Audit in nursinghomes in Hamar before and after implementation of care pathway for the dying patient

Project NSCPM 2017-2019

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Background (1:2)

Liverpool Care Pathway (LCP) is the best known structural treatment-plan for the dying.

This plan was meant to be a guide to holistic care for dying patients in hospices and hospitals. The LCP was abandoned in 2014 after massive criticism and investigation.

Background (2:2)

The regional center for Palliative Care in the Western part of Norway «Helse Bergen, Kompetansesenter for lindrende behandling" has developed a new treatment plan for the dying, based on a modification of the LCP and the experiences and research after LCP was abandoned.

This plan is called "Livets siste dager-plan for lindring I livets sluttfase" (LSD). LSD has been used in Norway since 2015.

Implementation of the reviced Liverpool Care Pathway: "Livets siste dager" in the nursinghomes in Hamar during 2017.

Aim

My objectives were to investigate

- If care for the imminent dying in the nursing home in Hamar was carried out according to LSD before its implementation
- If LSD is used according to recommendations in these nursinghomes after its implementation

Method: Audit

I assessed the electronical patient-journals (EPJ) and or paper records for the patients that died in the nursinghomes in 2016 and 2018: *before* and *after* implementation of the care pathway.

Demographics (1:2)

		2016	2018
Overall sample		100	118
Excluded	Found dead	8	3
	Acute death	11	11
	Dead on Palliative Ward	3	2
	Dead in Hospital	5	9
	Dead in own home	1	0
Sample		72	93

Demographics (2:2)

2018

		2016	2018	2018 without LSD	2018 with LSD
All patients	N= Mean age Ages range	72 87,5 54-104	93 88 68-101	64 88 68-100	29 88 69-101
Women	N= % Mean age Ages range	59 (82) 88,5 56-104	68 (72) 88,5 68-101	47 (74) 88 68-99	21 (72) 89,5 69-101
Men	N= % Mean age Ages range	13 (18) 84 54-95	25 (27) 86 72-100	17 (26) 87 72-100	8 (25) 83,5 74-95

Diagnoses

	2016 N=72		2018 N=93		2018 without LSD N=64		2018 with LSD N=29	
Diagnoses	103		124		87		37	
Dementia	42	(58)	55	(59)	37	(58)	18	(62)
Infection	18	(25)	11	(12)	8	(12,5)	3	(10)
Stroke/Cerebral infarction	12	(17)	10	(11)	9	(14)	1	(3)
Coronary disease	19	(26)	18	(19)	14	(22)	4	(14)
Cancer	5	(7)	9	(10)	6	(9)	3	(10)
Neurological illness	4	(6)	7	(8)	2	(3)	5	(17)
Pulmonary disease	2	(3)	8	(9)	6	(9)	2	(7)
Other	2	(3)	6	(6)	5	(8)	1	(3)

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Initial assessment (1:2)

Objectives considered:

1. non-essential medication are discontinuated
2. rescue-medication for subcutaneous administration is prescribed
3. non-essential measures are discontinuated (blood-work, antibiotics, fluid-treatment etc)
4. unneccesary care measures are discontinuated
5. subcutanous syrige-driver is considered/started
6. do not rescucitate (DNR) is documented

Initial assessment (2:2)

7. spiritual needs in the patient and family is discussed with the patient and family, and they have been offered spiritual guidance
8. information is documented on how to reach the family if the situation changes
9. weather practical information is given to the family regarding their needs; as to how to make contact to a health worker, parking, food etc
10. the primary health physician is informed of the patients condition
11. the treatmentplan is discussed with the patient
12. the treatmentplan is discussed with the the family

Assessment of ongoing care

Objectives considered:

1. Symptomes: pain, anxiety, rales, nausea, dyspnoe are assessed at least every 4th hour
2. oral hygiene is assessed every 4th hour
3. urination/defecation is evaluated every 4th hour
4. the rescue-medication is gives as prescribed

Care after death

Objectives considered:

1. is the family physician informed after the death
2. is the procedures after death done according to guidelines
3. procedures of taking care of valuables are followed
4. the next of kin is informed
5. the family is informed of routines after a death (orally)
6. the family is informed of routines after a death also in writing

Results

72 patients (72%) from 2016 and 93 (79%) from 2018 were included.

For the 93 patients from 2018, LSD was used only in 29 (31%) of the trajectories.

In the group where LSD was followed, the care provided was better documented for many of the aspects considered. The results are shown in table.

		2016 N= 72		2018 without LSD N = 64		2018 with LSD N = 29	
	Aspects	n	%	N	%	N	%
Initial assessment	Non-essential medications are discontinued.	31	(43)	44	(69)	27	(93)
	Rescue medication for subcutaneous administration is prescribed.	69	(96)	63	(98)	29	(100)
	Non-essential measures discontinued (blood samples; antibiotics etc)	32	(44)	23	(36)	25	(86)
	Unnecessary care measures are discontinued.	29	(40)	18	(28)	20	(69)
	Subcutanous syringe-driver is considered.	0	0	0	0	18	(62)
	Do not resuscitate (DNR) is documented.	56	(78)	60	(94)	28	(97)
	Spiritual needs of patient /family assessed, spiritual guidance offered.	2	(3)	4	(6)	13	(45)
	Documentation on how to reach the family if situation changes.	62	(86)	53	(83)	23	(79)
	Practical information is given to the family regarding their needs.	12	(17)	8	(13)	15	(52)
	Primary health physician is informed of the patient's condition.	0	0	0	0	10	(34)
	Treatment plan is discussed with the patient.	9	(13)	17	(27)	8	(28)
	Treatment plan is discussed with the family.	62	(86)	60	(94)	27	(93)
Assessment of care	Symptoms (pain, anxiety, rales, dyspnea etc) assessed every 4th hour	42	(58)	34	(53)	27	(93)
	Oral hygiene is assessed every 4th hour.	24	(33)	34	(53)	26	(90)
	Urination/defecation is assessed every 4th hour.	30	(42)	22	(34)	23	(79)
	Rescue medication is given as prescribed.	70	(97)	62	(97)	29	(100)
After death	Family physician is informed after death.	10	(14)	17	(27)	7	(24)
	Procedures after death are done according to guidelines.	14	(19)	5	(8)	13	(45)
	Procedures of taking care of valuables are followed.	18	(25)	14	(22)	9	(31)
	Family/next of kin is informed about death.	69	(96)	62	(97)	26	(90)
	Family is informed orally of routines after death.	12	(17)	16	(25)	19	(66)
	Family is informed in writing about routines after death.	8	(1)	7	(11)	14	(48)

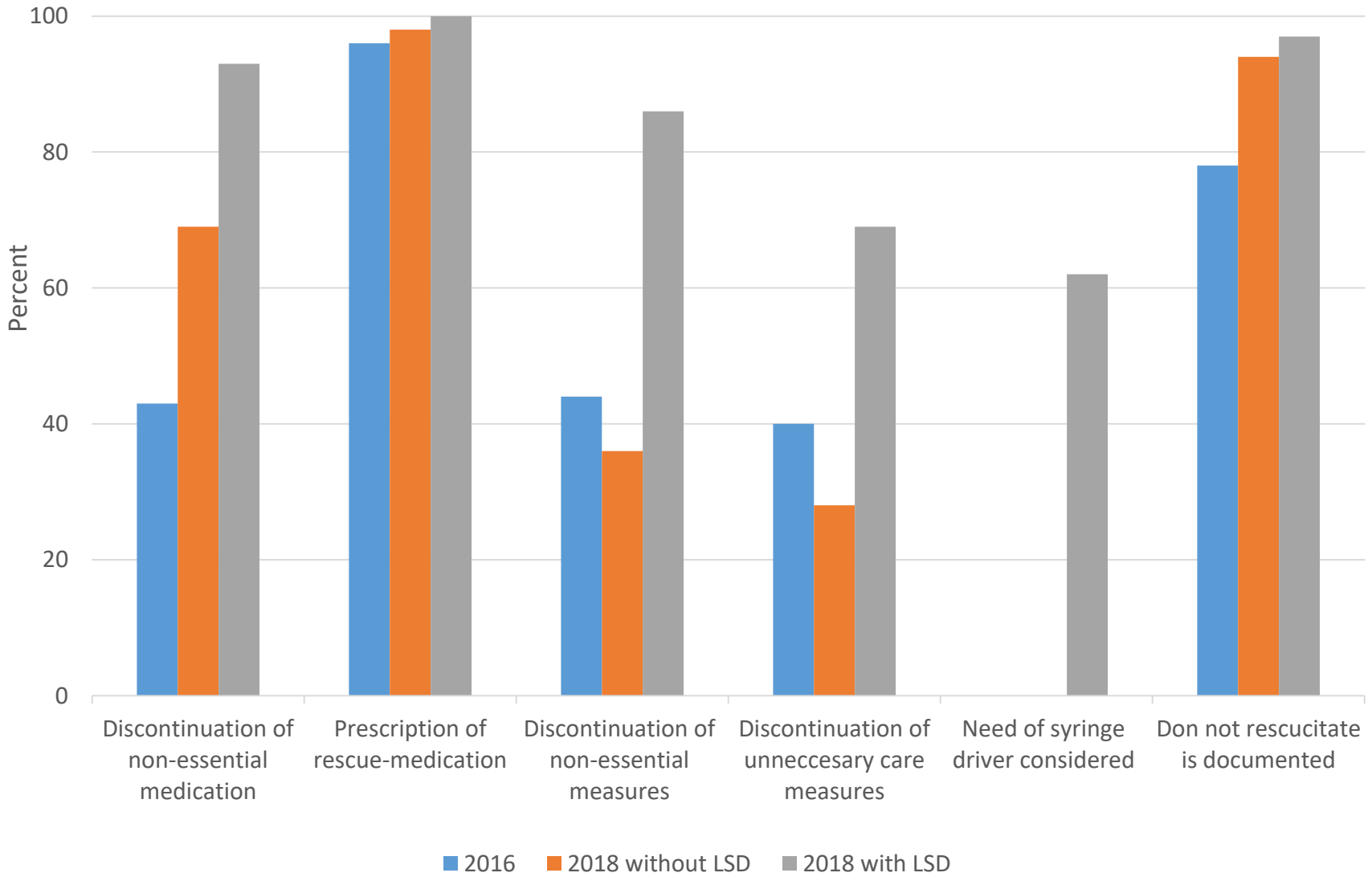
>20 in as where the tasks were documented in 2018 compared to 2016	**10-20% increase**	**<10% increase**	**No change, or decrease**

Discussion

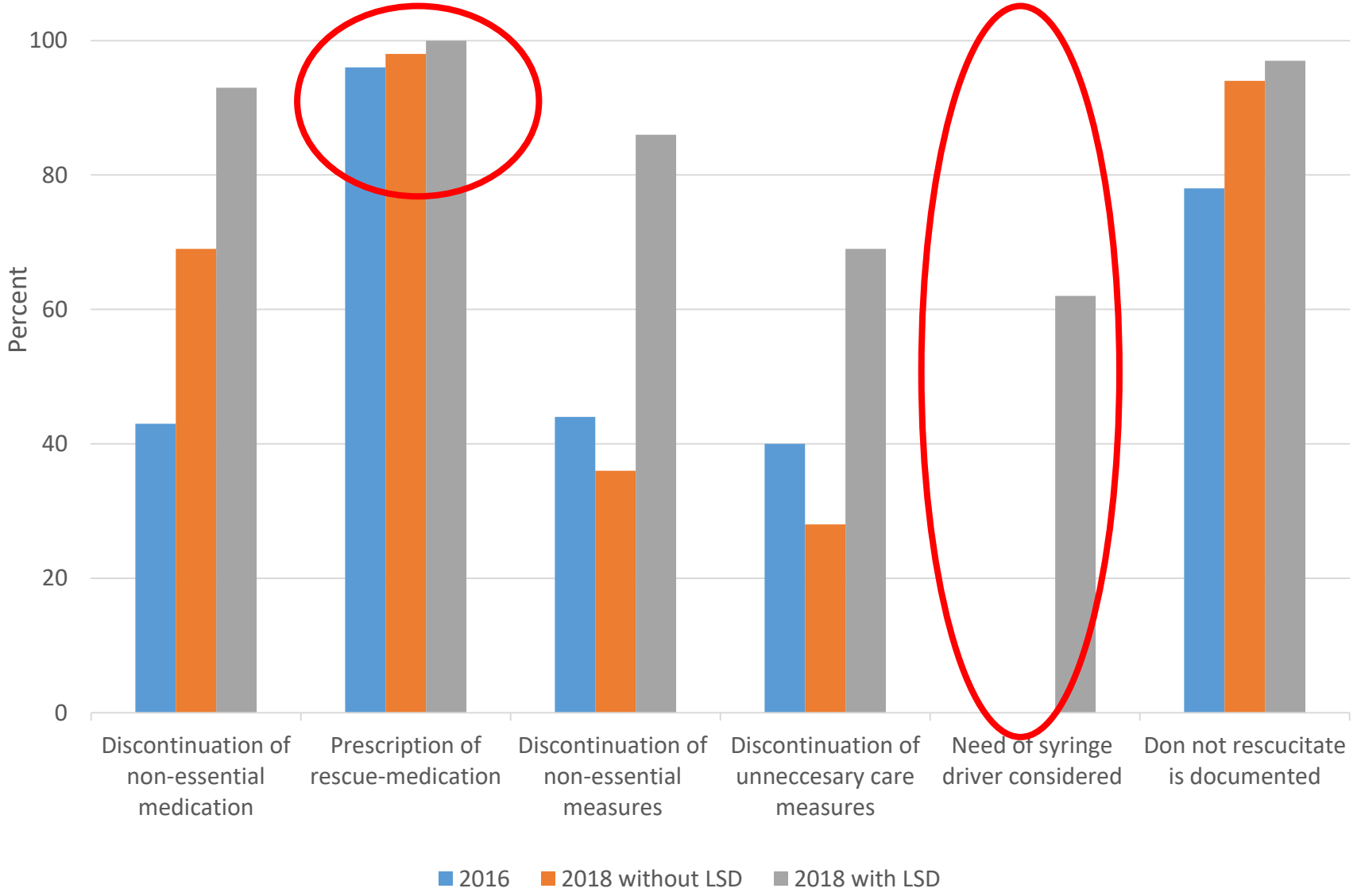
The LSD was used less often than expected, only in 25% of the total deaths, and 31% of deaths in the audit for 2018.

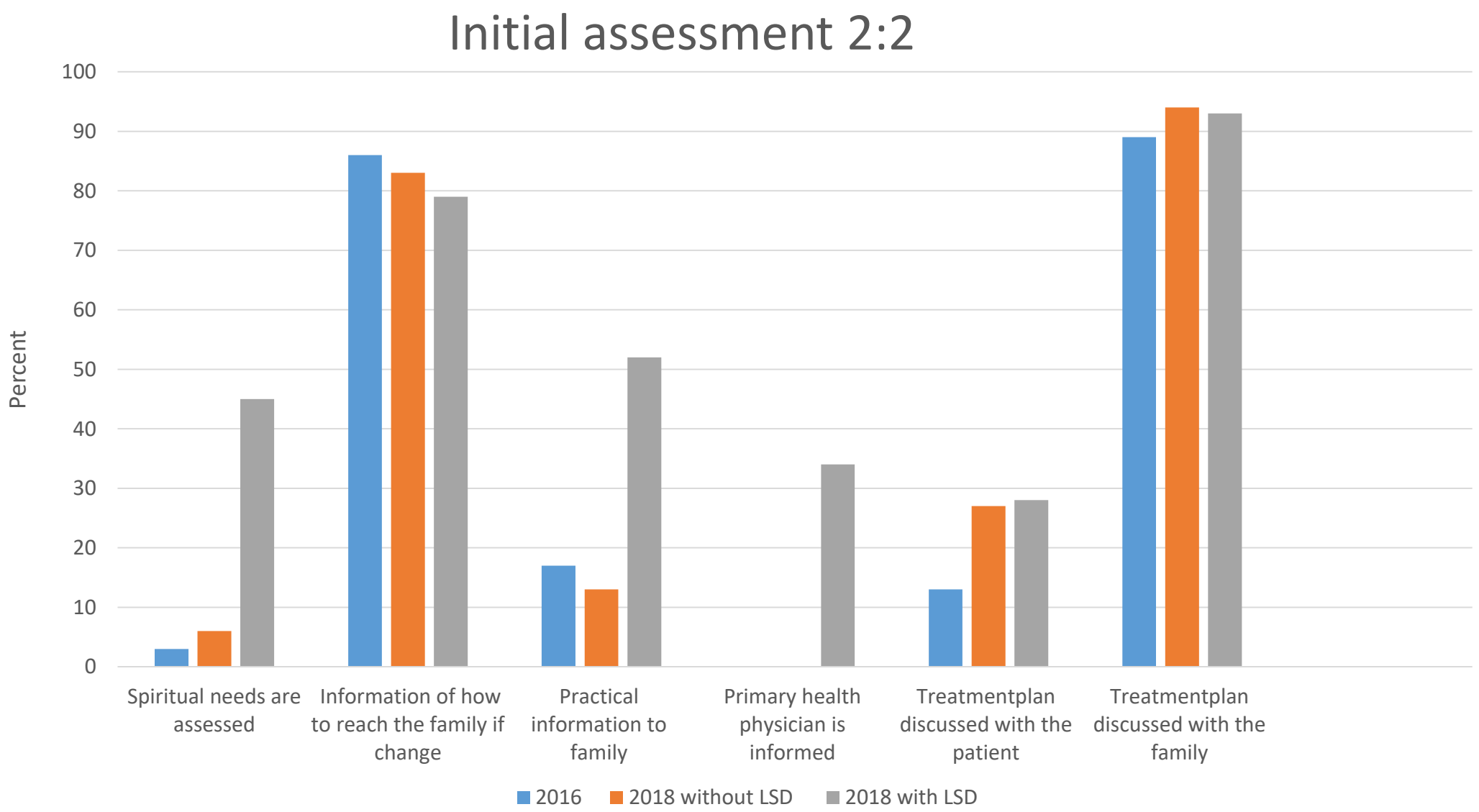
The documented treatment and care in these cases were overall better.

Initial assessment 1:2

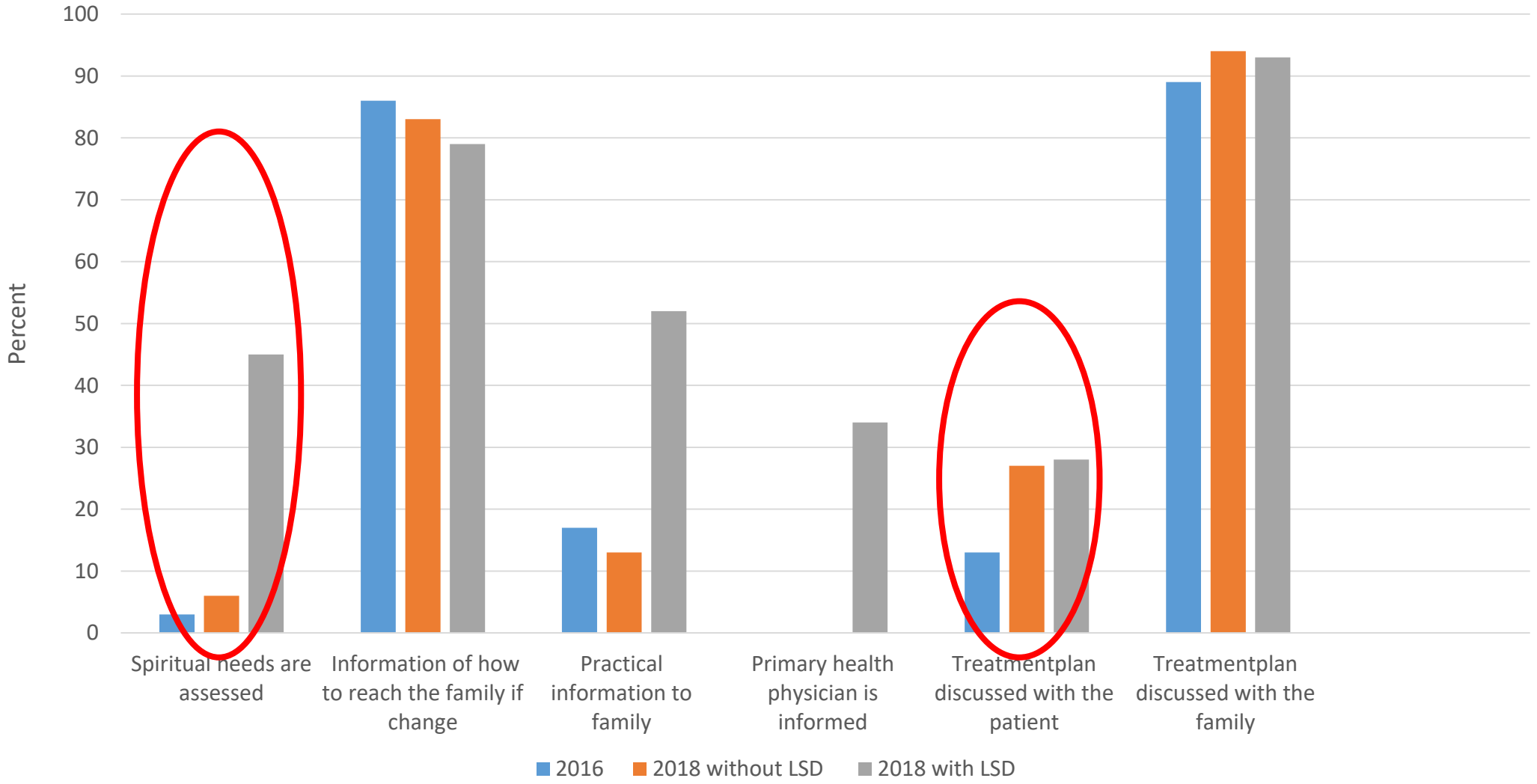


Initial assessment 1:2

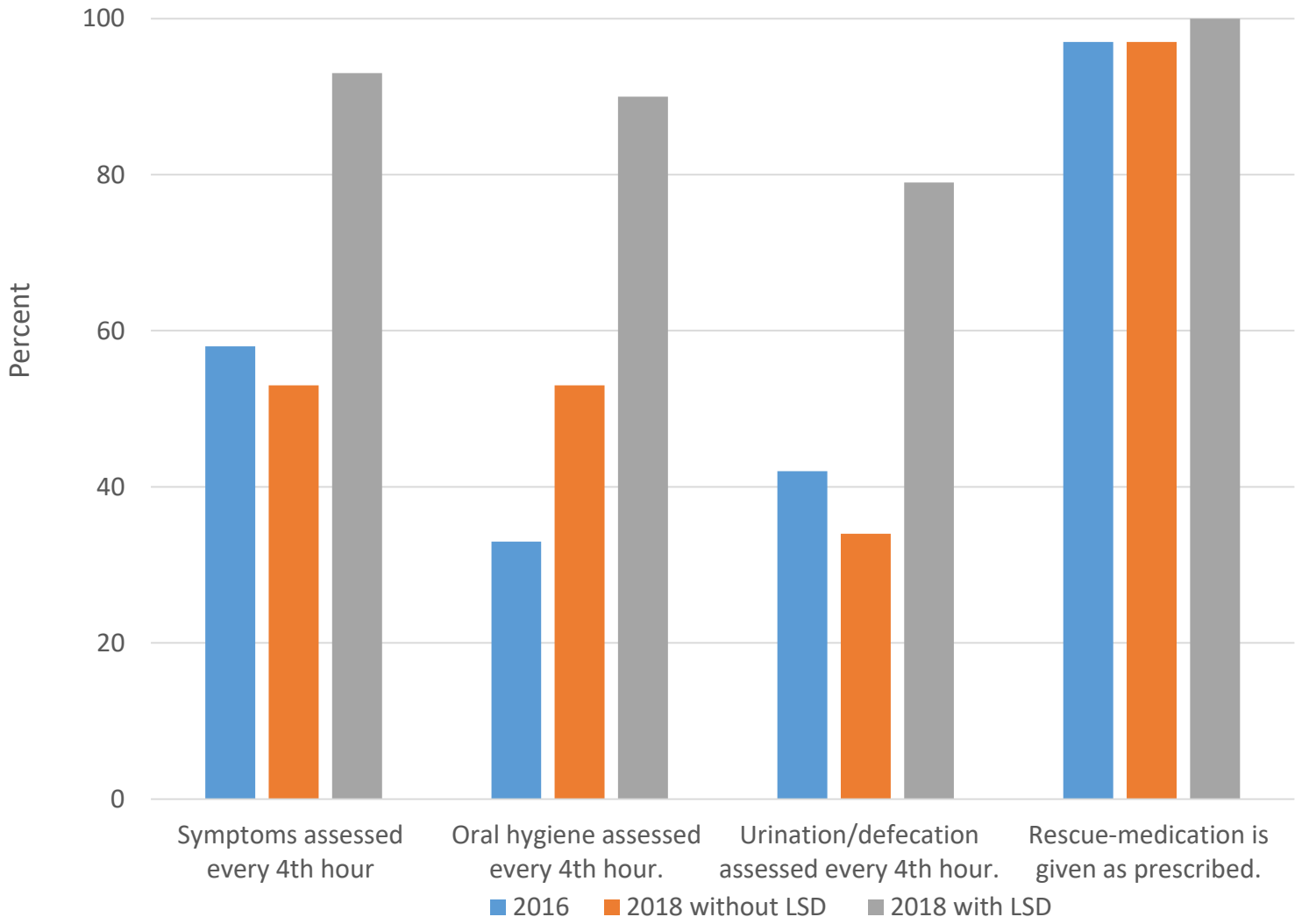



Initial assessment 2:2
Percent
100
90
80
70
60
50
40
30
20
10
0
Spiritual needs are assessed
Information of how to reach the family if change
Practical information to family
Primary health physician is informed
Treatmentplan discussed with the patient
Treatmentplan discussed with the family
2016
2018 without LSD
2018 with LSD

Initial assessment 2:2



Assessment of ongoing care



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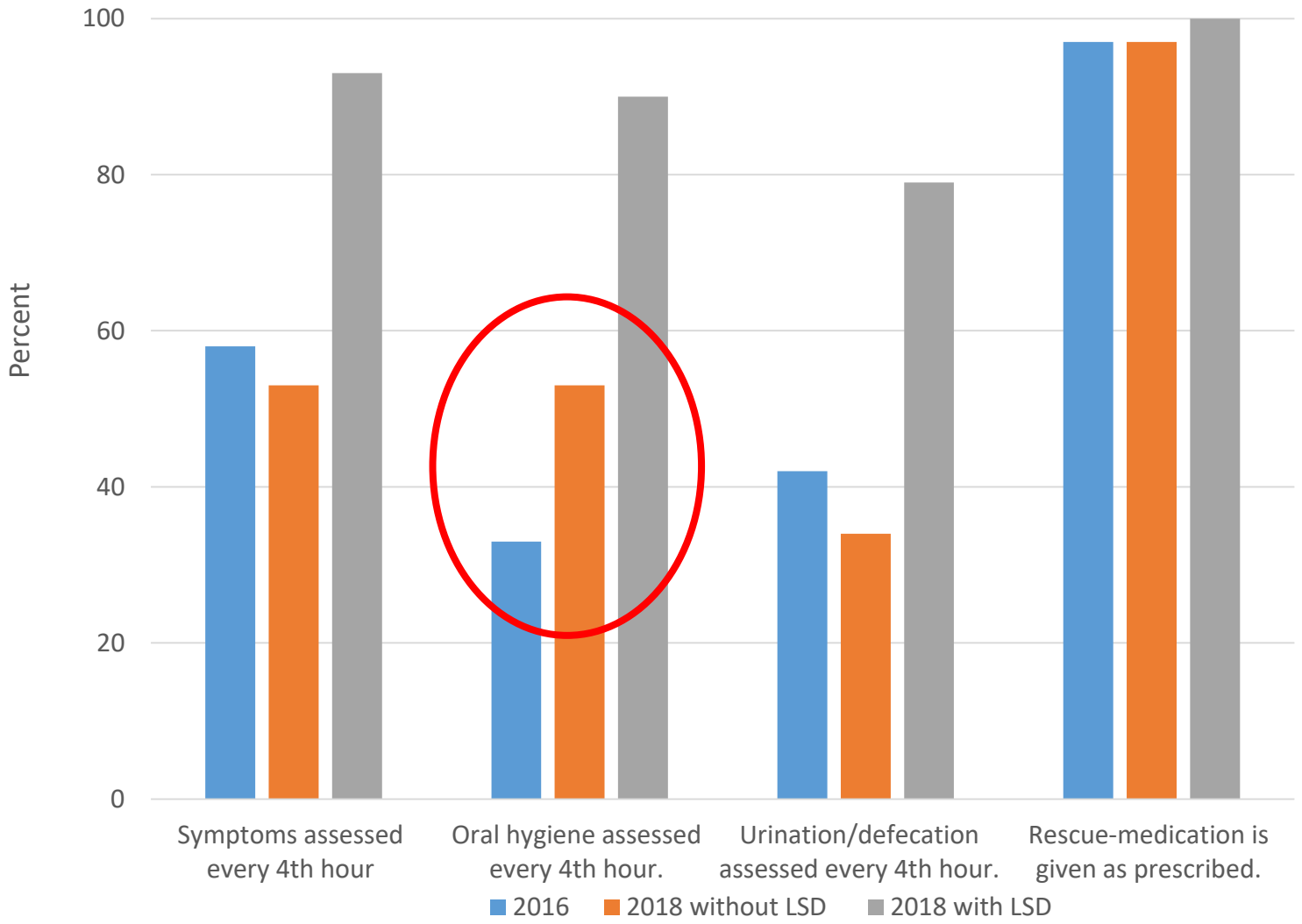
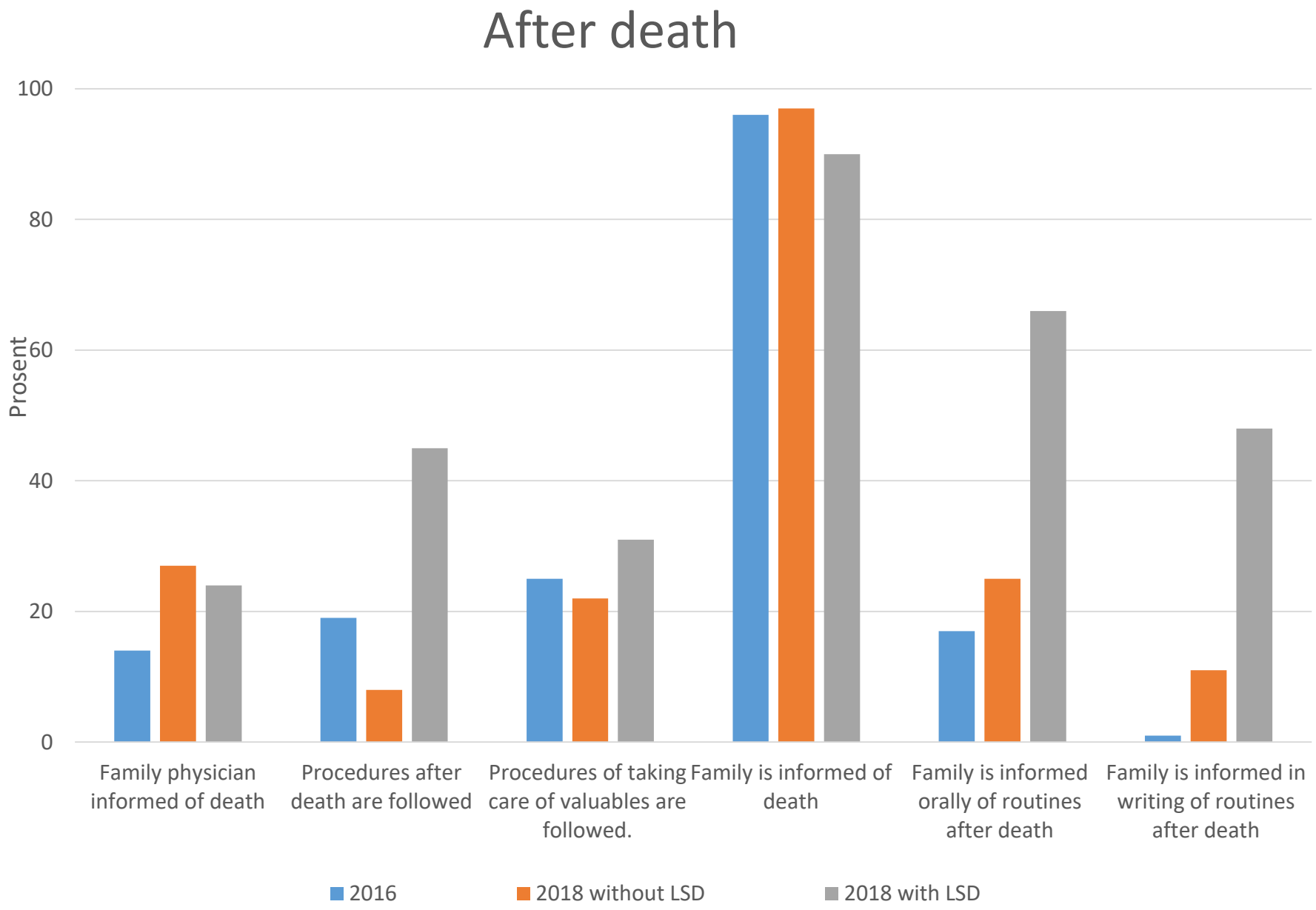
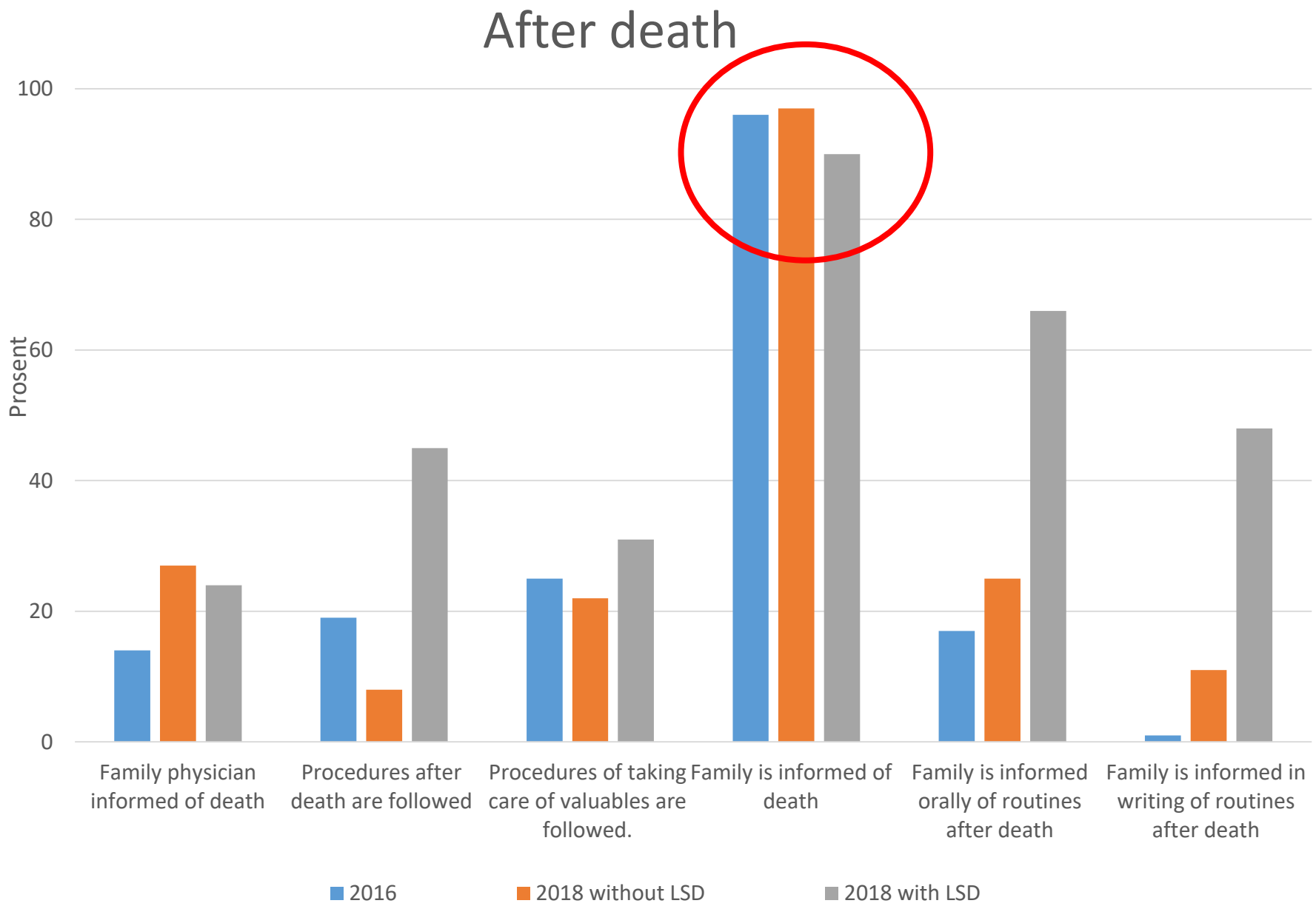



After death
100
80
60
40
20
0
Prosent
Family physician informed of death
Procedures after death are followed
Procedures of taking care of valuables are followed.
Family is informed of death
Family is informed orally of routines after death
Family is informed in writing of routines after death
2016
2018 without LSD
2018 with LSD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2016
2018 without LSD
2018 with LSD

Conclusion

This audit shows that better care is planned for and given, and procedures are followed more thoroughly, when a structured care pathway like LSD is implemented for the imminently dying.

There is a need for regular training / continued education on recognising dying and care for the dying, and detailed instructions on how to use LSD according to plan.

References

Oxford Textbook of Palliative Medicine, 5th edition.

https://helsedirektoratet.no/retningslinjer/nasjonalt-handlingsprogram-med-retningslinjer-for-palliasjon-i-kreftomsorgen

Palliasjon Nordisk lærebok, Kaasa, Loge

https://helse-bergen.no/kompetansesenter-i-lindrande-behandling

Further plan for Hamar:

Last year we have organized a **workinggroup** with representatives from all the nursinghomes, me as the physician at the Palliative ward and a specialized palliative nurse. We meet regularly to discuss issues and challenges that the different wards meet in taking the plan in use.

We have also started to have **follow-up lectures** in “caring for the dying patient” regularly.

We have reached out to the general physicians in the vicinity and to the physicians at the emergency rooms to inform them of “Livets siste dager”, but have not heard back from them yet.