

Liverpool care pathway essay sample

[Health & Medicine](#), [Nursing](#)



I am a rehab support worker at level three of the skills for health (2009) framework, within a multidisciplinary team of nurses, therapy and healthcare. This reflective account looks at my involvement and contribution to the care of an elderly gentleman, nursed in his own home living with his wife who provided him with nursing care between his private carer visits. The gentleman was also receiving care from a private agency and had district nurse involvement, as his condition worsened he had been referred by his doctor to a specialist palliative care team who assessed the patient and put him on the Liverpool Care Pathway (LCP). The LCP is a best-practice model of care, supporting care in the last hours/days of life driving the quality of care we give to patients and relatives (Ellershaw and Wilkinson, 2011). The LCP was developed 1997 as an integrated care pathway enabling us to focus on the quality of care delivery, supporting the individual and family needs. Providing on-going assessment, care after death, clear documentation and covers physical, psychological, social and spiritual needs. (LCP Pocket Guide 2011).

For this reflection I will be using the Gibb`s (1988) reflective cycle as a guide to focus on my actions, thoughts and involvement but also to help me reflect on the thoughts and actions of all the people; carers, family and the patient that were involved. I feel comfortable using the prompts in the Gibb`s cycle as they are clearly set out and follow a logical path I also feel it is an appropriate tool for this level of study. In line with; the NHS confidentially codes of practice (2003), the Data Protection Act (1998) and the NMC Code (2008) I have protected the patients confidentiality and renamed him John. It was agreed that we would supply support to the private agency care team

that were already in place as Johns care needs increased. I have had experience nursing palliative patients from when I worked on an elderly care ward, but there I had the full support of the nursing staff and had not been a lone worker. I had not had experience caring for a patient on the LCP.

I personally felt reassured to be doubled with agency carers as I felt they would have prior knowledge of the family and patient and have a relationship that would be valuable for me to learn from but also the familiarity would be reassuring for the family, making it easier to accept us as new carers in their home. Before my first visit with the patient I thought reflectively about my Fathers passing, about how, three years ago, he had died in a hospital assessment unit that was ill equipped to deal with our emotional or my father`s pain control needs, he was not on a palliative pathway and on reflection the nursing and caring staff didn`t have the communication skills or knowledge needed to facilitate a “ good death.” My father`s death left me angry and confused and with a sense that I and the nursing staff should have done more. Jasper (2003) discusses that reflection should be taking our experiences as a starting point for learning. Therefore thinking about them in a purposeful way we can come to understand them differently and take action as a result. By doing this I identified that I needed to have knowledge of the LPC and also of palliative care to ensure that I provided the best quality care.

The NMC code (2008) says that people in our care must be able to trust us with their health and wellbeing, using a high standard of practice at all times. That I must consult and take advice from colleagues when appropriate and I

must deliver care based on the best available evidence or best practice, finally that I must recognise and work within the limits of my own competence. Without knowing John or his family I had decided not to let my personal experience influence my care, but that I would also do all that I could to support and care for John and not avoid what may be delicate and difficult conversations and questions. Deborah Murphy, associate director and lead nurse for the Marie Curie Palliative care Institute, in an article for the International Journal Of Palliative nursing (2011) writes: Good clear communication is pivotal, it is clear from the experiences of relatives and carers that when there is a high level of communication and engagement, the last hours or days of life are managed more effectively and with greater care and compassion.

The World Health Organisation (2010) defines palliative care as: An approach that improves the quality of life of patients and their families facing problems associated with life threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. It is also our duty to support John and his wife`s in their decision for John to die at home, Department of health (2008) patients should have a choice over the care they receive and where. On my arrival at Johns I met the private care worker, Gail (made up name), waiting for me outside the house, we sat in my car as she wished to quickly discuss the patient. The car being more private than the street and she did not want to have the conversation in John`s house for fear of upsetting his family. She informed me John was now only being nursed on the bed and that movement seemed to cause pain and

agitation, John also had a pressure sore under his tummy fold and was taking little or no diet and only sips of water which was distressing his wife.

Gail also informed me that although John appeared to be sleeping he was in fact very aware of his surroundings and his general health had declined greatly in the last 48 hours. This was John`s morning visit, John`s wife was tired and agitated because John had slept badly and she had been awake all night attending to John and told us she was afraid to leave him alone. I introduced myself, identifying my job title and which nursing team I was from and reassured her we would take good care of John and that she could take this time to sit and have some breakfast and a cup of tea in peace as Gail knew John and was familiar with his needs. John although tired was talkative and we gained consent to wash and change his nightshirt, we had to be very careful doing this as movement and touch caused John discomfort. John declined to be rolled on the bed so we were unable to wash or examine his sacrum. On observation Gail pointed out that John's sore appeared worse than the day before and was concerned that we had not rolled John to wash his sacrum.

Talking to John we established he had had a good wash the night before, had not had his bowels moved since and that the wash had caused him pain which had kept him awake all night, John was more worried for his wife`s health and lack of rest. I went to the kitchen and talked to John`s wife, explained that I would like to phone the district nurse (DN) who was providing wound care to report and arrange a visit and that John was clean and comfortable explaining why John had not had a full wash. I also talked to

John`s wife about trying to arranging a night sit. Using the contact numbers in the LPC folder I contacted the DN to report the condition of John`s wound site and arranged a visit for later that day and with consent contacted my teams nurse co-ordinator to explain the DN visit and about arranging a night sit. I did this so our patient records could be quickly and accurately updated and the information cascaded to my colleagues before their visits. I then documented all actions and conversations in John`s notes. Conclusion

John`s wife was visited by a nurse from the palliative team and a night sit was arranged, she was worried that she may not be there when John died but was reassured that the sitter would be experienced and professional and would wake her if John worsened in the night. This reassurance allowed her to rest and our increased input also allowed her to return to being John`s wife and not John`s nurse. With the LPC I felt I had all the information needed to provide quality care to John, the pathway also empowered me to support his wife through effective communication (Ellershaw and Murphy, 2003.) It also allowed me deliver care in a patient centred and holistic manor as the emphasis was John`s needs not our nursing desire to “ tick boxes”. As suggested in The End of Life Strategy (Dept. Health 2008). “ How we care for the dying is an indicator of how we care for all sick and vulnerable people.

It is a measure of society as a whole and it is a litmus test for health and social care” We continued to input nursing care for John until his passing, John Died pain free and in his own home his needs met and his decisions and wishes at the heart of his care (Dept. Health, 2011), his family supported through this difficult time. The LCP provided all of us with a tool to facilitate

joined up working and the provision of near seamless care, after reading John`s care plan I knew his and his family`s wishes, his diagnoses and past medical history, it was also noted that John and his wife had a strong Christian faith. The care plan also contained a list of all the carers and care teams involved along with their contact details, which made communication and multi-disciplinary working easier. In recognition of all the carer`s nurses and doctor and the respect and hard work involved delivering this result I feel that it needs to be written that although the LPC is a great tool, any tool is only as good as the worker that uses it.

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