NHS
Cambridge University Hospitals
NHS Foundation Trust

Transfer from Critical Care to Hospice at End of Life

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Neurosurgical Critical Care Unit (NCCU)

23 beds

Major Trauma Centre

General ICU

20 beds

Liver Transplant Unit

Data

01/06/17-31/5/18

Admissions

- ICU - 1039
- Admissions NCCU - 976

Combined total - 2015

Deaths on the unit

- ICU – 180
- NCCU – 134

Combined total – 314

15.6% mortality in Critical Care

Patients discharged to the ward for End of Life Care

ICU – 6 NCCU – 25

- After removal of support
- Not an exact science
- From level 3 to level 1 patient
- Continuing high demand for level 3 beds
- Daily bed meeting – start looking for a ward bed
- Side room is rarely provided – Infection Control priority
- Prepare family for step down of care
- Refer to the Palliative Care team

Arthur Rank Hospice

- Newly built, 1.4 miles away
- 9 **nurse led** beds
- 1 year pilot commenced December 2017
- Beds funded by CUH
- Referral via Hospital Palliative Care Team
- Hospice nurse attends daily morning MDT where referrals are reviewed
- 9 beds for whole site – >1000 beds
- Patients who may have previously had to stay in hospital

Criteria

- In the final stages of life (last 14 days)
- Have chosen Hospice as their Preferred Place of Care/Death, are not able to be cared for at home
- DNACPR in place
- All active care has completed (or about to complete), including artificial nutrition and hydration
- Fitness for transfer on the day

Nurse led beds…

- Patients are not routinely reviewed by medical staff (X1 per week)
- Stable palliative needs, controlled symptoms
- Patients who do not require regular MDT input

However…patient 3

EVD (cut and tied off)

Stoma

PEG (feed discontinued)

Patient 1
December 2017

50 year old male

Unwell for several months

Admitted via ED with MOF

Subsequent new diagnosis of Hepatocellular Ca with Metastatic disease, Hep C/ EtOH cirrhosis- first presentation

Family discussion, palliative chemotherapy only option (in context of MOF for end of life care)

Terminally extubated

24 hours later remained comfortable and stable

The next day…

- Level 1 patient (on IV end of Life medication)
- Ward bed sought, discussed with NOK who wished to consider Hospice
- Referred to Palliative Care team, assessed by Hospice Liaison Nurse & accepted
- Medication converted to subcutaneous 24 hour pump
- 4 hours to wean IV and ensure symptoms managed on SC medication*
- Transferred to hospice with Ambulance crew*
- Died 3 days later

Patient 5

- Awake
- Fully engaged with discussions
- Requested hospice - accepted for nurse led beds
- Receiving haemodiafiltration and on 0.8mls/hr Noradrenaline
- Planned transfer the next day, interim weaning plan to stop HDF and Noradrenaline
- Filter off – Noradrenaline remained on
- Overnight PVC inserted, weaned from Noradrenaline to Metaraminol 3 mls/hr
- Concerns about suitability, re-discussed with Hospice - agreed to discontinue on arrival

Patient 5, continued

- Nurse transfer – receiving nurse had recent ICU experience
- Agreed with Hospice Consultant to keep Metaraminol infusion running whilst getting the patient and family settled (Son arriving from work, etc..)
- Patient went into the garden with family, had a beer
- A few hours later, returned to bedroom and made comfortable, Metaraminol weaned off and patient died that evening

The challenges so far…

- Resource allocation and management - With limited NHS resources, should we facilitate transfers out of ICU for such a short time at the hospice?

  Hospice versus acute trust view

- Communication – between several teams

- ICU-ward-hospice – Multiple moves at end of life, hospice capacity

Benefits of Hospice

- **Location** – in relation to CUH
- **Facilities** – beds can be taken outside, pets, accommodation for relatives
- **Expertise** – symptom management, psychological support to patient and family
- **Holistic** approach to individual needs
- **Environment** – versus ward and acute hospital

Looking ahead…

- 5 patients transferred to nurse led beds
- Future options for NIV and nasal hi flow* (specialist beds)
- Pathway planning underway
- Regular review of referrals and transfers
- Multi-team working; Critical Care, Palliative Care Team & Hospice
- Improving the transfer out of ICU at End of Life; to ward, hospice or home & policy to support

Learning points

- Timely decision making/transfer
- Ascertain patient wishes – ReSPECT
- Teamwork
- Family support
- Communication and lateral thinking

Questions?