Transitioning end of life from critical care to abode

Dr Avinash Jha, Dr Sudhindra Kulkarni, and Dr Shondipon Laha
Critical care unit
Lancashire Teaching Hospitals

SOA21

Introduction

An elderly male was admitted to the hospital with back pain and was diagnosed with cervical spine abscess secondary to staphylococcal infection.

He underwent surgical evacuation, following which he was admitted to the intensive care unit and progressed to irreversible quadriplegia requiring mechanical ventilator support. After four weeks of therapy and tracheostomy, a multi-disciplinary team discussion included the patient and the family.

The outcome decision was to move to end of life care (EoLC) after considering personal and religious wishes.
The patient requested that he wanted to be home with his loved ones during the final hours of his life.

Approach and the reasons behind it

A detailed progression plan was discussed with the family, and the anticipated series of events with the home transfer process and subsequent steps were communicated.
Before home transfer, he required pleural effusion drainage to ensure a safe transfer.
On arrival at home, we had a team of palliative care nurses and a consultant. As the family members gathered, a speaking valve with Non-invasive ventilation (NIV) mode was used, which helped the patient speak to the family members.

Once the patient spent adequate time with family, anticipatory medications were administered. The tracheostomy tube was removed and replaced with a face mask.
The patient took his last breaths of life at his house amidst his loved ones.
He was pain free, comfortable and had no signs of distress.

Around 20% of patients admitted to intensive care in the UK die in hospital[1]. Unfortunately, a unified approach to end-of-life planning cannot be applied to all patients; instead, it has to be individualized. The end of life should be based upon a multi-disciplinary team discussion involving shared decision making between patient, family members and the medical team and often leads to the provision of palliation care either in the intensive care unit or on the ward[1].

However, palliation at home is a more complex process, and several factors need addressing. A pragmatic approach helps provide individualized care and can be tailored as per the patient/ family requests, as shown in figure 1.
The economics of EoLC at home seems to be more cost-effective than in hospital management, as depicted in figure 2[2,3].

The focus should be on providing good death, and this can be achieved most simplistically by addressing patient preferences and keeping the patient pain free[4].
There are no specific outcome measures to define the quality of death that are not as straightforward as quality-adjusted life years.

Conclusion

Death is an important event not only for families but also for the patient. In certain circumstances, we as health care professionals can aid and enhance this process with a multi-faceted approach.

This will lead to a patient-centred delivery of services and can minimize the economic burden on healthcare resources.

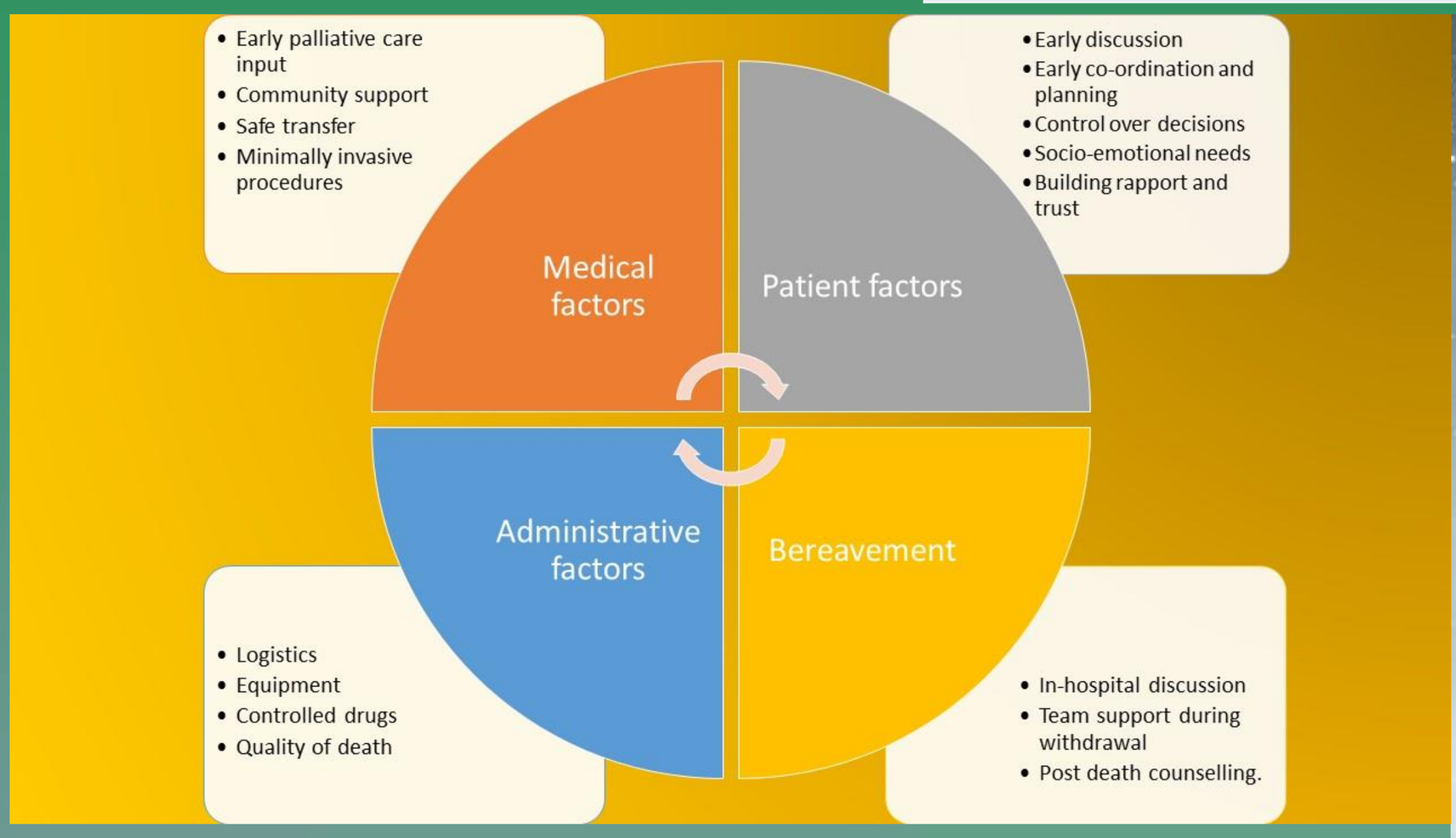


Figure 1: Multi-faceted approach in End of life care

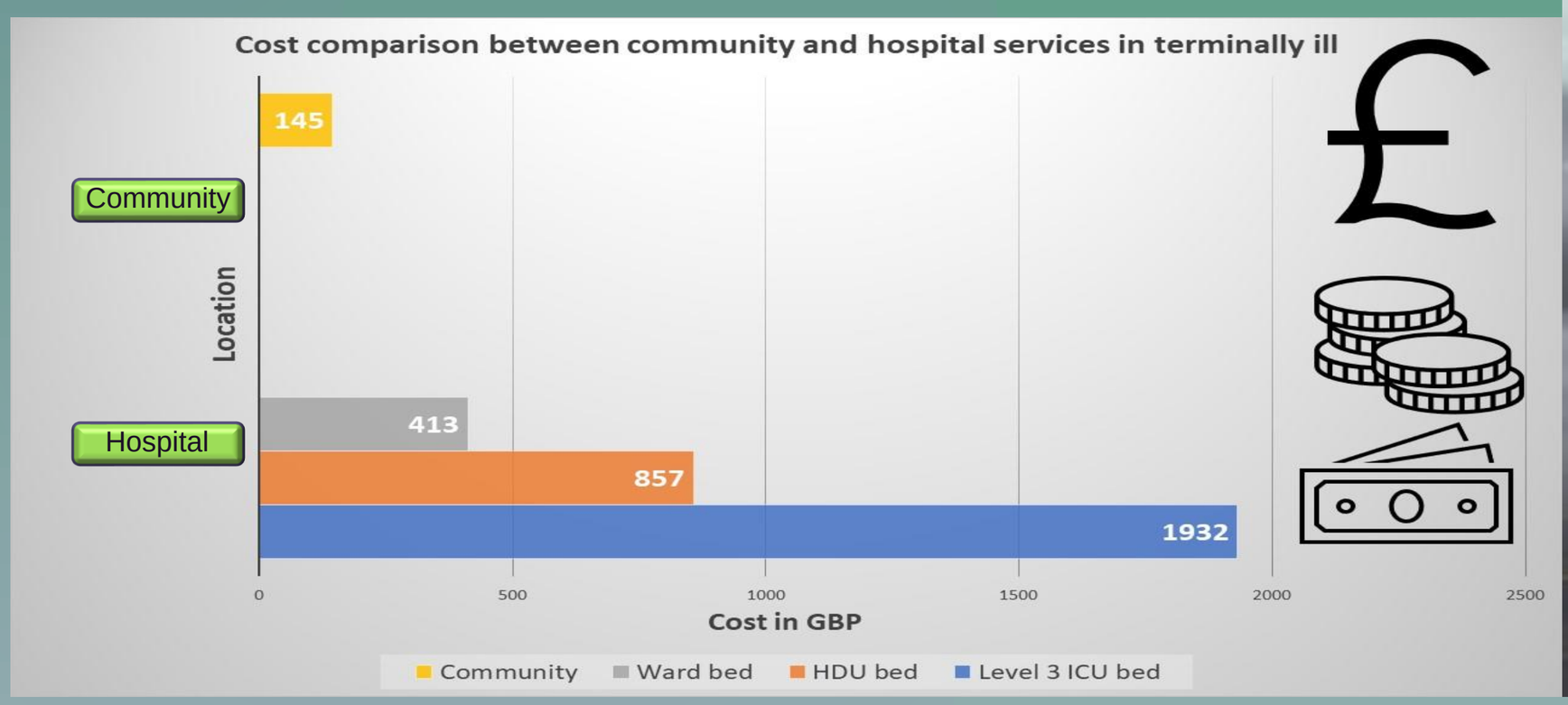
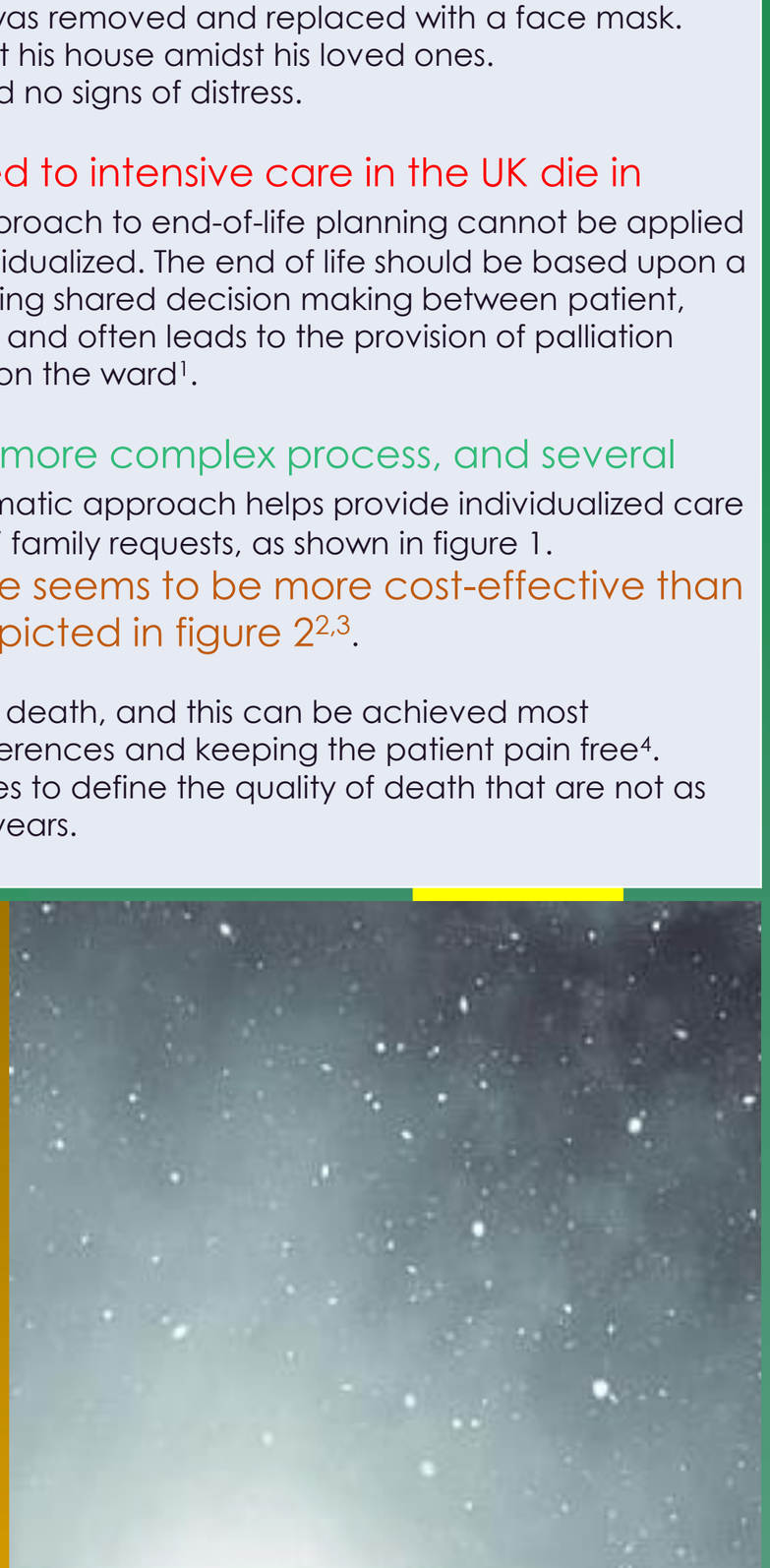


Figure 2:Cost comparison between community and hospital



References

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Intensive Care Society