Clinical Guidance for Critical Care Staff on Transferring the Critically Ill Patient Home to Die

UNIVERSITY OF Southampton

Stage 1: Assessing potential for transfer home

The 'right' patient characteristics:
Patient with mental capacity expressed wish to go home
Patient clinically stable for transfer

The 'right time'
Sufficient time to organise transfer
Transfer planned during core working hours

The 'right' circumstances
Family supportive/requesting transfer home
In-patient clinical team supportive of transfer home to die

Transfer home less likely if:
Patient intubated receiving multiple inotropes
High level of manual handling/turning needs
Planned organ donation
Coroner with police involvement
Intensive nursing care needs e.g. open wounds, high gastrointestinal losses
Family lack capability to support patient dying at home

Stage 2: Preparing for transfer

Consider:

Patient/family issues
Is patient/family realistic about care package at home?
Is patient/family aware of risk of dying during transfer?
Has re-admission to hospital been discussed?
Has family given consent for ICU follow up call?

Intensive care issues
Who will take the lead in transfer arrangements?
Who will accompany the patient home (staff and relatives)?
How are any treatments to be withdrawn, by whom and where?
Can the unit manage without the staff involved in the transfer?
Are there funding implications?

Community issues
Will GP support transfer of patient home to die ?
Is care package at home in place?
How will patient symptoms be managed at home?
Who will sign the death certificate?
Has there been discussion about how family can participate in care at home?

Transfer issues
Has time been built in for changes to care before transfer e.g. conversion to syringe driver ?
Do transfer staff know what to do if patient dies during transfer?
Are there any medico-legal/indemnity issues for health care staff involved in the transfer?
Are arrangements in place to return ICU staff and equipment to the hospital?

Home issues
Is home suitable for transfer and care e.g. stairs, toilet, bedroom ?

Potential contact personnel:
General Practitioner
Hospital palliative care team
Hospital rapid discharge team
Community nursing services
Community palliative care team
Ambulance services
ICU technicians
Coroner
Social worker
Pharmacist

Equipment and supplies:
Specialised bed/mattress
Oxygen and respiratory support
Continence supplies
Syringe driver
Medications and prescriptions
Dressings

Documentation:
ICU discharge letter
DNACPR form
Expected death form
Rapid discharge forms

NB: Families can say 'No' to transfer at any time

If transfer not possible then:
Discuss end of life management plan with family
Consider best place of care e.g. remain on ICU or alternative care setting

Stage 3: During the transfer

Follow local policy for transfer of critically ill patient

Stage 4: On arrival at home

Ensure patient comfortable at home and any symptoms managed
Follow care plan as discussed in hospital (including any treatment withdrawal)
Full handover to community team (incl. GP, community nursing staff) as arranged
Ensure family aware of who and when community doctors and nurses will visit
Ensure family aware of signs of deterioration and impending death
Ensure family aware of who to contact for support or in the event of patient death (written information may be useful)
Give advice to family as required e.g. family visiting, etc.

Stage 5: Follow up after the transfer

Contact family for feedback if consent previously given
Contact community teams for feedback
Update ICU transfer education and training as required
Consider formal case review
Offer debrief for all ICU staff involved
Update local transfer guidelines as required
Engage commissioners if any funding concerns