Integrated care pathway: quality of end of life

Task

Think of a service/programme which you believe could improve the quality of end-of-life care provision and write a report to management, in an attempt to persuade them to implement this service/programme. This report should include a description of the service, the rationale for implementation and the perceived challenges. It would also be beneficial to show an awareness of any possible limitations of this service/programme and measures to minimise these.

Table of Contents

Introduction

Death in the hospitals raises many ethical, familial and clinical issues. Although the primary goal of hospital care treatment is to assist patients to survive acute threats to their health, dying patients are an integral part of the population in our hospitals. However, their death should not be considered a failure; the only failure is if a person’s death is not as comfortable as possible.

Since in a hospital setting, the culture is often focused on cure, continuation of invasive procedures, investigations, and treatments (Mills, Davies, & Macrae, 1994), may be practiced at the expense of the comfort of the patient. Kinghorn & Gaines, (2001) acknowledged that care of the dying is an area of healthcare where one would hope to achieve excellence, and ensure a dignified and peaceful death.

Integrated care pathways (ICP) have been one acknowledgement to improve and standardise care while ensure dignity at the end of life. It is a

multidisciplinary care management tool designed to enable the implementation of evidence-based care and support the practical delivery of clinical governance (Mirando, Davis, & Lipp, 2005). Moreover, when patient care can be delivered in a consistent evidence-based approach, nurses can be empowered to decrease the variation of care (Rutledge & Kuebler 2005), while there is an increased likelihood for optimal patient outcomes (Dunne & Coates, 1999).

Description of an Integrated Care Path way

One of the initiatives that were developed recently to target end of life care is the ICP for the dying. ICPs are a workflow system and a documented record of care. Allen (2009) acknowledged that unlike guidelines, pathways specify the activities to be accomplished and require documentation to indicate compliance or non-compliance with the planned trajectory of care. Care pathways according to Jenkins & Jones (2007, p61) contain

- Algorithms defining the planned pathway within a time frame

- Referral, transfer and discharge guidance

- Local and national standards

- Evidence-based guidelines

- Patient information

- Information recording which will make the care pathway a full ICP and will structure all clinical records. For example, medical record, variance tracking, tests, charts, assessments, diagrams, letters, forms, information leaflets,

(Appendix 1) satisfaction questionnaires and so on. To individualise the care for a specific patient, scales for measurement and outcomes of clinical effectiveness and space to add activities or comments to a standard ICP are also available.

ICPs for end-of-life care management are used widely around the world and have been considered as the gold standard. They have been developed as a model to improve the end-of-life care of all patients, by guiding the care and aiding decision making, while providing efficient care. They aim to ensure that appropriate management occur at the most appropriate time, and are provided by appropriate health professional, while ensuring a consistent high quality provision. ICPs are patient centred and focus on the holistic needs of the patient whilst transferring evidence based care into practice. It incorporates the physical, psychological, social, spiritual and religious aspect of care (Ellershaw 2007) and sets out goals for adequate communication regarding patient and care giver insight (Becker, Sarhatlic, Olschewski, Xander, Momm, & Hubert, 2007). Additionally, Jenkins & Jones, (2007) argued that it provides evaluation of the impact of team service re-design and improvement.

One example is the Liverpool Care Pathway for the dying patient (LCP), (Appendix 2) which was developed in the 1990s. A project was structured between the Royal Liverpool University Hospitals NHS Trust and the Marie Curie Hospice Liverpool, to develop an ICP based on care of the dying within the hospice setting, with the aim to transfer best practice to the hospital setting. The LCP provides a multi-disciplinary, care evidence based and comprehensive template, for the last days and hours of life. It provides

guidance for comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions.

Rationale for Implementation

Scally & Donaldson (1998) affirmed that there is a need to measure and demonstrate the continuous improvement of the quality of care within the health care. ICPs provide a method of recording and measuring outcomes of care, whilst setting standards of care for symptom control in the dying phase of a patient's life. The document is multi-professional and replaces all previous documentation, consequently, reducing the time health staff spend carrying out repeated paperwork. Hence, it not only improves multidisciplinary communication and care planning, but also decreases unwanted practice variation. In a study to review symptom control in the last 48 hours of death, done by Ellershaw, Smith, Overill, Walker, & Aldridg (2001) by analyzing 168 inpatients that died over a one year period, they found that 80% of patients had one episode or complete control of a symptom, 10% had two episodes and another 10% had three episodes or more recorded.

ICPs extend beyond attention to physical needs. Relief of individual patients' emotional, social, and spiritual problems are also an integral part of the care. Besides it helps patient and relatives not getting conflicting messages from the multidisciplinary team. Furthermore, it describes an ethical framework that deals with issues related to the dying patient, including resuscitation, withholding and withdrawing treatment, foreshortening life, and futility. In addition ICP is a method of measuring symptom control in the dying patient and providing demonstrable standards, which are integrated into clinical

practice. It also facilitates the provision and implementation of symptom control guidelines, particularly in anticipatory prescribing for pain and agitation. As well as it serves as a visible record of practitioners with all legal requirements, and thus it can be seen as a positive affair in today’s era of suing.

Moreover, ICPs are also a means of improving systematic collection and abstraction of clinical data for audit and of promoting change in practice (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998). One may argue that ICPs connect the world of practice with the world of knowledge from evidence and experience indicators. Furthermore besides bridging the gap between patients and their caregivers, it improves clinician-patient communication and patient satisfaction, hence reaching or exceeding quality standards. It can be concluded that the multidisciplinary ICP has the potential to promote teamwork in patient care.

Limitations and challenges and actions to minimize them

The barriers are not insurmountable. Dying can be a complex area of care and the introduction of an ICP within a health care setting is a cultural change and takes time to become accepted and for staff to gain confidence in using it. Everyone finds change to be difficult, and as Hooker the renaissance English preacher acknowledged, “ Change is never made without inconvenience, even if it is from worse to better” (Richard Hooker Quotes, 1999-2010). Nonetheless, an essential element to overcome resistance is through effective involvement of all disciplines providing the care (Jenkins & Jones, 2007) and by providing education to all staff concerned.

Perhaps the most serious concern about integrating a care pathway relates to the opportunity costs of consigning financial and manpower resources (Campbell, Hotchkiss, Bradshaw, & Porteous, 1998) to the development, implementation and updating the pathways. It includes investment of time, and needs leadership, energy and good communication to be implemented successfully. Although locally there might be the lack of suitable existing evidence based guidelines and resources, such a pathway can be part of a Master's course thesis (similar to the ICP that was implemented in the orthopaedic wards for Total Knee Replacements). Thus while students are motivated by the fact that their work might be implemented, it supports a ' bottom up' approach to change, consistent with systems of continuous improvement. Additionally, the department will benefit by reducing the cost through enhancing clinical efficiency and with the improvement of quality of care through increased standardization of practice.

The decision to start using an ICP requires skilled practitioners to recognise and react appropriately to often subtle changes in the condition of the patient. In addition, it is essential that healthcare workers may not be discouraged to exercise appropriate clinical judgment to individual cases. In agreement with Murphy (2003) before implementing the LCP, practical considerations must be explored. He recommends a 10 step education strategy (Table 1)

Table 1 (Source; Murphy 2003)

Ten-step strategy to facilitate implementation of a Care Pathway

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

Month 2 to 5

4. Induction – education programme

5. Implementation – education programme

6. Reflective practice

Month 6to 10

7. Evaluation and training needs analysis

8. Maintenance of education programme

Month 10to 12

9. Training the teachers

10. Programme of ongoing feedback from analysis of LCP

This process may highlight the need for further resources, education and training in order to support and improve care in the last days of life. Since implementing a new process is complex, a pilot must be done initially in those areas where there are good leadership and enthusiasm for ICPs while regular feedback is important. Nevertheless, among the most important

implementation strategies is the identification of a local unit champion, a nurse and physician leader who could assist staff in the training, act as a culture change agent, and become the reference person for interactions with the staff. However, one must keep in mind that lack of credit given for improvements in the quality of care might serve as a barrier for the implementation. Nevertheless, one must also take into consideration that some are reluctant to change.

Conclusion

Care of the dying is an area of healthcare where one would hope to achieve excellence. Professionals are expected to provide the best evidence-based care possible at this time ensuring the person has a dignified and peaceful death while supporting his/her family. The introduction of ICP can be one response to improve care and best practice from the expanding evidence and facilitate dignity at the end of life.

References

Allen, D. (2009). From boundary concept to boundary object: The practice and politics of care pathway development. Social Science & Medicine , 69 (3), 354-361.

Becker, G., Sarhatlic, R., Olschewski, M., Xander, C., Momm, F., & Hubert, E. (2007). End-of-Life Care in Hospital: Current Practice. Journal of Pain and Symptom Management , 33, 711-719.

Campbell, H., Hotchkiss, R., Bradshaw, N., & Porteous, M. (1998). Integrated care pathways. British Medical Journal , 316, 133.

Dunne, K., & Coates, V. (1999). Care study: providing effective care in palliative nursing. British Journal of Nursing , 8, 1428-1434.

Ellershaw, J. (2007). Care of the dying: what a difference an LCP makes! Palliative Medicine , 21, 356-368.

Ellershaw, J., Smith, C., Overill, S., Walker, S., & Aldridge, J. (2001). Care of the dying: setting standards for symptoms control in the last 48 hours of life. Journal of Pain Symptom Manage , 21 (1), 12-17.

Jenkins, F., & Jones, R. (2007). Care pathways and the Allied Health. In F. Jenkins, & R. Jones, Key Topics in Healthcare Settings Understanding the big picture (pp. 57-81). United Kingdom: Radcliffe Publishing.

Kinghorn, S., & Gaines, S. (2001). Palliative Nursing: Improving end of life care. China: Churchill Livingstone Elsiever.

Mills, M., Davies, T., & Macrae, W. A. (1994). Care of dying patients in hospital. British Medical Journal , 309, 583-586

Mirando, S., Davis, P. D., & Lipp, A. (2005). Introducing an integrated care pathway for the last days. Palliative Medicine , 19, 33-39.

Murphy, D. (2003). The education strategy to implement the Liverpool Care Pathway for the Dying Patient (LCP). In J. Ellershaw, & S. Wilkinson, Care for the Dting: A Pathway to Excellence (pp. 106-120). Oxford: Oxford University Press.

Richard Hooker Quotes. (1999-2010). Retrieved December 29th, 2010, from ThinkExist. com Quotations: http://thinkexist. com/quotes/richard_hooker/

Rutledge, D., & Kuebler, K. K. (2005). Applying Evidence to Palliative Care. Seminars in Oncology Nursing , 21 (1), 36-43.

Scally, G., & Donaldson, L. J. (1998). Clinical governance and the drive for quality improvement in the new NHS in England. British Medical Journal , 317, 61.

Appendix 1C: UsersJosanneDesktopRelative information Leaflet_front_page. jpg

C: UsersJosanneDesktopRelative information Leaflet. jpg