement on 18.09.09 regarding the care of the dying and the	No	No	No	No	No	No	No	No

	Liverpool Care Pathway (LCP). The Statement can be viewed in full at www.mcpcil.org.uk								
1.10 Is there any doubt about answers to any of the questions?	No	No	No	No	No	No	No	No	No

Part Two

2.1 In what way does the policy impact on any particular group listed above? Include here what evidence you have collated, whether there are any gaps and what further information is required.

The equality impact assessment guidelines promote equity and fairness for all of the groups listed above. The document does not impact on any particular group disproportionately. However it should be noted that the Liverpool Care Pathway is a national pathway that has been developed by adult palliative care services for adult patients.

2.2 Adverse Impact - if you have identified potential or real direct or indirect discrimination? If so, can it be justified (e.g., legislation, clinical or social evidence)?

None

2.3 Positive Impact - does the policy actively promote equality of opportunity and/or good relations between different groups of people?

The guidelines positively promote equality of opportunity for all communities and individuals who are nearing the end of life. The Liverpool Care Pathway is continuous quality improvement model for care of the dying that informs and responds to the national agenda. It provides a benchmarking of care provision within a National Audit Process and assists the organisation to identify real or potential adverse impact or discrimination and enable appropriate action to be taken to eliminate any inequality or disadvantage arising. The End of Life Care End of Life Care Strategy (2008) fully promotes the use of the Liverpool Care Pathway & Professor Mike Richards, Chair of the National End of Life Care Strategy Advisory Board states ""How we care for the dying must surely be an indicator of how we care for all our sick and vulnerable patients. Care of the dying is urgent care; with only one opportunity to get it right to create a potential lasting memory for relatives and carers."

Further evidence can be viewed on; http://www.mcpcil.org.uk

Part Three

Policy Title (as it appears on the Document Management System) Liverpool Care Pathway for Care of the Dying Patient Version 12 (LCP)	**Policy Number** CPME 146	
Ratifying Committee: Divisional Governance Committee for Medicine Division	**Date sent to Committee:**	
This policy has been assessed as having no or low equality impact. Part 1 is completed.		**Yes**
This policy has been assessed as having low to medium impact. Parts 1 and 2 have been completed. Full impact assessment is unnecessary.		
This policy has been assessed as having medium to high impact. Parts 1 and 2 have been completed. **Full impact assessment is necessary.**		

Assessors Name	**Designation**	**Signed***
Yvonne Loughlin	Macmillan Specialist Palliative Care Clinical Nurse Specialist	

Equality Champion **Mike Griffiths**	**Directorate** **Division of Medicine**	 **Signed***Mike Griffiths
Date **21st February 2011**		**Please scan or insert electronic signature**

Appendix 3 - The LCP

The Pennine Acute Hospitals NHS Trust

Name:…… Unit/NHS no:…… Date:……

Liverpool Care Pathway for the Dying Patient (LCP) supporting care in the last hours or days of life

Information sheet to be given to the relative or carer following a discussion regarding the plan of care.

The doctors and nurses will have explained to you that there has been a change in your relative or friend's condition. They believe that the person you care about is now dying and in the last hours or days of life.

The LCP is a document which supports the doctors and nurses to give the best quality of care. All care will be reviewed regularly.

You and your relative or friend will be involved in the discussion regarding the plan of care with the aim that you fully understand the reasons why decisions are being made. If your relative or friend's condition improves then the plan of care will be reviewed and changed. All decisions will be reviewed regularly. If after a discussion with the doctors and nurses you do not agree with any decisions you may want to ask for a second opinion.

Communication

There are information leaflets available for you as it is sometimes difficult to remember everything at this sad and challenging time. The doctors and nurses will ask you for your contact details, as keeping you updated is a priority.
In the community setting you will be provided with the contact details of your nursing/medical team.

Medication

Medicine that is not helpful at this time may be stopped and new medicines prescribed. Medicines for symptom control will only be given when needed, at the right time and just enough and no more than is needed to help the symptom.

Comfort

The doctors and nurses will not want to interrupt your time with your relative or friend. They will make sure that as far as possible any needs at this time are met. Please let them know if you feel those needs are not being met, for whatever reason.

You can support care in important ways such as spending time together, sharing memories and news of family and friends.

The Pennine Acute Hospitals NHS Trust

Information sheet to be given to the relative or carer continued:

Reduced need for food and drink

Loss of interest in and a reduced need for food and drink is part of the normal dying process. When a person stops eating & drinking it can be hard to accept even when we know they are dying. Your relative or friend will be supported to eat and drink for as long as possible. If they cannot take fluids by mouth, fluids given by a drip may be considered.

Fluids given by a drip will only be used where it is helpful and not harmful. This decision will be explained to your relative or friend if possible and to you.

Good mouth care is very important at this time. The nurses will explain to you how mouth care is given and may ask if you would like to help them give this care.

Caring well for your relative or friend is important to us. Please speak to the doctors or nurses if there are any questions that occur to you, no matter how insignificant you think they may be or how busy the staff may seem. This may all be very unfamiliar to you and we are here to explain, support and care.

We can be reached during daytimes at:……

Night time at:……

Other information or contact numbers (e.g. palliative care nurse / district nurse):

……

……

……

……

……

This space can be used for you to list any questions you may want to ask the doctors and nurses:

……

……

……

……

Name:…… Unit/NHS no:…… Date:……

Liverpool Care Pathway for the Dying Patient (LCP) supporting care in the last hours or days of life

Location: (e.g. hospital, ward, care home etc.):……

As with all clinical guidelines and pathways the LCP aims to support but does not replace clinical judgement

- The LCP generic document guides and enables healthcare professionals to focus on care in the last hours or days of life. This provides high quality care tailored to the patient's individual needs, when their death is expected.
- Using the LCP in any environment requires regular assessment and involves regular reflection, challenge, critical senior decision-making and clinical skill, in the best interest of the patient. A robust continuous learning and teaching programme must underpin the use of the LCP.
- The recognition and diagnosis of dying is always complex; irrespective of previous diagnosis or history. 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. Seek a second opinion or specialist palliative care support as needed.
- Changes in care at this complex, uncertain time are made in the best interest of the patient and relative or carer and needs to be reviewed regularly by the multidisciplinary team (MDT).
- Good comprehensive clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative or carer. The views of all concerned must be listened to and documented.
- If a goal on the LCP is not achieved this should be coded as a variance. This is not a negative process but demonstrates the individual nature of the patient's condition based on their particular needs, your clinical judgement and the needs of the relative or carer.
- The LCP does not preclude the use of clinically assisted nutrition or hydration or antibiotics. All clinical decisions must be made in the patient's best interest.
- A blanket policy of clinically assisted (artificial) nutrition or hydration, or of no clinically assisted (artificial) hydration, is ethically indefensible and in the case of patients lacking capacity prohibited under the Mental Capacity Act (2005).
- For the purpose of this LCP generic version 12 document - The term best interest includes medical, physical, emotional, social and spiritual and all other factors relevant to the patient's welfare.

The patient will be assessed regularly and a formal full MDT review must be undertaken every 3 days.

The responsibility for the use of the LCP generic document as part of a continuous quality improvement programme sits within the governance of an organisation and must be underpinned by a robust education and training programme.

References:

Ellershaw and Wilkinson Eds (2003) *Care of the dying*: *A pathway to excellence*. Oxford: Oxford University Press.

National Institute for Clinical Excellence (2004) Improving Supportive and Palliative Care for Adults with Cancer. London, NICE MCPCIL (2009) National Care of the Dying Audit Hospitals Generic Report Round 2. www.mcpcil.org.uk

The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Algorithm – Decision making in: diagnosing dying & use of the LCP supporting care in the last hours or days of life

Assessment

Deterioration in the patient's condition suggests that the patient could be dying

Multidisciplinary team (MDT) assessment

- Is there a potentially reversible cause for the patient's condition e.g. exclude opioid toxicity, renal failure, hypercalcaemia, infection
- Could the patient be in the last hours or days of life?
- Is Specialist referral needed? e.g. specialist palliative care or a second opinion

Clinical Decision

Patient is **NOT** diagnosed as dying (in the last hours or days of life)

Review the current plan of care

Patient is diagnosed as dying (in the last hours or days of life)

Patient, relative or carer communication is focused on recognition & understanding that the patient is dying

Communication

Discussion with the patient and relative or carer to explain the new or revised plan of care

Discussion with the patient, relative or carer (IMCA as required) to explain the current plan of care & use of the LCP

Management

The Liverpool Care Pathway for the Dying Patient (LCP) is commenced including ongoing regular assessments

Reassessment

A full multidisciplinary team (MDT) reassessment & review of the current plan of care should be triggered when 1 or more of the following apply:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and or

Concerns expressed regarding management plan from either patient, relative or carer or team member

and or

It is **3 days** since the last **full** multidisciplinary team (MDT) assessment

Always remember that the Specialist Palliative Care Team are there for advice and support, especially if:
Symptom control is difficult and/or if there are difficult communication issues or you need advice or support regarding your care delivery supported by the LCP

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Name:…… Unit/NHS no:…… Date:……

Healthcare professional documenting the MDT decision

Following a full MDT assessment and a decision to use the LCP:

Date LCP commenced:……

Time LCP commenced:……

Name (Print):…… Signature:……

This will vary according to circumstances and local governance arrangements. In general this should be the most senior healthcare professional immediately available.

The decision must be endorsed by the most senior medical professional responsible for the patient's care at the earliest opportunity if different from above.

Name (Print):…… Signature:……

Please record the patient's preferred place to die here:……
(e.g. Home / Care Home / Hospital / Hospice / Unknown) if 'unknown' please record as Variance

All personnel completing the LCP please sign below

You should also have read and understood the guidance on pages 3 - 4

Name (print)	*Full signature*	*Initials*	*Professional title*	*Date*

Record all full MDT reassessments here (including full formal MDT reassessment every 3 days)

Reassessment date:…… Reassessment time:……..

Reassessment date:…… Reassessment time:……..

Reassessment date:…… Reassessment time:……..

Reassessment date:…… Reassessment time:……..

If the LCP is discontinued please record here:

Date LCP discontinued…… Time LCP discontinued……

Reasons why the LCP was discontinued:……

……

……

Decision to discontinue the LCP shared with the patient **Yes** ☐ **No** ☐

Decision to discontinue the LCP shared with the relative or carer **Yes** ☐ **No** ☐

The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Diagnosis & Baseline Information

DIAGNOSIS:..... .... Co-morbidity:.....
..... Ethnicity:.....
DOB:..... Age:..... NHS no:..... Female ☐ Male ☐

At the time of the assessment is the patient:

In pain	**Yes ☐ No ☐**	Able to swallow	**Yes ☐ No ☐**	Confused	**Yes ☐ No ☐**
Agitated	**Yes ☐ No ☐**	Continent (bladder)	**Yes ☐ No ☐**	*(record below which is applicable)*	
Nauseated	**Yes ☐ No ☐**	Catheterised	**Yes ☐ No ☐**	Conscious	☐
Vomiting	**Yes ☐ No ☐**	Continent (bowels)	**Yes ☐ No ☐**	Semi-conscious	☐
Dyspnoeic	**Yes ☐ No ☐**	Constipated	**Yes ☐ No ☐**	Unconscious	☐
Experiencing respiratory tract secretions			**Yes ☐ No ☐**		
Experiencing other symptoms (e.g. oedema, itch)			**Yes ☐ No ☐**		

Communication

Goal 1.1: The patient is able to take a full and active part in communication.
Achieved ☐ Variance ☐ Unconscious ☐

Barriers that have the potential to prevent communication have been assessed
First language..... Other issues identified.....
Consider need for an interpreter: (contact no) .....
Other barriers to communication.....
Consider: Hearing, vision, speech, learning disabilities, dementia (use of assessment tools) neurological conditions and confusion
The relative or carer may know how specific signs indicate distress if the patient is unable to articulate their own concerns

Does the patient have:-

An advance care plan? **Yes ☐ No ☐**
An expressed wish for organ/tissue donation? **Yes ☐ No ☐ Not Assessed ☐**
An advance decision to refuse treatment (ADRT)? **Yes ☐ No ☐**
Does the patient have the capacity to make their own decisions on their own treatment at this moment in time?
Yes ☐ Unknown ☐ consider the support of an IMCA – if required document below:
Comments:.....
.....

Goal 1.2: The relative or carer is able to take a full and active part in communication Achieved ☐ Variance ☐

First language..... Other Issues identified.....
Consider need for an interpreter (contact no):.....
Other barriers to communication:.....

Goal 1.3: The patient is aware that they are dying Achieved ☐ Variance ☐ Unconscious ☐

Goal 1.4: The relative or carer is aware that the patient is dying Achieved ☐ Variance ☐

Goal 1.5: The Clinical team have up to date contact information for the relative or carer as documented below
Achieved ☐ Variance ☐

1st contact name:.....
Relationship to the patient:..... Tel no:..... Mobile no:.....
When to contact: At any time ☐ Not at night-time ☐ Staying with the patient overnight ☐
2nd contact:.....
Relationship to the patient:..... Tel no:..... Mobile no:.....

When to contact: At any time ☐ Not at night-time ☐ Staying with patient the overnight ☐

Next of kin - this may be different from above N/A ☐
Name:.....
Contact details:.....
.....
.....

Lasting Power of Attorney (LPA) (if applicable) N/A ☐
Name:.....
Contact details:.....
.....
.....

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Name:..... Unit/NHS no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Facilities

Goal 2: The relative or carer has had a full explanation of the facilities available to them and a facilities leaflet has been given **Achieved ☐ Variance ☐**

Facilities may include: car parking, toilet, bathroom facilities, beverages, payphone, accommodation .

In the community setting this may include access details to DN services, palliative care services, out of hours services, GP, home loans, what to do in an emergency.

Spirituality

Goal 3.1: The patient is given the opportunity to discuss what is important to them at this time eg. their wishes, feelings, faith , beliefs, values **Achieved ☐ Variance ☐ Unconscious ☐**

Patient may be anxious for self or others. Consider specific religious and cultural needs

Consider music, art, poetry, reading, photographs, something that has been important to the belief system or the well-being of the patient

Did the patient take the opportunity to discuss the above **Yes ☐ No ☐ Unconscious ☐**

Religious tradition identified, please specify: .....

Support of the chaplaincy team offered **Yes ☐ No ☐**

If no give reason:.....

In-house support Tel/bleep no: .....Name: ..... Date/time: .....

External support Tel/bleep no: .....Name: ..... Date/time: .....

Needs now:.....

.....

.....

.....

.....

Needs at death:.....

.....

.....

Needs after death:.....

.....

.....

Goal 3.2: The relative or carer is given the opportunity to discuss what is important to them at this time e.g. their wishes, feelings, faith, beliefs, values **Achieved ☐ Variance ☐**

Comments.....

.....

.....

Did the relative or carer take the opportunity to discuss the above **Yes ☐ No ☐**

Medication

Goal 4.1: The patient has medication prescribed on a prn basis for all of the following 5 symptoms which may develop in the last hours or days of life (please refer to the prescribing guidance for the Liverpool Care Pathway for Care of the Dying Patients document).

Achieved ☐ Variance ☐

Pain ☐

Agitation ☐

Respiratory tract secretions ☐

Nausea / Vomiting ☐

Dyspnoea ☐

Anticipatory prescribing in this manner will ensure that there is no delay in responding to a symptom if it occurs

Current Medication assessed and non essentials discontinued

Medicines for symptom control will only be given when needed, at the right time and just enough and no more than is needed to help the symptom

Goal 4.2: Equipment is available for the patient to support a continuous subcutaneous infusion (CSCI) of medication where required

Achieved ☐ Variance ☐ Already in place ☐ Not required ☐

If a CSCI is to be used explain the rationale to the patient, relative or carer. Not all patients who are dying will require a CSCI

Time/Date CSCI commenced: .....

Please follow Trust guidelines for use of Graseby MS26 syringe driver and Saf-T Intima subcutaneous cannula

The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Current Interventions

Goal 5.1: The patient's need for current interventions has been reviewed by the MDT Achieved ☐ Variance ☐

	Currently not being taken/ or given	Discontinued	Continued	Commenced
5a: Routine blood tests	☐	☐	☐	
5b: Intravenous antibiotics	☐	☐	☐	☐
5c: Blood glucose monitoring	☐	☐	☐	
5d: Recording of routine vital signs	☐	☐	☐	
5e: Oxygen therapy	☐	☐	☐	☐

5.2: The patient has a Do Not Attempt Cardiopulmonary Resuscitation Order in place Achieved ☐ Variance ☐

Please complete the appropriate associated documentation according to policy and procedure
Explain to the patient, relative or carer as appropriate

5.3: Implantable Cardioverter Defibrillator (ICD) is deactivated Achieved ☐ Variance ☐ No ICD in place ☐

Contact the patient's cardiologist. Refer to the ECG technician & refer to local/ regional - policy/procedure.
(Information leaflet given to the patient, relative or carer as appropriate)

5.4: GP issues statement of intent to Out of Hours service to issue medical certificate Achieved ☐ Variance ☐

Nutrition

Goal 6: The need for clinically assisted (artificial) nutrition is reviewed by the MDT Achieved ☐ Variance ☐

The patient should be supported to take food by mouth for as long as tolerated
For many patients the use of clinically assisted (artificial) nutrition will not be required
A reduced need for food is part of the normal dying process

If clinically assisted (artificial) nutrition is already in place please record route NG ☐ PEG/PEJ ☐ NJ ☐ TPN ☐

Is clinically assisted (artificial) nutrition Not required ☐ Discontinued ☐ Continued ☐

Consider reduction in rate / volume according to individual need if nutritional support is in place
Explain the plan of care to the patient where appropriate, and to the relative or carer

Hydration

Goal 7: The need for clinically assisted (artificial) hydration is reviewed by the MDT Achieved ☐ Variance ☐

The patient should be supported to take fluids by mouth for as long as tolerated
For many patients the use of clinically assisted (artificial) hydration will not be required
A reduced need for fluids is part of the normal dying process
Symptoms of thirst / dry mouth do not always indicate dehydration but are often due to mouth breathing or medication. Good mouth care is essential

If clinically assisted (artificial) hydration is already in place please record route IV ☐ SC ☐ PEG/PEJ ☐ NG ☐

Is clinically assisted (artificial) hydration Not required ☐ Discontinued ☐ Continued ☐ Commenced ☐

Consider reduction in rate / volume according to individual need if hydration support is in place.
Explain the plan of care to the patient where appropriate, and the relative or carer

Skin Care

Goal 8: The patient's skin integrity is assessed Achieved ☐ Variance ☐

The aim is to prevent pressure ulcers or further deterioration if a pressure ulcer is present. Use a recognised risk assessment tool e.g. Waterlow to support clinical judgement. The frequency of repositioning should be determined by skin inspection, assessment and the patient's individual needs. Consider the use of special aids (mattress / bed)

Record the plan of care on the initial assessment MDT sheet where appropriate and refer to local policy for guidance

Explanation of the plan of care

Goal 9.1: A full explanation of the current plan of care (LCP) is given to the patient
Achieved ☐ Variance ☐ Unconscious ☐

Goal 9.2: A full explanation of the current plan of care (LCP) is given to the relative or carer
Achieved ☐ Variance ☐

Name of relative or carer(s) present and relationship to the patient:.....

.....

Names of healthcare professionals present:.....

Information sheet at front of the LCP or equivalent relative or carer information leaflet given Yes ☐ No ☐

Parents or carer should be given or have access to age appropriate advice and information to support children/adolescents

Goal 9.3: The LCP Coping with dying leaflet or equivalent is given to the relative or carer Achieved ☐ Variance ☐

Goal 9.4: The patient's primary health care team / GP practice is notified that the patient is dying / Out of Hours Service Achieved ☐ Variance ☐

G.P practice to be contacted if unaware that the patient is dying, message can be left or sent via a secure fax

If you have recorded a variance against any of the goals of care please record on the variance sheet, see page 10

The Pennine Acute Hospitals NHS Trust

Name:…… Unit/NHS no:…… Date:……

Section 1	***Initial assessment***	
Signatures	**Please sign here on completion of the initial assessment**	
	Doctor's name (print):…… **Doctor's signature:……** **Date……Time……**	**Nurse's name (print):……** **Nurse's signature:……** **Date…… Time……**

***Section 1 Initial assessment* MDT progress notes**	
Date	***Supportive information: Plan of care to monitor skin integrity, nutrition / hydration - include here any specific information regarding this patient; relative or carer that has not been captured in the initial assessment that you believe needs to be highlighted.***

The Pennine Acute Hospitals NHS
NHS Trust

Name:…………………………………………………………… Unit/NHS no:…………………………………… Date:…………………………………

Variance analysis sheet for initial assessment

What variance occurred & why? (what was the issue?)	Action taken (what did you do?)	Outcome (did this solve the issue?)
Goal: ***Signature:…………………………………….*** ***Date / Time:………………………………***	***Signature:…………………………………*** ***Date / Time:………………………………***	***Signature:…………………………………….*** ***Date / Time:………………………………***
Goal: ***Signature:…………………………………….*** ***Date / Time:………………………………***	***Signature:…………………………………….*** ***Date / Time:………………………………***	***Signature:…………………………………….*** ***Date / Time:………………………………***
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The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP DAY……..

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care	**and or**	Concern expressed regarding management plan from either the patient, relative or team member	**and or**	It is 3 days since the last **full** MDT assessment

Consider the support of the specialist palliative care team and/or a second opinion as required. Document all reassessment dates and times on page 5

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

Record an A or a V not a signature	**0400**	**0800**	**1200**	**1600**	**2000**	**2400**
Goal a: The patient does not have pain Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use a pain assessment tool if appropriate. Consider prn analgesia for incident pain						
Goal b: The patient is not agitated Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity						
Goal c: The patient does not have respiratory tract secretions Consider positional change. Discuss symptoms & plan of care with patient, relative or carer Medication to be given as soon as symptom occurs						
Goal d: The patient does not have nausea Verbalised by patient if conscious						
Goal e: The patient is not vomiting						
Goal f: The patient is not breathless Verbalised by patient if conscious, consider positional change. Use of a fan may be helpful						
Goal g: The patient does not have urinary problems Use of pads, urinary catheter as required						
Goal h: The patient does not have bowel problems Monitor – constipation / diarrhoea. Monitor skin integrity Bowels last opened:.....						
Goal i: The patient does not have other symptoms Record symptom here..... *If no other symptoms present please record N/A*						
Goal j: The patient's comfort & safety regarding the administration of medication is maintained If CSCI is indicated /required please refer to *Guidelines for staff using and managing the Graseby MS26 syringe driver and saf-t-intima cannula in palliative care. Community setting refer to own guidelines* The patient is only receiving medication that is beneficial at this time. *If no medication required please record N/A*						

The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP continued DAY....

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

	0400	0800	1200	1600	2000	2400
Goal k: The patient receives fluids to support their individual needs The patient is supported to take oral fluids / thickened fluids for as long as tolerated. Monitor for signs of aspiration and/or distress. If symptomatically dehydrated & **not deemed futile**, consider clinically assisted (artificial) hydration if in the patient's best interest. If in place monitor & review rate/volume. Explain the plan of care with the patient and relative or carer						
Goal l: The patient's mouth is moist and clean Relative or carer involved in care giving as appropriate. Mouth care tray at the bedside. Please refer to mouth care policy. Consider use of appropriate prescribed lubricants to keep mouth moist.						
Goal m: The patient's skin integrity is maintained Assessment, cleansing, positioning, use of special aids (mattress / bed). The frequency of repositioning should be determined by skin inspection and the patient's individual needs. *Waterlow score:*.....						
Goal n: The patient's personal hygiene needs are met Skin care, wash, eye care, change of clothing according to individual needs. Relative or carer involved in care giving as appropriate						
Goal o: The patient receives their care in a physical environment adjusted to support their individual needs Well fitting curtains, screens, clean environment, sufficient space at bedside, consider fragrance, silence, music, light, dark, pictures, photographs, nurse call bell accessible						
Goal p: The patient's psychological well-being is maintained Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. Spiritual/religious/cultural needs – consider support of the chaplaincy team						
Goal q: The well-being of the relative or carer attending the patient is maintained Just being at the bedside can be a sign of support and caring. Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer – support of chaplaincy team may be helpful. Listen & respond to worries/fears. Age appropriate advice & information to support children/adolescents available to parents or carers. Allow the opportunity to reminisce. Offer a drink						
Signature of the person making the assessment						
Signature of the registered nurse per shift	**Night**	**Early**		**Late**		**Night**

The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP DAY……..

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and or

Concern expressed regarding management plan from either the patient, relative or team member

and or

It is 3 days since the last **full** MDT assessment

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The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP continued DAY....

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

	0400	0800	1200	1600	2000	2400
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Signature of the person making the assessment						
Signature of the registered nurse per shift	**Night**	**Early**		**Late**		**Night**

The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP DAY……..

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and or

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The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

Section 2 Ongoing assessment of the plan of care – LCP continued DAY....						
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Signature of the person making the assessment						
Signature of the registered nurse per shift	**Night**	**Early**		**Late**		**Night**

The Pennine Acute Hospitals NHS Trust

Name:..... Unit/NHS no:..... Date:.....

***Section 2 Ongoing assessment* MDT progress notes**		
Date / time	**Record significant events / conversations / medical review / visit by other specialist teams e.g. palliative care / second opinion if sought**	**Signature**

Name:..... Unit/NHS no:..... Date:.....

***Section 2 Ongoing assessment* MDT progress notes**		
Date / time	**Record significant events / conversations / medical review / visit by other specialist teams e.g. palliative care / second opinion if sought**	**Signature**

Name:..... Unit/NHS no:..... Date:.....

Section 3 Care after death

Verification of death

Time of the patient's death recorded by the healthcare professional in the organisation:.....

Date of patient's death: ...../...../.....

Verified by doctor ☐ Verified by registered nurse ☐ Date / time verified:.....

Cause of death.....

Details of verification of death

Name of person verifying death..... (please print) Signature:.....

Bleep No:.....

Absence of carotid pulse for TWO minutes ☐

Absence of heart sounds using a stethoscope for TWO minutes ☐

Absence of breath sounds (using a stethoscope) and chest movement for TWO minutes ☐

No pupil response to light (pupils fixed and dilated) ☐

Persons present at time of death:.....

Relative or carer present at time of death: Yes ☐ No ☐ If not present, have the relative or carer been notified Yes ☐ No ☐

Name of person informed:..... Relationship to the patient:.....

Contact number:.....

Is the coroner likely to be involved: Yes ☐ No ☐

Consultant /GP:..... Doctor:..... Bleep No:..... Tel No:.....

Patient Care Dignity

Goal 10: last offices are undertaken according to policy and procedure **Achieved** ☐ **Variance** ☐

The patient is treated with respect and dignity whilst last offices are undertaken

Universal precautions & local policy and procedures including infection risk adhered to

Spiritual, religious, cultural rituals / needs met

Organisational policy followed for the management of ICD's, where appropriate

Organisational policy followed for the management & storage of patient's valuables, belongings & disposal of controlled drugs in accordance per local policy.

Relative or Carer Information

Goal 11: The relative or carer can express an understanding of what they will need to do next and are given relevant written information **Achieved** ☐ **Variance** ☐

Conversation with relative or carer explaining the next steps

Grieving leaflet given Yes ☐ No ☐

DWP1027 (England & Wales) or equivalent is given Yes ☐ No ☐

Information given regarding how and when to contact the bereavement office / general office / funeral director to make an appointment – regarding the death certificate and patient's valuables and belongings where appropriate

Wishes regarding tissue/organ donation discussed Yes ☐ No ☐

Discuss as appropriate: viewing the body / the need for a post mortem / the need for removal of cardiac devices / the need for a discussion with the coroner

Information given to families on child bereavement services where appropriate – national & local agencies

Organisation Information

Goal 12.1 : The primary health care team / GP is notified of the patient's death **Achieved** ☐ **Variance** ☐

The primary health care team / GP may have known this patient very well and other relatives or carers may be registered with the same GP. telephone or fax the GP practice, hospital consultants/specialsit nurses/AHP's involved etc.

Goal 12.2 : The patient's death is communicated to appropriate services across the organisation **Achieved** ☐ **Variance** ☐

e.g. Bereavement office / general office / palliative care team / district nursing team / care home/ community matron (where appropriate) are informed of the death

The patient's death is entered on the organisations IT system

Healthcare professional signature:.....

Date:..... Time:.....

Please record any variance on the variance sheet overleaf

Section 3 Care after death MDT progress notes ***- record any significant issues not reflected above***

Date	

The Pennine Acute Hospitals NHS
NHS Trust

Name:…………………………………………………………. Unit/NHS no:…………………………………… Date:………………………………….

Variance analysis sheet for section 2 and 3 of the LCP

What variance occurred & why? (what was the issue?)	Action taken (what did you do?)	Outcome (did this solve the issue?)
Goal: ***Signature:…………………………………….*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:…………………………………….*** ***Date / Time:………………………………***
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The Pennine Acute Hospitals NHS
NHS Trust

Name:……………………………………………………… Unit/NHS no:…………………………………… Date:…………………………………

Variance analysis sheet for section 2 and 3 of the LCP		
What variance occurred & why? (what was the issue?)	**Action taken (what did you do?)**	**Outcome (did this solve the issue?)**
Goal: ***Signature:…………………………………….*** ***Date / Time:……………………………….***	***Signature:…………………………………*** ***Date / Time:……………………………….***	***Signature:…………………………………….*** ***Date / Time:……………………………….***
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LCP SUPPORTING INFORMATION

Please ensure that you have attached the Trusts 'Prescribing Guidance for the Liverpool Care Pathway for the Dying Patient' (CPDI076). This can be accessed and downloaded from the 'Documents' page of the Intranet.