

Review

Leadership Alliance for the Care of Dying People, *ONE CHANCE TO GET IT RIGHT: Improving People's Experience of Care in the Last Few Days and Hours of Life*. London: LACDP, 2014, 168pp. (Pbk). Publications Gateway Reference 01509, free of charge.

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This document has been developed by the Leadership Alliance for the Care of Dying People (LACDP), which was established following an independent review of the Liverpool Care Pathway for the Dying Patient (LCP). The LACDP was a coalition of 21 national organizations that was set up to lead and provide a focus for improving the care of people who are dying and their families and those who are important to them.

Among the many organizations directly and indirectly represented in this Leadership Alliance, among such bodies as the Care Quality Commission, Department of Health, Royal College of Nursing and General Medical Council, one finds listed the "College of Health Care Chaplains". For many chaplains it will be pleasing to see that the document outlining the way forward for care of the dying, post-LCP, has had some input from Chaplaincy, and being one of the 21 authoring organizations should bode well for its content.

My intention in this review is to focus our attention on those elements that seem to bear most relevance to chaplaincy practice, both present and future. It is not to critique the extent to which a chaplaincy perspective has been adequately reflected in the final document. This may come as a relief to one of the editors of this journal (Meg Burton), given her central role over many months in its development.

What the Document Set Out to Do

Following the critical enquiry into the use of the LCP, *More Care, Less Pathway. A Review of the Liverpool Care Pathway*, <https://www.gov.uk/>

government/uploads/system/uploads/attachment_data/file/212450/Liverpool_Care_Pathway.pdf the government sought a way forward which would ensure the best quality care could be offered without simply creating another “pathway”. Rather than produce new guidance in-house, it opted (rather creatively) for the creation of guidance collectively by an alliance of all the key players in end of life care. Also, of course, this means that any failures in the new system will be equally shared across all players and not be directed at government, which was no doubt part of the thinking. More positively, it should mean that all the relevant bodies have a stake in delivering the new model of care.

Having said it does not aim to offer another single “pathway”, it does begin by setting out what it understands as the clear principles and priorities. A huge amount of effort went into the exact wording used, so I will not attempt to paraphrase the following:

Priorities for Care of the Dying Person

The Priorities for Care are that, when it is thought that a person may die within the next few days or hours...

1. This possibility is recognized and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

There are a host of further publications alongside “ONE CHANCE TO GET IT RIGHT”, including Commitment Statements from all the partner organizations, including from the College of Health Care Chaplains (see www.healthcarechaplains.org), which aim to support the implementation of these priorities, but perhaps most significantly, there is no recognized single national set of documents or plans to be used. The emphasis is on locally developed plans, systems and tools which result in compassionate delivery of care that is appropriate to, and personalized to, the individual. It is not that they expect every healthcare provider to reinvent the LCP, but rather every healthcare provider must be able to demonstrate how they are delivering these five priorities.

Consequences for Chaplaincy – in a Nutshell

There is an obvious consequence in the withdrawal of the LCP; notably, we do not have a single nationally prescribed set of paperwork which gives chaplaincy a clear remit. Priority five, however, makes explicit reference to spiritual support within an individualized plan of care and, further, that such care needs to be coordinated and delivered. That is the good news. Ironically, although spiritual support is evidently there within one of the core five principles, it finds very little mention in the chapter which expands priority five. It talks of the need to consider cultural, religious and spiritual care, but the emphasis in the main body of the document is on the more contentious issues of hydration, nutrition and the need to discuss plans with families.

So this document is not going to offer us a simple replacement for the LCP, but does challenge every healthcare provider to demonstrate how spiritual, religious and cultural care is being evaluated, talked through with the individual and their families, how this is recorded and how the resulting individualized care plan is delivered. There is less offered to chaplains “on the plate” but there is an awful lot of “meat on the bones” in the statement that enables a proactive chaplaincy to assert our need to have “a seat at the table” (to continue the food analogy!) in discussions, plans and ongoing audit of provision.

Chaplaincy could be sidelined in the implementation of new systems around end of life care over coming months if we let it be, but this document offers plenty for us to make it clear that our involvement is of real significance and, perhaps more strongly, without us being involved (in a clear and auditable way) it will be much harder for organizations to demonstrate that they are meeting the fifth Priority for Care. We are not being given a script, but we are most certainly invited to be part of the play. Many chaplaincies are already deeply involved in this process, and highlighting our place in Priority Five may just be grist to the mill. Any Acute Trusts (or other locations where patients may die) where the chaplaincy is not yet closely involved in finalizing the post-LCP arrangements needs to play rapid catch up, with this document (and examples of best practice from other departments) as a key tool.