Introduction

The Liverpool Care Pathway for the Dying Patient (LCP) has been developed in the U.K to transfer the hospice model of care into other care settings. It is a multi-professional document that provides an evidence-based framework for end of life care.

The LCP provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions.

Additional, psychological and spiritual care and family support are included.

The LCP replaces all other documentation in this phase of care and is applicable in hospital, hospice, and care home and community settings.

Each organisation should consider the most appropriate LCP document for their needs.

We have demonstrated that the LCP is transferable across care settings and meets local health economy needs.

Ownership by local healthcare services of the framework is imperative for implementation and sustainability of the LCP within the clinical arena.

However those services registered with us who want to be part of wider evidence and research programme and be involved in future benchmarking and National Audit activity will need to keep the core goals exactly as outlined within this document.

Nevertheless, the prompts which support the goals can be adapted to better reflect local practice, provided that they do not alter the meaning of the stated goal.

If you require further information or support please contact the LCP Central Team UK:

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GOAL 1 CURRENT MEDICATION ASSESSED AND NON ESSENTIALS DISCONTINUED

RATIONALE
- To avoid unnecessary distress of continuing with medication which may be futile when no clear benefit can be gained
- To consider an alternative route of administration

REQUIRED BEHAVIOUR
MDT discussion to:
Stop, Think, Assess, and Change your practice accordingly
- Review medication and discuss the purpose of all medications on commencement of the LCP
- Discontinue any inappropriate medication
- Convert any appropriate medication to subcutaneous route
- Consider the need for a continuous subcutaneous infusion of medication (via a syringe Driver)

CODING
- Code YES when all appropriate measures have been carried out
- Code NO when one or more appropriate measures has not been carried out

GOAL 2 PRN SUBCUTANEOUS MEDICATION WRITTEN UP FOR LIST BELOW AS PER PROTOCOL (2.1 – 2.5)

RATIONALE
- These 5 key symptoms have been recognised as actual or potential problems at the end of life.
- Anticipatory prescribing will ensure minimal delay responding to a symptom if or when they arise

REQUIRED BEHAVIOUR
Refer to the algorithms at the end of the LCP to underpin prescribing (appropriate medications/ dose etc) according to local policy and procedure.
Anticipatory Prescribing of appropriate PRN medication for all 5 symptoms (whether or not the patient is displaying these symptoms on commencement of pathway)

CODING
- Code YES when each of the appropriate medications has been written up according to protocol.
- Code NO against any drugs that have not been written up or not written up as per protocol
**GOAL 3 DISCONTINUE INAPPROPRIATE INTERVENTIONS**

3.1 BLOOD TESTS
3.2 ANTIBIOTICS
3.3 IV FLUIDS AND/OR MEDICATION

**RATIONALE**
To avoid invasive, futile, potentially painful and unnecessary procedures / interventions being carried out when no clear benefit can be gained

**REQUIRED BEHAVIOUR**
Stop, Think, Assess, and Change your practice accordingly
Practitioners are free to exercise their own professional judgment; however, any alteration to the practice identified within the LCP must be noted as a variance
- Discontinue **routine** blood tests
- Discontinue the use of antibiotics
- Discontinue IV fluids/medications

**CODING**
- Code **YES** against each intervention when it has been discontinued
- Code **NO** against any intervention that has not been discontinued
- Code **N/A** when an intervention was not being carried out

**GOAL 3.4 NOT FOR CARDIOPULMONARY RESUSCITATION (CPR) RECORDED**

**RATIONALE**
To avoid invasive, futile, potentially painful and unnecessary procedures/interventions being carried out when no clear benefit can be gained

**REQUIRED BEHAVIOUR**
Stop, Think, Assess, and Change your practice accordingly
- Follow local policy/procedure
- Complete appropriate associated documentation
- Record also directly on LCP
- Discuss and inform patient & or Relative / Carer as appropriate

**CODING**
- Code **YES** when a ‘not for CPR’ decision has been made and appropriately documented according to policy/procedure.
- Code **NO** when a decision has not been made and/or has not been appropriately documented according to policy/procedure
GOAL 3.5  DEACTIVATE IMPLANTED CARDIAC DEFIBRILLATORS (ICDs)

RATIONALE
Continuing cardiac defibrillation until the point of death can be distressing and confusing to family/carers when no clear benefit can be gained.

REQUIRED BEHAVIOUR
Stop, Think, Assess, and Change your practice accordingly
- Refer to and follow local policy and procedures for deactivation
- Contact the patient’s Cardiologist
- Give information leaflet to patient/carer wherever appropriate in support of best practice

CODING
- Code YES when appropriate policy and procedure has been carried out and cardiac defibrillator has been deactivated
- Code NO when the cardiac defibrillator has not been deactivated
- Code N/A when the patient did not have a cardiac defibrillator fitted

GOAL 3a  DECISIONS TO DISCONTINUE INAPPROPRIATE NURSING INTERVENTIONS TAKEN

RATIONALE
To ensure that nursing interventions are appropriate for a specific individual - some interventions will no longer be appropriate for this period of care.

REQUIRED BEHAVIOUR
Stop, Think, Assess, and Change your practice accordingly
- Stop taking routine vital signs
- Reduce frequency of or discontinue BM monitoring
- Change from routine turning regimes to a regime aimed at repositioning for comfort only

CODING
- Code YES if all the above have been carried out (wherever appropriate)
- Code NO if one or more of the above have not been carried out (wherever appropriate)
**GOAL 3b  SYRINGE DRIVER SET UP WITHIN 4 HOURS OF DOCTOR’S ORDERS**

**RATIONALE**
To ensure that equipment supporting continuous subcutaneous infusion of medication in support of symptom management is available as and when required.

**REQUIRED BEHAVIOUR**
Stop, Think, Assess, and Change your practice accordingly.
- If required obtain a syringe driver & use according to local policy and procedure
- If not available be able to manage symptoms with regular subcutaneous injections

**CODING**
- Code **YES** if a syringe driver was requested and was set up within four hours of doctor’s order
- Code **NO** when a syringe driver was required but not set up (at all or within 4 hours?)
- Code **N/A** if a Syringe Driver was not required on commencement of the LCP.

**GOAL 4  ABILITY TO COMMUNICATE IN ENGLISH ASSESSED AS ADEQUATE WITH PATIENT AND CARER**

4a) PATIENT
4b) FAMILY / OTHER

**RATIONALE**
- To support communication / psychological / insight into care management.
- Some patients and/or carers or members of their family may not use English as their first language.
- Some patients and/or carers or members of their family may have learning difficulties.

**REQUIRED BEHAVIOUR**
Consider the first language of your patient and relative / carer – if this is not English you may need to consider the use of an interpreting service.
If for any reason your patient, relative / carer cannot fully understand English due to any other reason e.g. learning difficulties, hearing impairment then you may need to seek support in your communication processes

**CODING**
- Code **YES** when no support is needed to facilitate appropriate communication with (a) patient and/or (b) carer/relative
- Code **NO** when you have identified the need for support to facilitate appropriate communication with (a) patient and/or (b) carer/relative
RATIONAL

• To ensure, where appropriate, that the Patient & or Relative / carer are aware of the patient’s diagnosis and that the patient is now thought to be in the dying phase
• To ensure that you as a health professional are aware of the knowledge status in support of future conversations you may have – particularly at the bedside - so as to maintain appropriate confidentiality and respect

REQUIRED BEHAVIOUR

Patient

• Remember this goal refers to your understanding of the knowledge level of your patient
• If you have prior knowledge that the patient has expressed an awareness then it may not be necessary to have a further conversation at this time if you feel that this is inappropriate
• If a conversation is deemed appropriate at this time, remember, it can be a difficult conversation to have. You need to recognise your limitations and seek advice and support where appropriate

Relative / Carer

Ascertain by using prior knowledge or current discussion the knowledge base of the relative / carer and code accordingly.

CODING

Patient

- Code YES if you know that the patient is aware, either due to your prior knowledge or because you have explained this to the patient at this moment in time.

- Code NO if you know that the patient is not aware or if you are unsure of their level of knowledge but despite having the opportunity you do not attempt to assess the patient’s insight, for example:
  - patient requested never to hear bad news
  - patient is alone & you want to have this conversation with a relative / carer present
  - patient is not well enough in your professional opinion to have this discussion despite being conscious
  - you do not feel able to address this issue at this time

- Code COMATOSED if you know that the patient is not aware or if you are unsure of their level of knowledge but you do NOT have an opportunity to have a conversation because the patient is comatose at this time.
**Relative / Carer**
- Code **YES** if you know that the relative / carer is aware, either due to your prior knowledge or because you have explained this to the relative / carer at this moment in time.
- Code **NO** if you know that the relative / carer is not aware or if you are unsure of their level of knowledge but despite having the opportunity you do not attempt to assess the relative/carer’s insight. For example:
  - patient requested that you do not discuss their care with a relative / carer
  - the relative / carer is not present at the time of the assessment and you need to address this at a later date
  - you do not feel able to address this issue at this time

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**GOAL 6 RELIGIOUS / SPIRITUAL NEEDS ASSESSED**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>6a)</td>
<td>PATIENT</td>
</tr>
<tr>
<td>6b)</td>
<td>FAMILY / OTHER</td>
</tr>
</tbody>
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**RATIONALE**
To ensure that any religious or spiritual need is highlighted and addressed if required now, at impending death or after death

**REQUIRED BEHAVIOUR**

**Patient**
- Because the focus of care has now changed to care of the dying, even if it is known that the patient has previously been asked about their religious or spiritual beliefs and may indeed have a documented formal religious tradition or spiritual belief on admission, a conversation to identify the patient’s present spiritual/religious needs must occur.
- The identified spiritual/religious needs must be documented appropriately.

**Relative / Carer**
- Irrespective of any prior knowledge or conversations at this moment in time you need to have a conversation with the relative / carer re
  - the patients beliefs and wishes if appropriate
  - the relative / carers own concerns or beliefs

**CODING**

**Patient**
- Code **YES** if you had a conversation with the patient and any religious / spiritual needs (or their absence) have been identified and documented appropriately
- Code **NO** if you did not have the conversation
- Code **COMATOSED** if it was impossible to have the conversation because your patient is comatose at this time
**Relative/Carer**
- Code **YES** if you had a conversation with the relative/carer and any religious/spiritual needs (or their absence) for the patient and the carer were identified and documented appropriately.
- Code **NO** if you did not have the conversation about either (or both) the patient or carer/relative’s religious/spiritual needs.

**GOAL 7 IDENTIFY HOW FAMILY / OTHER ARE TO BE INFORMED OF THE PATIENTS IMPENDING DEATH**

**RATIONALE**
- It is important when communicating information of a sensitive nature around patients deteriorating condition/impending death that the appropriate person is contacted at an appropriate time.
- Information that was accurate at any other time in this episode of care may not be accurate now that the focus of care has changed to care of the dying.
- Some carers may be working, elderly or indeed not want to be contacted until the following day irrespective of the patient’s condition.
- Establishing how relative/carer wish to be told of patients impending death is also very important.
- In some situations the next of kin may not be the most appropriate person to be contacted at the time of impending death or a list of people may be given or mobile numbers may be needed.

**REQUIRED BEHAVIOUR**
- Irrespective of prior knowledge or documentation the health professional must revisit this issue and have a conversation to ensure that the patient’s, where appropriate, and the Relative/carer’s wishes are known.
- Contact details should be reviewed to ensure the correct details are recorded.

**CODING**
- Code **YES** if you have had a conversation with the patient and/or relative/carer and you have identified and documented:
  - a primary and secondary contact
  - Appropriate times/circumstances in which they should be notified.
- Code **NO** if you have not had this conversation.
GOAL 8 FAMILY / OTHER GIVEN HOSPITAL INFORMATION

RATIONALE
It is important that written information is given to back up a conversation to ensure that relatives / carers are aware of facilities available to them at this time, particularly since a more flexible approach to visiting is now likely to be appropriate.

REQUIRED BEHAVIOUR
A specific information leaflet should be given to relative / carer

CODING
- Code YES if you have given available written documentation/ information
- Code NO if you have not provided written documentation/ information
  e.g. If you did not provide written information or leaflets do not exist or relative/ carer was not available at that point.

GOAL 9 GP PRACTICE IS AWARE OF PATIENTS CONDITION

RATIONALE
- The primary health care team are the primary team managing this patient and should always be kept informed of patients condition
- They need to know that the focus of care has changed and an LCP is in progress because
  - Other members of the family may be known to the practice.
  - The GP or other member of the primary healthcare team may want to visit the patient or carer.

REQUIRED BEHAVIOUR
- If the health professional has knowledge that the GP practice are aware that the patient has entered the dying phase (eg if the patient was referred from primary care for terminal care) there is no need to have further contact with the GP practice at this stage
- Otherwise, the Health professional needs to contact the GP Practice to make them aware of the current situation.

CODING
- Code YES if you know that the GP Practice is already aware or you have made contact with the practice (e.g. telephoned, faxed to a safe fax facility)
- Code NO If you know that the GP practice is not aware or you are unsure of their level of knowledge and you have not made contact with the practice (e.g. out of hours)
RATIONALE
It is important to ensure that the patient and family/ carer understand fully the aims of the new plan of care.

REQUIRED BEHAVIOUR
• A discussion must take place between the health professional and the patient (where possible and appropriate) and/or the Relative / carer to inform them in jargon free language that the focus of care has now changed to care of the dying
• It is at this time that health professionals may introduce the Coping with Dying leaflet in support of their conversation that outlines what signs and symptoms may be expected in the last hours / days of life, if deemed appropriate
• Similarly, the relative / carer may also benefit at this time from the LCP information leaflet. However, these leaflets should only be used to support the conversations undertaken.

CODING

10a) Patient
- Code YES if you have had a conversation in which you explained the revised plan of care to the patient
- Code NO if despite having an opportunity you did not have a conversation with the patient to explain the plan of care
- Code Comatosed if you did NOT have an opportunity to have a conversation because the patient was comatosed at this time

10b) Family / Carer
- Code YES if you have had a conversation in which you explained the revised plan of care to the family / carer
- Code NO if despite having an opportunity you did not have a conversation with the relative/carer to explain the plan of care
GOAL 11 FAMILY / OTHER EXPRESS UNDERSTANDING OF PLANNED CARE

RATIONALE
- It is important to ensure and to check that our communications have been fully understood.
- To give an opportunity to the Relative / carer to verbalise that they have understood that:
  - the focus of care has changed to care of the dying
  - a specific plan of care has been activated in support of the key goals of care for the last hours or days of life & their concerns are identified, valued and documented

REQUIRED BEHAVIOUR
A conversation must take place between the health professional and the relative / carer to
- enable the relative / carer to verbalise their understanding of the current situation
- given them an opportunity to express their concerns and recognize that these are valued and documented.

CODING
- Code YES if you have had the conversation during which the family clearly articulated their understanding of the situation
- Code NO if despite having an opportunity you did not have a conversation with the relative/carer OR if you had the conversation but the family did not articulate a clear understanding of the situation

GOAL 12 GP PRACTICE CONTACTED RE PATIENTS DEATH

RATIONALE
To improve communication between primary and secondary care the GP practice must be informed of the patient's death So that
- The GP can cancel any outstanding appointments for that patient.
- The GP can then support any family members who may be known to that practice

REQUIRED BEHAVIOUR
The Health professional must either
- speak to the GP directly
- leave a message with the receptionist
- Fax the information to a safe fax facility

If the patient dies out of hours and you are unable to contact the GP practice, they must be contacted at the next available opportunity.

CODING
- Code YES if you have contacted the GP or left a message with the receptionist.
- Code NO if you have not contacted the GP directly, left a message with the receptionist or received confirmation (electronic or otherwise) that a fax has been received by the GP Practice.
GOAL 13  PROCEDURES FOR LAYING OUT FOLLOWED ACCORDING TO HOSPITAL POLICY

RATIONALE
• It is important to ensure that the body is treated with dignity and respect and appropriately in line with any appropriate rituals for followers of particular faiths/beliefs
• Each hospital will have their own policy for laying out patients’, consult your own local policy.
• All specific religious/spiritual/cultural needs should be considered at this time

REQUIRED BEHAVIOUR
• local policy re laying out must be followed
• Any religious/spiritual/cultural needs of the patient/family must be respected

CODING
○ Code YES if you have followed local policy re laying out and you have adhered to the religious/spiritual/cultural needs of the patient/family
○ Code NO if you did not follow local policy or did not adhere to the religious/spiritual/cultural needs of the patient

GOAL 14  PROCEDURE FOLLOWING DEATH DISCUSSED OR CARRIED OUT

RATIONALE
• When the patient dies appropriate procedures need to be considered.  
• It is important that you discuss mortuary viewing with the family/carer as there may be family members who were not present at the time of death who may wish to view the deceased.
• If the patient has a cardiac device or pacemaker the family should be aware that this would need removing prior to cremation.
• There are some circumstances that require a Post Mortem to be carried out, These must be discussed with the family where appropriate.

REQUIRED BEHAVIOUR
Consider each of these procedures and discuss with family /carer as appropriate.

CODING
○ Code YES if you have considered the above points and discussed them with the family/carer as appropriate.
○ Code NO if you did not consider or discuss the above points with family or carer.  It may be deemed inappropriate to discuss at this time or family /carer may not have been available at that time.
GOAL 15  FAMILY /OTHER GIVEN INFORMATION ON HOSPITAL PROCEDURES

RATIONALE
At this distressing time retaining verbal information may be difficult. Family/other must be given written information regarding local policies and procedures that must be performed after the death (e.g. how/when to collect death certificate from the bereavement office).

REQUIRED BEHAVIOUR
Family/other must be given written information regarding local policy and procedures

CODING
o Code YES if you provided such written information
o Code NO if you did not provide such written information

GOAL 16  HOSPITAL POLICY FOLLOWED FOR PATIENTS VALUABLES & BELONGINGS

RATIONALE
Sometimes seemingly insignificant items belonging to the deceased patient can hold special memories for relatives/carers. It is, therefore, important that all items belonging to the patient are collected and stored appropriately until the family are able to collect them.

REQUIRED BEHAVIOUR
- When a patient dies their valuables and belongings must be listed, packed and stored according to local policy.
- Family/other must be informed of how belongings and valuables can be collected

CODING
o Code YES if you followed local policy
o Code NO if you did not follow local policy
GOAL 17  NECESSARY DOCUMENTATION & ADVICE IS GIVEN TO THE APPROPRIATE PERSON

RATIONALE
This can be a distressing time for families and retaining verbal information may be difficult. Family/other must be given written information regarding any legal requirements at the time of death for which they are responsible.

REQUIRED BEHAVIOUR
Ensure family/other are provided with written information about their responsibilities. The DSS ‘what to do after death’ booklet is a relevant piece of national information that should be given at this time.

CODING
- Code YES if you provided the DSS ‘What to do after Death’ booklet and/or other relevant piece of national information
- Code NO if you did not provide DSS ‘What to do after Death’ the booklet and/or other relevant piece of national information

GOAL 18  BEREAVEMENT LEAFLET GIVEN

RATIONALE
This can be a distressing time for families and friends and retaining verbal information may be difficult. It is important that they are made aware of bereavement issues, both about the grieving process and about how to access help and support locally.

REQUIRED BEHAVIOUR
Ensure family/other are provided with written information about:
- The grieving process
- How to access help and support locally

CODING
- Code YES if you have given written information about the grieving process and how to access help and support locally
- Code NO if you have not given written information about the grieving process and/or how to access help and support locally
VARIANCE REPORTING

- Variance tells the true story of the patient journey
- If you have coded a no against any goal this must be recorded as a variance on the Variance Sheet. Variance is not negative but may highlight an appropriate clinical professional judgement for a moment in time that promotes individualised patient care.
- A variance should be documented to include:
  - What variance occurred & why?
  - The Action taken by the healthcare professional at this time
- Variance recording also allows an opportunity for the healthcare professional to make an intervention and record an outcome accordingly

ONGOING ASSESSMENT

In the ongoing assessment section it is the condition of the patient that is assessed (i.e. whether the patient is comfortable against a series of indices). It is suggested that the patient should be assessed four hourly or twelve hourly at the times indicated on the document as a minimum standard of care in inpatient units and at each visit in the patient’s own home. This reflects the patient’s condition for that moment in time only. If you assess the patient more regularly that the stated four or twelve hourly minimum and you find that the patient is not comfortable against any of the indices, you should record your finding directly on to the variance sheet, along with an explanation of action taken and subsequent outcome. In this way, a comprehensive and ongoing record of the patient’s condition and action taken is available on the variance sheets for scrutiny by the clinical team.

Where the patient is free from symptoms at a timed assessment a single A should be documented in the box corresponding with the time of the assessment which indicates that the goal of patient comfort was Achieved. If the patient displays any of the symptoms at the time of assessment then a single V should be documented in this box which indicates a Variance (i.e. that the patient comfort was not achieved). A corresponding entry should then be made on the variance sheet detailing the nature of the discomfort, and an explanation of the action taken and the subsequent outcome.

If you have any problems or concerns re this LCP Data dictionary please do not hesitate to contact the LCP Central Team:

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