

THE LCP FOR THE DYING PATIENT: A GUIDE TO IMPLEMENTATION

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The Liverpool Care Pathway for the Dying Patient (LCP) is a multiprofessional tool that has been designed to improve and standardise care for dying patients in all health care settings. It is endorsed by the NHS End of Life Care Programme, which is a national programme aiming to improve end-of-life care for everyone, irrespective of diagnosis. This article describes how the LCP can be implemented within an organisation, explaining the various sections of the document, and examining how it can work in practice. The term 'variance recording', which is an integral part of the LCP document, is also explained and the relevance for audit of these variances is discussed. The sustainability, benefits and potential barriers against the use of the LCP will be considered. *Declaration of interests: none*

KEY WORDS

Care of the dying
Liverpool Care Pathway
Multiprofessional team
Palliative care

Integrated care pathways are evidence-based, structured, multidisciplinary care plans. They detail steps of care designed for patients with particular clinical conditions and can be used as audit tools. They enhance multidisciplinary communication and care planning, enabling staff to spend less time on paperwork (Campbell et al, 1998).

Such pathways exist for different clinical conditions and have been adapted for use in the field of palliative care. The Liverpool Care Pathway for the Dying Patient (LCP) was developed in 1997 to improve the care of patients at the end of their lives (Ellershaw and Wilkinson, 2003). The LCP is outcome-

focused (i.e. the outcomes of care are clearly documented which enables evaluation/auditing of care), thus providing a method of standardising care during the final days of a person's life.

The Department of Health (DH, 2003) has identified that patients and carers want improved choice in relation to end-of-life care. Central funding has been made available to support the NHS End of Life Care Programme, the aim of which is to promote high-quality end-of-life care for all patients, regardless of diagnosis. The LCP is one of three tools being advocated for use as part of this national programme and is recommended by the National Institute for Health and Clinical Excellence (2004). The other tools are the Gold Standards Framework and Preferred Place of Care. The LCP is recommended for patients with malignant and non-malignant diagnoses and long-term conditions who are at the end of their lives (DH, 2005a,b).

Although originally designed to facilitate the transfer of the hospice model of care to the hospital setting, the LCP is now used in all health care situations, including the community and nursing homes (Foster et al, 2003). The LCP framework was developed in Liverpool and the LCP Central Team continues to co-ordinate the project

nationally (Ellershaw and Murphy, 2005). This article will provide an overview of implementing the LCP and describe its main components.

Implementing the LCP

Before implementing the LCP, practical considerations must be explored. Murphy (2003) recommends a 10-step education strategy (Table 1). It is suggested that implementation is possible within 6 to 12 months, depending on the size of the organisation involved. In Liverpool, as in many trusts and settings, it was the palliative care team that led the implementation of the LCP, although clinical facilitators are now being developed in other areas of practice (Mellor et al, 2004).

A key element required for the success of the LCP is ensuring appropriate members of the multidisciplinary team agree a clear project plan at the outset. It is important to designate a suitable ward or area in which to pilot the LCP. Units in which the number of deaths is relatively high (i.e. more than two a month) with staff members keen to work with the LCP are suitable (Mellor et al, 2004).

Project leadership

Before establishing the project in any organisation, it is essential to obtain executive approval (Murphy, 2003).

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Senior management must endorse the LCP and facilitate the support of staff. The author's clinical experience suggests that it is useful to involve a variety of professionals within a multidisciplinary steering group in order to lead the project (Table 2). In practice, a smaller working party may be useful to carry out specific pieces of work (e.g. planning a teaching programme).

One role of the steering group is to examine and adapt the national LCP document for local use and to liaise with local committees (e.g. the senior nursing board and medical committee), the approval of which may be required before LCP implementation (Mirando et al, 2005). While it is important to adapt the LCP to allow local ownership, the LCP Central Team advises that the core goals of an adapted LCP document should remain the same as the national document. For referral, the current national LCP document is Version 1.1. Referring to the national document ensures that benchmarking exercises can be used to compare care across different clinical settings.

Issues that the steering group must consider also include developing an

implementation plan with achievable timescales, an education strategy and administrative practicalities.

Education strategy

Before implementation, a retrospective audit of current documentation is recommended. This provides an opportunity to examine current practices in an organisation (Murphy, 2003). The LCP Central Team recommends a review of 20 patients' clinical notes, examining the documented end-of-life care and comparing it to provided pro formas (standard forms). The LCP Central Team will then analyse these data within a 4–6 week time frame. Further information about this process can be obtained from the: <http://www.mcpcil.org.uk> website. (The LCP Central Team has now been incorporated into the Marie Curie Palliative Care Institute, Liverpool). Once received, the feedback can be used to inform teams about their strengths and limitations and provides a helpful focus for the education programme.

Education sessions should be multidisciplinary and encompass set training objectives (Mirando et al,

2005). The compilation of a resource folder, enabling staff members to familiarise themselves with the LCP and its documentation, is recommended. Key areas for training include symptom control, communication and bereavement support (Jones and Johnstone, 2004).

Table 2

Multidisciplinary steering group members for the LCP

- Senior clinicians from the local palliative care team and the pilot area
- LCP facilitator (if in post)
- Palliative care clinical nurse specialists
- Ward manager and staff nurse
- Senior nurse representative
- Clinical audit department
- Service improvement facilitator
- Pharmacy
- Chaplain
- Bereavement office
- Administrator

Table 1

Ten-step strategy to facilitate implementation of the Liverpool Care Pathway

Month 1	Steps
Month 1	1. Establishing the project, i.e. gaining executive and multidisciplinary endorsement for the LCP project
	2. Development of documentation
	3. Retrospective audit of current documentation
Months 2 to 5	4. Induction — education programme
	5. Implementation — education programme
	6. Reflective practice
Months 6 to 10	7. Evaluation and training needs analysis
	8. Maintenance of education programme
Months 10 to 12	9. Training the teachers
	10. Programme of ongoing feedback from analysis of LCP

Source: Murphy (2003)

Implementing the Liverpool Care Pathway

Key issues for consideration within the LCP include:

- ▶▶ Criteria for its use
- ▶▶ Initial assessment process
- ▶▶ Ongoing assessment process
- ▶▶ Care after death (Ellershaw et al, 1997).

The LCP also incorporates clinical guidelines for symptom control that may be adapted to incorporate local guidelines and supporting information.

Criteria for use of the LCP

The inclusion of a patient on the LCP follows a multiprofessional team decision that the patient is dying and meets certain criteria, such as being comatose and unable to take oral medication (Ellershaw et al, 1997).

Once a patient commences on the LCP, the medical and nursing staff

members are required to carry out an initial assessment that includes details of the patient's diagnosis, demographics (e.g. date of inpatient admission, ethnicity, date of birth, NHS number and gender) and baseline physical condition. The care is then planned as a series of goals, with interventions that act as prompts to support the care (Ellershaw et al, 1997). An example of such a goal is given in *Table 3*. The key goals of initial assessment are listed in *Table 4*.

Measures promoting comfort include reducing the number of unnecessary medications the patient is taking and ensuring all interventions for symptom control are planned. It is recommended that inappropriate oral medications for common end-of-life symptoms (i.e. pain, agitation, respiratory tract secretions, nausea/vomiting and dyspnoea) are stopped or administered subcutaneously (National Council for Palliative Care, 2005a,b). This is to avoid the unnecessary distress of continuing with medication that may be futile, when no clear benefit can be gained and that there is no delay in responding to a symptom. It is also because patients on the LCP are much less likely to be able to swallow oral medications. 'As required' medications should always be available, so that if a symptom does occur it can be responded to immediately. The drugs, dose and route to be used, according to local protocol, are detailed in the

Table 3

Example of a goal and prompts relating to medication

Goal

Current medication assessed and non-essentials discontinued

Suggested prompts

Appropriate oral drugs converted to subcutaneous route and syringe driver commenced if appropriate

Inappropriate medication discontinued

Table 4

Key goals of assessment

- Measures to promote patient comfort
- Psychological insight
- Religious/spiritual support
- Communication with family/general practitioner
- Summary of care

LCP supporting clinical guidelines that are printed at the end of the pathway (Kinder and Ellershaw, 2003).

Consideration is also given to the reduction of unnecessary medical and nursing interventions. The LCP recommends that blood tests, antibiotics, intravenous fluids/medications are discontinued and that a patient's cardiopulmonary resuscitation status should be recorded. Nursing interventions such as recording of temperature, pulse and blood pressure should cease and the patient should only be repositioned to maintain comfort (Kinder and Ellershaw, 2003).

Practitioners are free to exercise personal judgment, but any alteration to the LCP must be documented as a variance. For example, it is possible for patients to be entered onto the LCP if a decision has been made to continue intravenous/subcutaneous fluids. Relatives frequently express concern about a lack of fluid intake, but a blanket policy banning or promoting intravenous/subcutaneous hydration is questionable. However, administering fluids by these means may constitute an unnecessary burden, particularly in the last few days of life. Regular assessment of this intervention is advised (National Council for Palliative Care, 2005a,b).

When a patient is commenced on the LCP, assessment of the patient's and family's insight into the diagnosis and prognosis is undertaken. Religious/spiritual needs and communication issues are also considered (Kinder and Ellershaw, 2003). These can be difficult

areas to address, but a study which explored the views of nurses using the LCP found that, following these assessments, communication with relatives became more open and nursing staff felt more confident to meet the needs of dying patients (Jack et al, 2003).

At the end of the initial assessment the agreed plan of care is summarised. After completing this process, staff members are required to commence an ongoing patient assessment.

Table 5

Example of a goal and prompts relating to breathlessness

Goal

Breathlessness is not distressing for patient

Suggested prompts

Patient verbalises if conscious

Consider need for positional change

Ongoing assessment (section 2)

Assessment sheets must be completed every 24 hours that a patient remains on the LCP. There are daily sheets, with a series of 4- and 12-hourly assessments. These assessments create a series of goals with supporting prompts. An example is given in *Table 5*. Symptoms that dying patients often experience requiring assessment every 4 hours include those listed in *Table 6*.

Table 6

Common symptoms of dying patients

- Pain
- Agitation
- Respiratory tract secretions
- Nausea and vomiting
- Dyspnoea

Source: *Liverpool Care Pathway Central Team (2005)*

The process of the LCP prompts staff to recognise and manage these key symptoms. Jack et al (2003) interviewed nurses in an acute hospital who reported that symptom control was poor, but since the introduction of the LCP there had been an improvement in the management of chest secretions and terminal agitation.

Other goals assessed 4-hourly include comfort measures, medications, treatments and procedures. One of the key support goals prompts staff to check the understanding of family members, including those not present at the initial assessment and children in the family. Mobility, safety, psychological insight and religious support goals are assessed every 12 hours (Ellershaw et al, 1997). Examples of the prompts for the goal relating to the care of the family/others are shown in *Table 7*. These will remind practitioners to check that the family's needs are being addressed.

There has been criticism that the LCP reduces care of the dying to a flow diagram and series of boxes to be ticked (Kelly, 2003). While this may be true to some extent, this viewpoint is somewhat one-dimensional. The LCP provides a framework that can support carers and families to form a unique and individual plan for those who are dying. It can also minimise some of the unstructured care processes around the care of dying patients that currently exist (Smith et al, 2003). The LCP is not meant to replace sensitive and holistic end-of-life care, it exists as a tool to complement this approach.

Care after death (section 3)

Following the death of a patient, the LCP guides staff to document that appropriate tasks have been completed according to local policy. This section of the pathway includes verification of death, focusing on care and support of families and carers. It also incorporates their need for information. Informing GPs of their patient's death is also recommended (Kinder and Ellershaw, 2003). It ensures that the GP is involved and able to offer support to the bereaved family. Any goal that was unachieved should be documented as a

variance. The phenomenon of 'variance' will now be discussed in further detail.

Variance recording

Any variance from the LCP national guidelines and any unachieved goal of the integrated care pathway should be recorded separately. Variance may occur for a number of reasons. It may be that the patient or his/her clinician decides that an aspect of the pathway is not appropriate and should be modified to meet the patient's needs, e.g. if a clinician decides to continue antibiotics. It is vital that variances are documented accurately, ensuring that each variance can be tracked and monitored (Campbell et al, 1998).

An example of a variance is as follows: If a patient is pain free at 08.00 this would be documented as achieved. If the patient had pain at 10.00, this would be recorded as a variance. If the patient was then pain free at 12.00 it would again be recorded as goal achieved, but the episode of pain would have been recorded and could be tracked. This enables the symptom to be monitored. Examples of how variances are documented are shown in *Table 8*. Analysis of variance documentation can highlight areas suitable for research and development (Fowell et al, 2002). Such analysis also enables estimation of quality of care and can promote changes to practice (Murtagh et al, 2004).

The LCP as an audit tool

Information gained from completed variance sheets has been used to

inform the audit process, and provide a tool for benchmarking exercises (Ellershaw et al, 2001; Fowell et al, 2002). Concerns have been raised that there is no validated evidence to show that the LCP ensures a 'good death'.

Shah (2005) questions whether improved prescription of medications translates into appropriate use and desired outcome. In other words, just because medications are prescribed, it does not necessarily follow that staff will know when to give them appropriately and therefore symptom control may not be optimal. He suggests that it may be beneficial to compare outcomes on units implementing the LCP against units where it is not currently used. In practice this may not be useful because, as Shah states, there are no universally accepted tools to test the outcomes of the LCP.

During 2007, information gained from the National Care of the Dying Audit of hospitals will be reported back to organisations to influence current practice. In a previous benchmarking exercise, Fowell et al (2002) analysed 500 variance sheets from patients who had died while on the LCP. It was reported that pain management, agitation, excess respiratory secretions and mouth care were problematic. It also reported difficulties with pain control in 44% of the hospitals, 61% of the hospices, 36% of the inpatient units and 54% of community patients. It was acknowledged that the variance sheets provided a relatively crude tool for the monitoring of quality care and that further research is required. There will always be variances occurring within the LCP. However, detailed analysis of the actions taken following variance and studying whether a goal is unachieved will identify whether the LCP is being used correctly.

Diagnosing when a patient is dying and potential barriers to the use of the LCP

In order to use the LCP, there must first be a consensus of opinion that the patient in question is entering the last few days of life. This is not always an easy decision to reach. In acute

Table 7	
Goal and prompts for family care	
Goal	The needs of those attending the patient are accommodated
Suggested prompts	Consider health needs and social support
	Ensure awareness of ward facilities

hospitals the culture of care is usually orientated towards cure. Invasive procedures may be pursued at the expense of patient comfort (Ellershaw and Ward, 2003). In other settings, such as the community, lack of forward planning may result in inappropriate hospital admissions for those about to die (Pooler et al, 2003). However, if consideration is given to the planning of a person's death, it is possible to prevent inappropriate interventions.

One trust that has been using the LCP for over 5 years carried out an audit of LCP use in its elderly care units. The trust used the LCP for 25% of the patients in these units (King's College Hospital Palliative Care Team, 2004). The audit suggested that, of the 75% of patients not on the LCP, 25% experienced sudden death and in the other 50%, death was not always anticipated. A review of relevant notes suggested that many of those patients could have benefited from a systematic approach to end-of-life care. In many cases, active medical management, while not inappropriate, did obscure the patient's actual physical, psychosocial and spiritual

needs (King's College Hospital Palliative Care Team, 2004).

Use of the LCP can only occur when the dying process is acknowledged, yet there are numerous difficulties that clinicians face in making that decision. Hope may remain that a patient will recover. There may be disagreement among the multidisciplinary team and between the team and the family over the patient's condition. There may also be concerns about ethical issues, such as withdrawal of treatment, and lack of knowledge. All these factors present as overwhelming barriers to LCP implementation (Ellershaw and Ward, 2003). Inability to communicate effectively with the family and patient is another key factor. If clinicians are reluctant to address the fact that the patient is dying, then implementation of the LCP is less likely to occur. It could even be seen as just another obstacle to overcome for certain under-confident staff.

If the diagnosis that the patient is dying is not made, conflicting messages may be given by the multiprofessional team, which can lead to loss of trust

(Ellershaw and Ward, 2003). The patient and family may be unaware that death is imminent, preventing them from completing final tasks and hindering vital communication at that time. It may also lead to complex bereavement problems (Ellershaw and Ward, 2003).

The LCP Central Team (2003) recognises that a key challenge is to change the culture of end-of-life care. The LCP document can reinforce educational programmes for care of the dying and provides a tool to address quality of care (Ellershaw and Murphy, 2005). Educational programmes that address these challenging issues are vital to promote increased uptake of the LCP in areas where use is not consistent. Case studies that illustrate how the LCP can benefit practice may provide a useful educational and promotional tool.

Case scenario

Trevor (pseudonym) was a 59-year-old man with end-stage renal disease (ESRD), diabetes, hypertension and ischaemic heart disease. Trevor had a history of learning difficulties and had

Table 8

Variance analysis

What variance occurred and why?	Action taken	Outcome
<p>IV continued. Decision taken by consultant but patient needs to be reviewed in 24 hours</p> <p>Signature: J. Smith.....</p> <p>Date/Time: 04/01/07 17.00</p>	<p>Continue with IV fluids (1 litre over 24 hours)</p> <p>Review 05/01/07</p> <p>Signature: J. Smith.....</p> <p>Date/Time: 04/01/07 17.00</p>	<p><i>Reviewed - very chesty. Fluids stopped</i></p> <p>Signature: <i>K. Brown</i>.....</p> <p>Date/Time: 05/01/07 16.00</p>
<p><i>Patient is unsettled and distressed. Complains of feeling nauseated</i></p> <p>Signature: <i>K. Brown</i>.....</p> <p>Date/Time: 05/01/07 20.00</p>	<p><i>Given midazolam 2.5mg and haloperidol 1.5mg S/c</i></p> <p>Signature: <i>K. Brown</i>.....</p> <p>Date/Time: 05/01/07 20.00</p>	<p>Settled. No longer nauseated</p> <p>Signature: J. Smith.....</p> <p>Date/Time: 05/01/07 21.00</p>
<p>Signature.....</p> <p>Date/Time.....</p>	<p>Signature.....</p> <p>Date/Time.....</p>	<p>Signature.....</p> <p>Date/Time.....</p>

lived in a residential home for 5 years. His closest family member was an uncle, who was in his 80s and frail. Trevor had been diagnosed with ESRD 9 months previously and, following detailed discussions with the multiprofessional team, Trevor and his community key-worker agreed that haemodialysis should be commenced, with the proviso that treatment would be reviewed every 3 months. Since that time Trevor attended the outpatient dialysis unit three times a week.

Trevor was admitted as an inpatient to hospital with a chest infection and increasing frailty. During the admission, Trevor initially improved, but his condition worsened. He suddenly became unresponsive. A scan revealed that Trevor had suffered a massive cerebrovascular accident. Trevor's case was referred to the stroke team. It was agreed that his condition was irreversible. His prognosis was very poor, i.e. a few days, and it was agreed that the LCP should be commenced.

Trevor was bed-bound and no longer able to swallow tablets. His oral medications were discontinued and subcutaneous injections prescribed for his symptoms according to the LCP guidelines. At the time he did not have any symptoms; however, 'as required' subcutaneous medications were written up as per protocol (including medications for pain, agitation, respiratory tract secretions, nausea and vomiting and dyspnoea). In this way anticipatory prescribing ensured there would be no delay in responding to a symptom if it occurred.

Communication issues were addressed. Staff members liaised with Trevor's key-worker and his uncle to inform them of the situation. At that time Trevor was unconscious and unable to be included in these conversations. His close friends from his home were informed of his condition and were able to visit and spend time with him.

The next day Trevor became restless, with no obvious cause found. He was given 2.5 mcg of

subcutaneous midazolam, after which he quickly relaxed. This agitation was documented as a variance on the LCP documentation. That evening Trevor exhibited excessive respiratory tract secretions, which were documented as a variance, and treated with 200 mcg of glycopyrronium. His uncle was visiting and requested that the hospital chaplain be contacted. Trevor died 2 hours later with his uncle present.

The LCP provided a useful framework for staff when providing care for Trevor in the last few days of his life. The communication needs of Trevor's family and friends were met. They were all aware that Trevor was expected to die and were offered the opportunity to spend time with him. Trevor's symptoms were controlled and the staff caring for him felt that his death had been peaceful. The staff also felt that by using the LCP their confidence had increased.

Sustainability of the LCP

It is important to consider how the LCP can be maintained and embedded within an organisation. Some of the factors that may influence its sustainability are:

- ▶▶ Team ownership
- ▶▶ Engaging managers
- ▶▶ Coherence with the wider context
- ▶▶ Reinforcing factors (LCP Central Team, 2003).

As part of the 10-step education strategy (see *Table 1*), Murphy (2003) suggests involving two nurses from each clinical area in a network nurse programme, choosing individuals who have a particular interest in palliative care, to help support the use of the LCP in their own area.

The programme in Liverpool consists of a monthly meeting that incorporates educational elements and aims to provide general nurses with skills to care for dying patients. The Liverpool programme has been formally evaluated by the use of a questionnaire, which was sent out to 41 nurses who had received education from the Liverpool team. It had an 80% response rate. It was shown that

nurses have increased knowledge and feel empowered to discuss treatment options within the multiprofessional team (Jack et al, 2004). Although this study provides useful information, the sample size is small and further research is needed. Sustainability of the LCP is a challenge, but it is necessary for the LCP to be realised fully and to ensure that any changes to general practice are maintained.

Recommendations for practice

Recommendations for practice are:

- ▶▶ The LCP should be endorsed nationally as a tool to improve end-of-life care. Implementation across all health care settings is recommended.
- ▶▶ A clear project plan based on Murphy's (2003) 10-step education strategy and local ownership at all levels is essential for successful implementation of the LCP within an organisation.
- ▶▶ A local, base review of current documentation is advised. The information gained from this can inform teams about current strengths and limitations, providing a tool to inform the education programme.
- ▶▶ There are no universally accepted tools to test the outcomes of the LCP. This is an area that requires further research.
- ▶▶ Diagnosing when a patient is dying remains a challenge for clinicians. The LCP may help improve patient care around this time.
- ▶▶ Sustainability of the LCP within an organisation is a key issue. The use of network or link nurses may help with this aim.

Conclusion

This article has examined how the LCP provides a comprehensive framework that can support patients and carers and health care professionals when a patient is at the end of his/her life. Many challenges remain concerning end-of-life care and the LCP alone cannot solve all of these issues. However, it may promote best practice in care of the dying and provide a framework that can be developed. The LCP cannot change

the cultures that exist around care of dying patients, but it may be viewed as a useful step in the right direction.

There is a lack of evidence-based research supporting the assessment of LCP outcomes (Shah, 2005), but there is a wealth of information to be gained from audits that have examined use of the LCP (Ellershaw et al, 2001; Fowell et al, 2002). Further work is needed to ensure that the LCP continues to provide and promote best practice that is evidence-based in order to improve care of the dying for all. **EOLC**

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Key Points

- ▶▶ The Liverpool Care Pathway for the Dying Patient (LCP) is a multiprofessional tool designed to improve and standardise care for dying patients.
- ▶▶ The LCP incorporates clinical guidelines for symptom control of patients at the end of life. It enables the nurse to assess measures to promote patient comfort, the need for religious/spiritual support, and facilitate communication with the patient and family members.
- ▶▶ It has been found that nurses who use the LCP feel more confident when meeting the needs of patients and their families and are better able to communicate with and support them.
- ▶▶ Lack of communication with families at this time can impede the bereavement process.