Intensive Care Society

Guidance for:

The transfer of critically ill adults to an outdoor space during end of life care

Endorsing Organisations

Contents

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Introduction

This document has been produced to provide guidance for intensive care teams to facilitate end of life care for their patients in an outdoor space. We hope that it will encourage and empower the healthcare team to address what matters most to our patients at the end of their lives where these wishes include an outdoor space.

For this document, we define the outdoor space as any environment that is not within the fully enclosed direct patient care area of the intensive care unit and might include garden rooms that are separate from the immediate ward environment. This guidance considers patients with varying levels of nursing dependency or organ support needs. We define end of life care as the care delivered to patients who are deemed to have little or no chance of recovery, and a senior decision has been taken to focus on comfort and dignity in this final phase of a patient's life. This may include situations when withdrawal of life sustaining treatment is planned.

Recommendations

The Conversation

- Practice should focus on early recognition of the potential for dying and sensitive exploration of the patient and/or family 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. We suggest the use of the question “What matters most?”. The wishes and/or best interests of the patient should be the primary consideration in the decision-making process.
- A holistic needs assessment (including physical, social, psychological, and spiritual needs) should be documented that helps inform the decision and planning process.
- All adult intensive care patients reaching the end of their life should have the opportunity for transfer to an outdoor space. The patient and/or their family should be offered a visit to an outdoor space and be involved in the discussions of the actualities of the decision and planning process.
- In the process of deciding whether to transfer the patient to an outdoor space, a risk assessment should be performed and clearly documented in the patient’s record. This should include the risks of dying during transfer to the outdoor space and the possibility of not dying outside (even when this was an expressed wish) due to other constraints (in the cases of withdrawal of life sustaining treatment, and so requiring transfer back to the intensive care unit for ongoing end of life care). This component of the conversation should include the steps that would be taken to manage these risks and mitigate against distress. The checklist provided in the appendix of this document may assist with this.
- The senior responsible clinical decision maker (most likely the consultant in charge of the patient’s care) and the intensive care unit nurse in charge should be involved in the decision-making process and approve the transfer.
- The conversation and process should involve staff from the multi-disciplinary team and may benefit from the involvement of a specialist palliative care team (the involvement of whom would be encouraged in the implementation of this guidance).

The Outdoor Space

- Intensive care units should explore the feasibility of obtaining (either outright or access to) an outdoor space.
- There should be consideration for the issue of privacy and dignity in the outdoor space.
- There should be consideration for maintaining lines of communication between the transfer party and the intensive care unit.
- The prevailing weather should be considered in preparing for a transfer to an outdoor space and any necessary modifications to preparations made prior to departure. This should not unduly delay the transfer, so we recommend that equipment such as extra blankets, coats and waterproof covers etc. are readily available. This may form part of the risk assessment (see recommendation 4) and should also consider the risks to accompanying family and staff.
- Where an outdoor space is not presently available to a intensive care unit, the team should consider alternative environments or environmental modifications to better fulfil the patient’s and/or family’s wishes.

The Transfer

- Intensive care units should consider the standards and recommendations outlined in the Intensive Care Society’s Guidance On “The Transfer of the Critically Ill Adult” [1] and “Transfer of Critically Ill Patients to the Outdoors” [2] when adapting this guideline to local organisation policy. It is accepted that not all the standards or recommendations made in these other documents will apply in the context of a patient for who the priorities are weighted towards best end of life care as opposed to ongoing definitive treatment.

- The necessary equipment required for the transfer should be considered on an individual patient basis.
- Consideration should be made for the provision and disposal of necessary personal protective equipment for the duration of the transfer. This includes disposal of any other consumables used during the transfer.
- Consideration should be made for the patient, their family, and the escorting staff during the transfer.
- The plan for transfer should include the process for return of the patient to the intensive care unit (or other agreed location) following death.
- Each transfer should be completed by a staff debrief to celebrate what went well and to establish any components of the process which might be improved for future transfers. This is also an opportunity to ensure staff wellbeing.

Medicines Management

- Prior to departure, continuous infusions (intravenous and/or subcutaneous) should be checked to ensure that there is sufficient supply for the intended duration of the transfer. The power supply for the infusion device should also be checked and replaced/sufficiently charged if necessary.
- Prior to departure, the intensive care team should assess whether the patient requires any as required medicines to be administered for symptom management. If indicated, administer before departing.
- Anticipatory medicine requirements for symptom control should be reviewed for the previous 24 hours to estimate the required supply for the intended duration of the transfer.
- Medicines should be prepared prior to departure in the usual environment on the intensive care unit against the patient's prescription and clearly labelled, according to the local organisations' medicines policy. These medicines will accompany the patient on the transfer.
- An agreed version of the patient's prescription should accompany the patient in case of any medicine administration in the outdoor environment. This might be the patients actual paper chart, an appropriately charged electronic device or a printout from the patient's electronic record, as agreed by the local organisation.
- Local organisations should seek to review and amend (if required) their controlled medicines policy to detail the standards for the preparation, handling, administration, and where necessary disposal of controlled medicines in the context of this guidance.
- Where one or more controlled medicine forms the anticipatory medicines accompanying the patient to the outdoor environment, there should be a second staff member who is authorised to witness administration of these drugs, in addition to that staff member who has taken responsibility for safe custody. This staff member may either remain with the patient or be able to be called upon when required. Again, this should be outlined in locally agreed policy.
- During the design and construction of designated outdoor spaces, local organisations should consider provision for the temporary storage of medicines (including controlled medicines) and seek to review and amend (if required) their controlled medicines policy to support this facility.

Background

Although the intention of admission to an intensive care unit is most often to provide life sustaining treatment, the mortality of intensive care patients is around 20%, of which a significant proportion of these deaths is preceded by a decision to withdraw life sustaining interventions.[3] The General Medical Council 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,[4] 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. Realising and addressing this need earlier may enable teams to identify and manage patient and family needs for support before, during and after death.

The Faculty of Intensive Care Medicine's report on care at the end of life outlines that care which as professionals we should strive to provide to our individual patients and their families and covers all these domains.[3]

Care at the end of life is also covered in section 3.11 of the Guidelines for the Provision of Intensive Care Services 2nd Edition (GPICS2). Points pertinent to our guidance include:

"In order to identify dying patients and respond to changes in their condition, those at high risk of dying must have their condition regularly reviewed to assess whether they are improving or deteriorating, enabling early and appropriate organisation of treatment and care.

Patients with capacity should be kept informed of their clinical condition, and of the possibility that they may be dying. Best practice dictates that those close to the patient should also be informed.

Once patients are recognised as being in their final days/hours of life, therapeutic goals should be reviewed and accordingly altered to focus on comfort and dignity. Interventions which do not contribute towards this should be withdrawn. The discussion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) is intrinsic to palliative care in critically ill patients.

Care should address dying patients' need for spiritual and emotional support and include that of their families and others close to them." [5]

This latter point, along with further emphasis placed upon understanding the patient as an individual in section 3.8 of GPICS2 ("The Patient and Relative Perspective")[5], is where establishing "what matters most" to the patient becomes key. Many of the conversations we have in intensive care focus on what not to do as the patient nears the end of their life: "do *not* attempt cardiopulmonary resuscitation" or "*not* for invasive ventilation" etc. When considering the final phase of a person's life it is just as, if not more important, to consider what our patient does want and what wishes we *can* fulfil. These are decisions that the patient and their family, rather than the healthcare team, can own, and 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.[6]

The "3 Wishes Project" (an initiative involving intensive care units in the United States of America and Canada) encompasses this ethos by seeking to elicit and implement wishes of intensive care patients at the end of their life. The project has produced multiple research publications, demonstrating how the project improves patient and family experiences, enhances staff morale, translates institutional missions and values into front-line practice, and creates positive public relations.[7]

It is important to involve the patient as much as is practicably possible. If it is established that a person lacks capacity at the relevant time to make the relevant decision, as may well 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.[8] This will involve consulting with anyone engaged in caring for the person, close relatives, friends or others who take an interest in the person's welfare, or a deputy appointed by the patient before capacity was deemed lacking. This decision would then be referred to as a "best interests decision". In our recommendations we refer to these people as the patient's family.

A review of the effect of environmental design on end of life care suggested many positive impacts that an outdoor environment (nature) might have on the management of physical and psychological symptoms, as well as spiritual wellbeing, and patient, family, and staff satisfaction. It also recommended other design factors such as improving visibility and line of sight, hidden medical equipment and management of light and temperature – all of which can potentially be achieved in an outdoors environment.[9] This is supported by an earlier report by The King's Fund, of which a key finding was that "environments of care at the end of life need to strive for a reassuring atmosphere of calm contemplation that is culturally and religiously neutral and is not overtly and unnecessarily clinical."[10] As explored more comprehensively in a companion guideline to this document[2], a well-designed garden has, amongst other things, been showed to reduce stress, provide opportunities for escape from stressful clinical settings, heighten patient, family and staff satisfaction and increase care quality[11], all of which might also be considered important at the end of life.

In this guideline we have considered medicines management as part of the process for the transfer of the adult intensive care patient to an outdoor space in the context of end of life care. This group of patients may have continuous infusions in-situ (either an intravenous infusion or continuous subcutaneous infusion) or may require anticipatory medicines for symptoms control whilst in the outdoor space. The prescribing, administration, record keeping, safe custody and destruction should be in keeping with local organisational policy and based upon national guidance.[12]

References

[1] The Intensive Care Society and The Faculty of Intensive Care Medicine, “Guidance On: The Transfer of the Critically Ill Adult,” The Intensive Care Society, London, 2019.

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[12] Medicines Prescribing Programme, “Controlled drugs: safe use and management. NICE guideline NG46. Methods, evidence and recommendations.,” National Institute for Health and Care Excellence, London, 2016.

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Checklist for the transfer of critically ill adults to an outdoor space during end of life care

The following is a suggested template for conversations prior to undertaking the transfer.

Making a decision

- Establish the patient's clinical trajectory and treatment priorities – is dying likely? Is end of life care or withdrawal of life sustaining treatment being considered in this patient?
- Discuss the patient's clinical trajectory and treatment priorities with them and their family*
- If not already done, establish "what matters most" to the patient and their family. Based on your conversation, you may need or wish to make suggestions, including transfer to an outdoor space
- Establish whether transfer of the patient to an outdoor space is a consideration in the patient's or family's wishes in these circumstances
- Identify potential risks and mitigating measures that could be taken
- Discuss this risk assessment with the patient and their family
- Decide whether transfer of the patient to an outdoor space is desired and feasible

* Family are those closest and most important to the patient. This may be close friends or staff from residential care.

Agreeing an action plan

Consider the following:

- Where will the transfer be to?
- When will the transfer take place?
- Who will be required to escort the patient?
- What family will be with the patient, and will they need additional staff support?
- How will privacy and dignity be maintained in the outdoor space?
- If withdrawal of life sustaining treatment is planned in the outdoor space, how will this be performed?
- What monitoring will be required during the transfer? Will this be removed if withdrawal of life sustaining treatment is planned in the outdoor space?
- If the patient deteriorates on transfer, what steps will be taken? These may include temporarily increasing support measures or allowing a natural death.
- If the patient dies during transfer to the outdoor space, what action will be taken? E.g. Will the patient and family return immediately to the intensive care unit?
- If death is anticipated in the outdoor environment, what action will be taken when the patient dies? Will a period of time be spent outside in the outdoor space? How will the patient and family be returned to intensive care?

Documenting each step

- Ensure that the conversation and resulting action plan are documented clearly within the patient notes including either verbal consent or a best interests decision
- Consider whether formal documentation of a treatment escalation plan or resuscitation decision is required at this stage

Consider the environment

- ◯ Have the prevailing weather conditions been considered?
- ◯ What is the temperature outdoors? Is the necessary warming or cooling equipment available?
- ◯ Will sun or rain protection be required? If so, is it available?
- ◯ What are the light conditions outdoors and are they likely to change during the transfer? Are provisions available to account for this?

Check your equipment

- ◯ Is appropriate monitoring available and checked? (if required)
- ◯ Is portable suction (for transfer and if mains suction not available at destination) for oral care and airway management (if latter is required) available and checked?
- ◯ Are sufficient power sources available and checked? (Consider availability of power adapters or batteries if a mains power source will not be available; consider batteries for any continuous subcutaneous infusion devices)
- ◯ Are sufficient oxygen supplies available and checked?
- ◯ Are there sufficient drugs including those for active treatment (vasopressors etc.) and emergency drugs (if appropriate), as well as ample anticipatory medicines available and checked? If an infusion is in-situ - is the infusion supply sufficient? (Consider whether it requires refilling prior to departure)
- ◯ Is there sufficient drug administration equipment (syringes, needles for drawing up and administration, dilutants, flushes) available and checked?
- ◯ Are there sufficient mouth care equipment and resources, including drinks? (as appropriate)

The patient

- ◯ If applicable, are they fully informed of the action plan and prepared for the transfer?
- ◯ Are they sufficiently stable to transfer?
- ◯ Are they comfortable? Do any anticipatory medicines need administering prior to transfer?
- ◯ Is their temperature controlled? Is heat loss prevented?
- ◯ Are they secure in their bed?

Their family

- ◯ Are those who plan to accompany the patient present?
- ◯ Are they fully informed of the action plan and prepared for the transfer?
- ◯ Are there adequate facilities at the destination for the family? (Consider whether additional seating will be required and how they will access toilets or refreshments)
- ◯ Are they adequately clothed for the prevailing weather?

Our staff

- ◯ Are they fully informed of the action plan and prepared for the transfer?
- ◯ Are there sufficient registered professionals for the administration of controlled drugs/ anticipatory medicines?
- ◯ Are they adequately clothed for the prevailing weather?
- ◯ Do they have a means of contacting the intensive care unit if needed?

Debrief

- ◯ Firstly, celebrate what went well! Are there any components of the process that might be improved for future end of life transfers?
- ◯ Are there any staff well-being needs to be addressed?

Associated Guidance:

The following companion guidelines are available on the website of the Intensive Care Society:

The Transfer of the Critically Ill Adult

Transfer of Critically Ill Patients to the Outdoors

Notes

Notes

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