



Guideline for the transition of care from a Critical Care area at the end of life

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Location:	Trust Intranet: Clinical Policies, Procedures & Guidance		
This document should be read in conjunction with:	> Care Agreement for the Last Hours and Days of Life (Cerner Document) > Guidelines for the Care and Management of a Patient with a CME Medical T34 Syringe Pump for Adult Palliative Care Patients – May 2026 > Symptom Management Guidelines for Dying Patients (Adults) - June 2023 > Trust Medicines Policy – Section: 6. Controlled Drugs – Nov 2025 > Trust Medicines Policy – Section: 17. Injectable Medicines Policy – July 2026 > Trust Medicines Policy Section 31. Medicines Management Training – March 2027		
Author/Further information:	Dr Anna Bradley - Palliative Medicine Consultant, Sabrina Persaud - Palliative Care CNS,		
Stakeholders involved:	Specialist Palliative Care Team, Adult Intensive Care units		
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Introduction

The primary purpose of admission to Intensive Care units is to provide life-sustaining treatment. However, the mortality rate of Intensive Care patients is approximately 20%, of which a significant proportion of these deaths are preceded by the decision to withdraw life-sustaining treatment (The Faculty of Intensive Care Medicine, 2021). The General Medical Council (2024) defines patients approaching the end of life as those likely to die within the next 12 months, including those with a risk of dying from a sudden acute crisis in their condition or life-threatening acute conditions caused by sudden catastrophic events, thus including many of the patients admitted to Intensive Care units.

Palliative care is relevant at all stages of illness including during curative treatment and at the end of life, to address not only physical symptoms, but also the psychological, social and spiritual aspects of health and illness. For this reason, it is important to realise that palliative care may have a role throughout the course of an Intensive Care patient's journey. Addressing these needs earlier may enable teams to identify and manage patient and family needs for support before, during and after death.

When considering the final phase of a person's life it is just as important to consider what the patient does want and what wishes we can fulfil. These are decisions that the patient and their family can discuss with the healthcare professionals to allow the healthcare team to connect on a more human level with them. Through this, we can begin to address the psychological and spiritual needs of our patients and formulate an individual plan of care, which is priority five of the five Priorities for care of the Dying Person as developed by the Leadership Alliance for the Care of Dying People (2014). If it is established that a person lacks capacity at the time to make the relevant decision, which may apply to several patients at the end of life in Intensive Care units, then a decision must be taken in their best interests in accordance with the Mental Capacity Act (2005). This will involve consulting with anyone engaged in caring for the person, close relatives, friends, or a lasting power of attorney appointed by the patient before capacity was deemed lacking.

Once patients are recognised as being in their final days or hours of life, therapeutic goals should be reviewed to focus on comfort and dignity. Interventions which do not contribute towards this should be withdrawn. This document has been produced to provide guidance for Intensive Care teams to facilitate end of life care for their patients. This guidance considers patients with varying levels of nursing dependency or organ support needs.

CARE AT THE END OF LIFE:

by the Faculty of Intensive Care Medicine (2019)

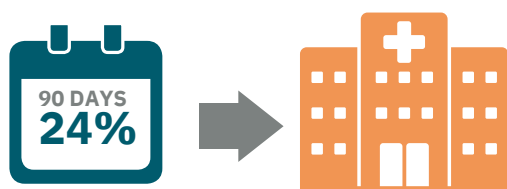
- 1 Within the UK intensive care survival has improved significantly, nevertheless **15–20%** of UK intensive care admissions die in hospital.



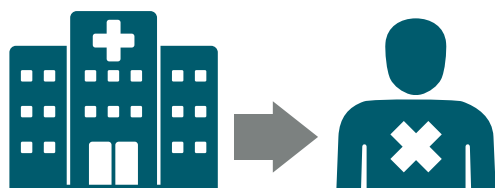
- 2 Intensive care survival, particularly when associated with emergency and prolonged admission (>48–72 hours), carries significant physical and psychological burdens impacting on quality of life.



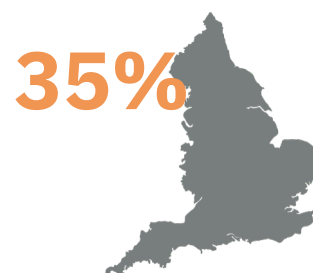
- 3 Scotland (2005–2013) **24%** of intensive care survivors are **re-admitted to hospital inside 90-days of discharge**. The reason for re-admission is usually related to chronic health status prior to original intensive care admission.



- 4 Wales (2006–2013) **one in five** intensive care survivors **die within a year of discharge from hospital**.



- 5 England 2016 approximately **35%** of adult in-patients were in their last year of life.



- 6 Advance Care Planning and the information to the left therefore has the potential to:

Allow patients, those close to them and clinical teams to better utilise **shared decision making** when planning care.



Reduce confusion and conflict when patients are acutely ill, have lost capacity and have a **high risk of dying**.



Improve clarity of communication surrounding care at the end of life and **reduce the severity of grief amongst friends and families**.



Reduce the incidence and impact of burn-out in healthcare professionals.



Transferring a patient from ICU to another ward at the end of life

When a patient has been recognised as dying, if they are not expected to die in the next 24 hours it may be appropriate to consider transferring their care from ICU to another ward area. When determining whether a patient is suitable to transfer off of ICU, this is always an individualised decision. Several factors should be considered, including:

1. **Prognosis:** if the patient is rapidly deteriorating and is expected to die in a short period of time, such as hours, it may not be appropriate to move them to a new setting.
2. **The patient's preferred place of death:** It should be explored with the patient or, if they lack capacity, those important to them where they would want to die and what matters most to them.
3. **If the patient's care needs can be met outside of the ICU setting.** Clinical stability should ideally be established prior to transfer, e.g. symptom control.
4. The decision to transfer a dying patient from out of ICU should be a multidisciplinary one and should be led by the ICU consultant, the nurse in charge on shift and Palliative Care support.

< These should be considered before transferring a dying patient

01

Clinical plan

A clinical plan should be in place and documented in the patient's medical notes. Are there treatments/interventions that are no longer of clinical benefit? What treatments will be continued? Are there interventions that need to be started? e.g. for symptom control.

02

CPR status, TEP and 'Care Agreement for the Last Hours and Day of Life'

The patient's CPR status and TEP must be updated and communicated with the patient and those important to them. Additionally, a care agreement for the last hours and days of life should be completed on cerner taking into consideration the clinical plan.

03

Communication

The patient and those important to them should be fully updated regarding their clinical plan and end of life care should be discussed prior to a patient leaving ICU. These discussions should be clearly documented in the medical notes.

04

Referral to specialist palliative care

It is highly recommended that the patient is referred to the specialist palliative care team prior to them being transferred from ICU. Ideally the team should meet the patient whilst still on ICU. A referral to the SPCT can be made on cerner.

Steps towards a successful transfer to a ward area within the trust



Agreeing an action plan with SPCT and the MDT

Reviewing the patient and switching IV medications to SC or CSCI route for readiness to discharge to a ward area. *If unable to transfer on the same day, SPCT to support during hours. ****Wider team to clarify OOH CSCI support for ICU on both sites*****



Reviewing ICU treatments: can they be stopped?

Therapeutic treatment considerations: Inotropic/vasopressor drugs, hemofiltration discontinuation; deactivation of ICD, removal of lines (arterial line, CVC, Vas cath, NG). What will be the most appropriate route of administration for any continued medications? (e.g: if the patient is on anti-seizure medications or medications for Parkinson's Disease these should be continued).



Prescription of PRN SC medications for symptom control

These should be considered for all dying patients transitioning out of ICU. Please refer to the Trust Symptom Guidelines for Dying Patients (Adults). Please contact the Specialist Palliative Care Team for advice if the patient has uncontrolled symptoms e.g. pain, nausea and vomiting, breathlessness, agitation or respiratory secretions; if they have renal or hepatic impairment; or if they are already taking regular opioids.



Clinically Assisted Nutrition and Hydration (CANH)

Decisions around CANH should be individualised and should be reviewed daily. CANH is a medical intervention and so the perceived benefits must be weighed against the burdens and risks.



Identify ward for stepdown

Identifying appropriate place to be transferred to: e.g. available butterfly rooms within the trust and inform the patient and/ or their family the potential of a transfer to another ward setting.



Handover of care to receiving ward

Members of the ICU MDT should hand over verbally to the receiving ward. Consider also if the receiving team should be involved in MDT discussions and patient/family communication whilst still on ICU.

Individualising care

Individualised care plans minimise confusion and omissions. The aim is to make dying patients the focus of care, allowing a natural death with minimal interference from medical technology. Any treatment that does not advance such aims should be considered for withholding or withdrawal (NICE, 2015). On occasion consideration can be given to discharging patients (ward area or stepdown) noting the potential for harm (including a sense of abandonment), and discomfort during transfer. Therefore, advance care planning is essential to providing a successful transition of care.

1. Symptom review and interventions

Assessing symptoms, and anticipating them is a cornerstone of supportive care. However, with critical care patients, symptom assessment can be challenging and non-verbal assessments may be necessary. It is also important to reassess current interventions asking yourself the question... is it adding any benefit? what will you do with the results? If it is not going to change the outcome then it should be stopped to minimise any discomfort to the patient. For example, continuous monitoring and observations - are these going to alter patient management? if no, then this could be discontinued and invasive lines removed so the patient can look and feel more like themselves.

2. Pain and pain Control

Pain is common in critical care patients near the end of their life. Visual or numerical pain scales can assess pain in patients with capacity. However, where patients are unable to communicate, assessment relies on observing physiological and behavioural manifestations of pain e.g. the Behavioural Pain Scale (BPS) and Critical Care Pain Observation Tool (CPOT).

The choice of opioid may be determined by the nature of multi-organ dysfunction e.g. in acute kidney injury codeine, morphine and tramadol can accumulate leading to unpleasant side-effects. It is important when planning the transition of care to a ward area, that the choice of opioid is appropriate for ward based limitations, **e.g diamorphine infusion is not utilised outside of critical care.**

3. Anxiety/Distress/Terminal agitation/Delirium

Agitation and delirium are common near the end of life with the incidence of the latter being increased in ventilated patients. If communication is possible, calm reassurance, information, distraction and the presence of family can assist in minimising symptoms. For patients who cannot communicate, or where these approaches are unsuccessful, administration of a Benzodiazepine (such as Midazolam or lorazepam) can be considered after easily reversible causes have been excluded e.g. pain. There is some tentative evidence that music therapy can not only support the patient but also help reduce family anxieties.

4. Dyspnoea and Respiratory Secretions

Breathlessness can compound anxiety and non-pharmacological treatments (including hand-held fans) can assist and opioids can reduce the sensation of breathlessness. With respect to respiratory secretions, non-intubated patients have a build-up of respiratory secretions causing noisy breathing. Suctioning can cause distress so there is a role for anti-cholinergic agents such as glycopyrronium to minimise secretion production, noting the potential side-effects of a dry mouth.

5. Nausea and vomiting

Nausea is an unpleasant sensation of the feeling of need to vomit, which can often be accompanied by other symptoms such as pallor, cold sweat and tachycardia. There are many causes of nausea and vomiting at the end of life including medications, metabolic causes (hypercalcaemia or renal failure) and gastric status (ascites, hepatomegaly, peptic ulcers or gastritis). The underlying cause should be managed where feasible, or other simple measure may help relieve nausea and vomiting such as smaller amounts of oral intake, or aroma therapy sticks (which can be provided by the mulberry centre). Where these approaches are unsuccessful anti-emetics should be considered. Your choice of anti-emetic will depend of the cause and the patients underlying condition.

Transferring a patient home to die from ICU

All adults in a critical care environment reaching the end of their life should have the opportunity to explore where they would prefer to be cared for during the dying process (preferred place of care) and where they would prefer to die (preferred place of death). Standard practice should focus on early recognition of the potential for dying and sensitive exploration of the person's and/ or their family's wishes regarding priorities of care at the end of life. This could form part of treatment escalation planning discussions, or where feasible, advance care planning conversations. If a patient has expressed home as their preferred place of death, it may be appropriate to consider if discharging home for end of life care can be facilitated.

01

Family discussion

The ICU team should involve the patient's family in the decision-making process. Those who cannot participate in these conversations (e.g, because of sedation or lacks capacity) should have their wishes explored with their family and decisions made in their best interests, in line with the Mental Capacity Act 2004.

02

Referral to specialist palliative care

Early referral to the specialist palliative care team is essential to assess the practicalities of discharging home for end of life care and to support a rapid discharge from ICU to home.

03

Withdrawal of life sustaining treatments

If the decision has been made to transfer the patient home for end of life care, the multidisciplinary team should assess the patients current artificial support requirements and plan to wean or withdraw treatment in a safe manner e.g. ventilatory support or inotropic support.

04

Social assessment

It is important to establish if the patient's family are aware of the demands of caring for a dying person at home and are prepared to support the patient after transfer. The need for any specialised equipment (such as bed/ mattress) should be identified. The need for any additional package of care should be assessed and arranged where necessary and feasible.

Other considerations:

- > Discharge medication: Inform pharmacy team of rapid discharge as the patient will need anticipatory medications for discharge.
- > Handover of care to GP in advance of discharge to inform the patient will be discharged home for end of life.

Steps towards a successful transfer to a preferred place of care and death



Rapid discharge home for end of life care

If it has been agreed that the patient can be discharged home for end of life care, together the SPCT and the ICU team, we will begin the process for a rapid discharge home for end of life care. This is a multidisciplinary team effort, please see below the task involved for each healthcare professional.



Fast track home POC paperwork

- Does the patients family have plans to support care at home or did the patient have care in place prior to admission? If yes, the fast track paperwork does not require completion.
- If no to the above, does the patient require a package of care (POC) to be in place to support with care needs at home? If yes, the fast track paperwork will need to be commenced by the ICU doctors and the NIC.



ICU doctors

- **Fast track pathway tool** and **consent form** needs to be completed (you can find resources on the 'End of Life Matters' page on the Trusts intranet under important documents, once completed email to the NIC.
- New DNACPR forms X2 (x1 transport & x1 for patients home)
- Discharge summary - including EOLC section and summary of ACP
- TTAs including anticipatory medications



ICU NIC

- Complete the second part of the Fast track application - **Standardised Pan London care plan** which can be found on the end of life matters page on the Trust intranet under important documents -> discharging patients -> fast track pathway), once completed email to caw-tr.wm-palliativecare@nhs.net together with the fast track pathway tool and consent form
- District nursing referral (this can be complete via eNBA on cerner (Adhoc -> Discharge forms -> discharge needs based assessment)



Ward Clerk

- Book transport: HATS exclusive ambulance or Patient transport and highlight this is an end of life care discharge. This should be booked in early as possible with a predicted discharge time, as this can be delayed but will ensure it is prioritised.
- Print discharge paperwork that will go with the patient



Therapist

- Check if any equipment is required such as a hospital bed and order if required
- ICRS referral



Palliative Care

- Community SPC referral and handover
- Useful community telephone numbers for patient/family
- Authorisation Chart for anticipatory medications (MAAR chart)
- Marie Curie Rapid response referral
- UCP Record creation
- Transport letter

Individualising care

1. Social assessment

If the preferred place of dying have been identified as home, the team should take steps with the patient's family to ensure the environment is suitable and ready for the transfer. This may involve obtaining photos of the access of the property to ensure a stretcher can access the property. The need for any specialised equipment (such as a bed/ mattress) should be identified and arrangements made for prompt delivery. Staff should ensure the family are aware of the demands of caring for a dying person at home, and are prepared to support the patient after transfer. The need for any additional package of care should be assessed and arranged as above.

2. The conversation

In the process of deciding whether to transfer the patient home for end of life care, the risks should be discussed with the patient and their family. This should include the risks withdrawing life sustaining treatment as well as the risk of dying during transfer. This component of the conversation should include the steps that would be taken to manage these risks and mitigate against distress. Discuss these with the patient and their family and confirm if transfer of the patient to their preferred place of death is still desired.

3. CSCI management

If a CSCI is required for symptom control, ensuring this can be accommodated in the community also plays a role in the decision making process.

Suitable for transfer home:

Patient expressed a wish to go home
Withdrawal of life sustaining treatments (how will treatments be withdrawn? Plan for indwelling devices?)

Situation
Family understanding and able to support care at home
Clinical stability achieved

Transfer home less likely if:

Planned organ donation
Coroner with police involvement
Organ support dependency, i.e. inotropes
Unsuitable home environment

But, this isn't always the case.
You might also consider what alternatives would be acceptable to the patient and their family e.g. hospice

Contraindications to transitioning care

Patients should NOT be transitioned if ANY of the following apply:

- Imminent death (expected within 24 hours)
- Physiologically unstable, requiring ongoing intensive monitoring or interventions
- Complex or uncontrolled symptom management needs that cannot be met on a general ward
- Family expresses strong preference for the patient to remain in ICU
- Receiving treatments that cannot be safely administered at ward level



Specialist Palliative Care team

Both sites require a referral on cerner

REFERRAL OPTIONS:

1. **Advance care planning** – This refers to discussions with the patient (if able) and their family about future care preferences, goals of care, and treatment decisions.
2. **Advice on direction of care** – This involves seeking advice from the palliative care team regarding the most appropriate course of care. It may include decisions about transitioning from curative to palliative treatment, considering hospice care, or adjusting treatment goals in alignment with the patient's condition and wishes.
3. **Care of the dying patient** – This applies when a patient is in the final days or hours of life. The palliative care team provides holistic support in symptom management, comfort care, and communication with family members.
4. **Discharge with complex care needs** – Some patients with a downward trajectory require specialised support upon discharge. The palliative care team helps coordinate care plans, home palliative services and referrals to community resources to ensure a smooth transition.
5. **Symptom control** – This involves managing symptoms such as pain, breathlessness, nausea, vomiting, or terminal agitation. The palliative care team offer expertise in optimising medications and non-pharmacological interventions to improve comfort and quality care in the last phase of life.

OUR SERVICE :

WMH

Working hours:
Mon to Fri: 9am–5pm
Weekends & BH: 8am–4pm
Bleep 018 or Ext 6822

Out of hours telephone
advice can be obtained from
Supportive Care UK (SCUK)
on 0207 666 3413

CWH

Working hours:
Mon to Fri: 9am–5pm
Weekends & BH: 8am–4pm
Bleep 4026 or Ext 58499

Out of hours telephone
advice can be obtained from
SpR on-call at Trinity Hospice
on 020 7787 1000

Please be aware SCUK or SpR on-call at Trinity may not be aware of medications utilised within the trust. Please refer to the Trust Symptom Guidelines for Dying Patients (Adults) if you are unsure what medications can be used outside of ICU.

Glossary of terms

Advance care planning (ACP) - ACP offers people the opportunity to plan their future care and support, including medical treatment, while they have the capacity to do so. Not everyone will want to make an advance care plan, but it may be especially relevant for people at risk of losing mental capacity – for example, through progressive illness (NICE, 2024).

Anticipatory medications – Medications that are prescribed on the PRN side of the patients drug chart to manage symptoms that may arise during the dying phase. In addition, these medications may be sent home with the patient in the form of a MAAR chart.

Care Agreement for the Last Hours and Day of Life - A care agreement for the last hours and days of life is a documentation on cerner that ensures an individuals preference and needs are respected during the final stages of life. It is created in collaboration with the patient, their family and healthcare professional. The agreement focuses on comfort, dignity, and quality of life during the dying process.

CSCI - A syringe driver or syringe pump which is a continuous subcutaneous infusion (CSCI). It delivers medications under the patient's skin (subcutaneously) over a 24-hour period. Syringe driver medications are used for symptom management. In this trust we use the T34 models.

Holistic assessment – A comprehensive assessment that considers all the physical, emotional, social, and spiritual needs of an individual, to develop a tailored care plan. It is often used in the context of end-of-life care, where the goal is to improve quality of life and provide holistic support.

Preferred place of care – The place where a patient would prefer to be cared for during the dying process.

Preferred place of death – The place where a patient would prefer to die.

Priorities for care – Five priorities for care of the dying person as laid out in the Leadership Alliance for Care of Dying People' guidance – “One chance to get it right”. These priorities are 1. Recognising and communicating possibility of death, 2. Sensitive communication, 3. Involvement of the dying person and their family in decision making, 4. Meeting the needs of family and friends, and 5. Agreeing to an individual plan of care.

Treatment escalation plan – A document that outlines a person's preferences for medical treatment as their condition worsens or changes. It helps healthcare professionals to know what treatments to provide or withhold in different circumstances, and to ensure that the person's wishes are respected. It includes information about resuscitation, and the use of medical interventions such as mechanical ventilation or intravenous medication.

Universal care plan – A document under london care record that outlines an individual's preferences for care if they are unable to communicate their wishes due to illness or injury. It may include instructions regarding life-sustaining treatment, as well as preferred place of care and death.