**Transitioning Patients in the Last Hours and Days of Life from the Intensive Care Unit (ICU) to General Wards**

**Contents**

1. [Purpose and Scope](#purpose-and-scope)
2. [Introduction and Background](#introduction-and-background)
3. [Definitions](#definitions)
4. [Responsibilities](#responsibilities)
5. [Identifying Patients Suitable for Transition](#identifying-patients-suitable-for-trans)
6. [Transition Process](#transition-process)
   * 6.1 [Communication Protocol](#communication-protocol)
   * 6.2 [Documentation Requirements](#documentation-requirements)
   * 6.3 [Symptom Management](#symptom-management)
7. [Post-Transition Care](#post-transition-care)
8. [Training Requirements](#training-requirements)
9. [Monitoring Compliance](#monitoring-compliance)
10. [References](#references)
11. [Appendices](#appendices)

**1. Purpose and Scope:**

This policy provides a structured framework for the transition of patients in the last hours and days of life (PILHDL) from the Intensive Care Unit (ICU) to general wards. It aims to ensure consistent, compassionate, and high-quality care during these transitions while upholding the patient's dignity and providing appropriate support to family members.

This policy applies to all healthcare professionals involved in the care of patients approaching the end of life within the ICU setting at West Middlesex University Hospital and Chelsea and Westminster Hospital NHS Foundation Trust.

**2. Introduction and Background:**

The transfer of PILHDL from the ICU to general wards necessitates meticulous planning and seamless coordination. The paramount goal is to safeguard the well-being and satisfaction of both patients and their family members during this transition.

Several factors drive the decision to transfer dying patients to other areas within the hospital. These include high bed occupancy rates in ICUs and the ethical imperative to allocate beds to patients with ongoing critical care needs. In addition, the bustling and often impersonal environment of the ICU can be daunting for some patients nearing the end of life. When relocating PILHDL patients to general wards, continuity of their individualized end-of-life care plans must be ensured.

The Faculty of Intensive Care Society (FICM), in its recommendation 2.1.11, underscores the importance of discharging patients who are unlikely to die within 24-48 hours of commencing end-of-life care from the ICU. Despite this guidance, practical execution of such transfers remains underexplored and inadequately documented.

This policy addresses identified gaps in current practice, including:

* Inconsistent communication protocols
* Variable documentation practices
* Potential for accidental cessation of essential medications
* Underutilization of Specialist Palliative Care (SPC) services
* Limited understanding of appropriate criteria for transition

**3. Definitions:**

* **Patients in the Last Hours and Days of Life (PILHDL)**: Patients who have been recognized as approaching the end of life, with death anticipated within days.
* **Continuing Care Agreement (CCA)**: The trust's electronic documentation form for patients identified as being in the last hours or days of life, which outlines the agreed care plan.
* **End of Life Care (EOLC)**: Care that helps those with advanced, progressive, incurable illness to live as well as possible until they die.
* **Specialist Palliative Care (SPC)**: Specialist multidisciplinary team input for patients with complex palliative care needs.

**4. Responsibilities:**

**ICU Consultant**

* Make the initial assessment regarding transition suitability.
* Lead discussions with the patient (where possible), family, and healthcare team.
* Complete and review the CCA documentation.
* Ensure appropriate communication with the receiving ward / outrach team.

**ICU Nursing Team**

* Contribute to the assessment of transition suitability.
* Support discussions with families.
* Ensure all documentation is complete.
* Facilitate the physical transfer of the patient.
* Provide a comprehensive handover to the receiving ward / Outreach nursing team.

**Specialist Palliative Care Team**

* Provide specialist input into symptom management.
* Support complex communication with patients and families.
* Assist with transition planning.
* Provide ongoing support to ward teams post-transition.

**Receiving Ward / CCOT Team**

* Prepare appropriately for the patient's arrival / transfer.
* Receive a comprehensive handover.
* Continue the agreed care plan.
* Communicate effectively with the patient, family, and wider healthcare team.

**Family Liaison / Clinical Psychologist:**

* ICU nurses trained in family support / ICU Clinical Psychologist will act as the primary point of contact for families for difficult conversations.
* Ensure families are involved throughout the transition process.
* Provide emotional support and clear information.

**5. Identifying Patients Suitable for Transition:**

**Assessment Criteria:**

Patients should be considered for transition from ICU to a general ward if they meet ALL of the following criteria:

1. The patient has been recognized as being in the last hours or days of life.
2. Death is not anticipated within the next 24-48 hours.
3. Patient is clinically stable enough for transfer (minimal or no inotropic support, not requiring invasive ventilation).
4. The patient's symptoms are controlled.
5. ICU stay has been ≥14 days (though shorter stays may be considered on a case-by-case basis).
6. Specialist Palliative Care team involvement has been initiated.
7. A comprehensive care plan has been developed and documented.

**Contraindications for Transition**

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

1. Imminent death (expected within 24 hours)
2. Physiologically unstable, requiring ongoing intensive monitoring or interventions.
3. Complex symptom management needs that cannot be met on a general ward.
4. Family expresses strong preference for the patient to remain in ICU (after discussion).
5. Receiving treatments that cannot be safely administered on a general ward.

**6. Transition Process:**

**6.1 Communication Protocol**

**ICU Team to Family Communication**

1. Initiate a family meeting to discuss the transition plan, ideally with SPC team involvement.
2. Explain the rationale for transition in clear, non-technical language.
3. Address concerns and questions openly.
4. Provide written information on the transition process.
5. Document the discussion in the patient's record.

**ICU Team to Receiving Ward Communication**

1. ICU team to contact receiving ward team directly.
2. Discuss the patient's condition, prognosis, and care plan.
3. Schedule the transfer at an appropriate time that allows for adequate staffing on the receiving ward. Utilise butterfly rooms services.
4. Complete a structured handover document.

**SPC Team Involvement**

1. SPC team to be involved at least 48 hours before planned transition where possible.
2. SPC team to liaise with both ICU and receiving ward.
3. SPC team to review and optimize symptom management plan.
4. SPC team to provide guidance on anticipatory prescribing.

**6.2 Documentation Requirements:**

The following documentation MUST be completed prior to transition:

1. **Continuing Care Agreement (CCA)** - Fully completed and signed on Cerner.
2. **CCA Daily Review** - Most recent review documented on Cerner.
3. **Medication Reconciliation Form** with specific attention to:
   * Subcutaneous anticipatory medications
   * Subcutaneous syringe driver prescriptions (if applicable)
   * Regular medications for symptom control
4. **SBAR Handover Documentation** (Situation, Background, Assessment, Recommendation)
5. **Family Communication Record** documenting all discussions with family members.

**6.3 Symptom Management**

**Essential Medications**

The following medications should be prescribed and available on the ward BEFORE transfer:

1. **Pain Management**
   * Subcutaneous diamorphine or appropriate alternative for breakthrough pain
   * Regular analgesia via appropriate route
   * Consider continuous subcutaneous infusion for patients with regular opioid requirements.
2. **Agitation/Restlessness**
   * Subcutaneous midazolam for breakthrough agitation
   * Consider regular sedation via appropriate route for persistent symptoms.
3. **Respiratory Secretions**
   * Subcutaneous glycopyrronium or hyoscine butylbromide.
4. **Nausea and Vomiting**
   * Subcutaneous levomepromazine or alternative antiemetic
5. **Breathlessness**
   * Subcutaneous morphine or appropriate alternative
   * Consider oxygen therapy as appropriate

**Subcutaneous Syringe Driver**

If a patient requires a subcutaneous syringe driver:

1. Ensure it is set up and running effectively before transfer.
2. Provide at least a 4-hour window of stable administration before transfer.
3. Document the time of next syringe driver change.
4. Ensure the receiving ward has the necessary medications and equipment.

**7. Post-Transition Care:**

**First 24 Hours**

1. CCOT team to call the ward at 2 hours post-transfer to check on patient status.
2. SPC team to review the patient within 24 hours.
3. Family liaison to contact family within 24 hours to ensure they are receiving appropriate support.

**Ongoing Support**

1. CCOT outreach team to be available for advice if required.
2. SPC team to provide ongoing input as needed.
3. Regular communication between ward team and family to be maintained.
4. CCA Daily Review to be completed by ward team.

**8. Training Requirements:**

All ICU staff involved in transitioning PILHDL should receive training in:

1. Recognition of dying patients
2. Communication skills for end-of-life discussions
3. Symptom management in the last hours and days of life
4. CCA documentation
5. Transition process and protocol.

Training will be provided through:

1. Simulation-based training scenarios
2. Ward-based teaching sessions

**9. Monitoring Compliance:**

Compliance with this policy will be monitored through:

1. Regular audit of CCA documentation completion rates
2. Retrospective case note review of all PILHDL transitions.
3. Family feedback surveys
4. Staff knowledge and confidence surveys
5. Review of incident reports related to PILHDL transitions.

Findings will be reported quarterly to:

1. Critical Care Governance Meeting
2. End of Life Care Steering Group
3. Trust Quality and Safety Committee

**10. References {#references}**

1. <https://www.ficm.ac.uk/sites/ficm/files/documents/2021-10/ficm-critical-condition_0.pdf>
2. National Institute for Health and Care Excellence. Care of dying adults in the last days of life. 2015.
3. Cox S, Handy JM, Blay A. Palliative Care in the ICU. 2012. Journal Intensive Care Society, 13(4):320-326.
4. Coyle MA. Transfer anxiety: preparing to leave intensive care. Intensive Crit Care Nurs. 2001;17(3):138-143.

**11. Appendices:**

**Appendix A: Family Information Leaflet - Transition from ICU to Ward**

**Family Information Leaflet**

**Moving from Intensive Care to a Ward**

Information for Families and Loved Ones

***Understanding the Transition:***

When someone close to you has been in the Intensive Care Unit (ICU) and is now in the last hours or days of life, the healthcare team may suggest moving them to a general ward. This leaflet explains why this move might be recommended and what you can expect.

***Why is a Move to a Ward Being Suggested?***

There are several reasons why a move from ICU to a ward might be better for your loved one:

**A calmer environment:** ICUs are busy, often noisy places with constant activity. A ward provides a quieter, more peaceful setting which can be more comfortable for someone nearing the end of life.

**More natural surroundings:** Ward rooms feel less clinical and can often be personalized with photos, cards, and meaningful items from home.

**Flexible visiting:** Ward settings usually offer more flexible visiting arrangements, allowing family members to spend more time with their loved one.

**Appropriate level of care:** When a patient no longer needs intensive monitoring or treatments unique to ICU, the ward environment can provide the right level of care focused on comfort and dignity.

***What Will Happen During the Move?***

The move will be carefully planned to ensure your loved one's comfort:

* The ICU team will discuss the plan with you before any move takes place.
* A bed will be prepared on the receiving ward.
* All necessary medications and care plans will be arranged before the move.
* Your loved one will be accompanied by experienced staff during the transfer.
* The ICU team will provide a thorough handover to the ward team.
* The ICU team will follow up within 24 hours to ensure continuity of care.
* The Specialist Palliative Care team will also be involved to ensure symptom control is maintained.

***What Will Care Be Like on the Ward?***

The focus of care will be on comfort and dignity:

* Symptom control will be the priority, ensuring your loved one is comfortable and pain-free.
* Care will be guided by the Continuing Care Agreement that has been discussed with you.
* The ward nurses will continue to provide personal care, mouth care, and position changes for comfort.
* All medications will continue as needed, with a focus on controlling symptoms.
* Staff will be available to support both your loved one and your family.

***How Can You Help?***

Your presence and involvement are valuable:

* Continue to visit and spend time with your loved one.
* Bring in personal items that might bring comfort (photos, favorite music, soft clothing).
* Share with the ward staff any preferences or information about your loved one that might help with their care.
* Take care of yourself too – ask about facilities for refreshments, rest areas, or overnight stays if needed.
* Don't hesitate to ask questions or raise concerns with the ward staff.

***Who Will Be Looking After Your Loved One?***

Several healthcare professionals will be involved in your loved one's care:

* Ward Nurses and Doctors: Will provide day-to-day care and medical oversight.
* Specialist Palliative Care Team: Specialists in end-of-life care who will advise on symptom management.
* ICU Outreach Team: Will visit to ensure continuity from ICU care.
* Chaplaincy: Available for spiritual support if desired.
* Family Support Team: Can provide emotional support and practical advice.

Important Contact Information

Ward Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ward Sister/Charge Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Palliative Care Team: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Support Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chaplaincy Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Questions You Might Have***

***Will the standard of care be different?***

The focus of care will change from intensive monitoring and interventions to comfort-focused care, but the quality and attention to your loved one's needs will remain the highest priority.

***What if my loved one's condition changes?***

The ward team is experienced in caring for patients at the end of life. They will respond promptly to any changes and adjust care accordingly. The ICU and Palliative Care teams remain available for advice.

***Can we stay overnight?***

Most wards can accommodate a family member staying overnight. Please discuss this with the ward staff who will do their best to arrange this for you.

***What about personal belongings?***

We encourage you to bring in comfortable clothing, photographs, and other meaningful items. Please discuss with staff what would be appropriate.

***Additional Support***

This can be a difficult time. Support is available for you through:

* The ward staff and palliative care team
* Hospital chaplaincy services
* Bereavement support services
* Family support services

Please ask any member of staff if you would like to access these services.

**Appendix B: PILHDL Transition Flowchart:A black and white background with white rectangles

AI-generated content may be incorrect.**

**Appendix C: Symptom Management Guidelines**