

WITHDRAWAL OF CRITICAL CARE AT HOME

Barking, Havering & Redbridge
University Hospitals

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BACKGROUND

In January 2015, a patient with resistant non convulsive status epilepticus and a poor prognosis was cared for on our Intensive Care Unit. The partner of this patient requested that withdrawal of critical care took place in their own home rather than in hospital, as the patient had previously expressed a wish to die at home. We were able to accommodate her wishes for which she was very grateful and specifically asked that we consider offering this option to other patients.



METHOD

TAKING PRIDE IN OUR CARE TOGETHER

Barking, Havering and Redbridge University Hospitals NHS Trust

Individualised End of Life Care Plan for Critical Care Patients and Withdrawal of Critical Care at Home

Making a difference: Compassionate Care for all

To be kept with your patient.

Commencement Date _____

Name	
Preferred Name	
DOB	
NHS Number	
Hospital Number	

Patients must be reviewed daily by Consultant / SPR

Start date	Designation	Signature
Day 1		
Day 2		
Day 3		
Day 4		
Day 5		

Literature review,
cost analysis and
ethical assessment

Guidelines and specific
Individualised End of
Life Care Plan

Working group: Critical
Care & Palliative Care
Consultants, Specialist
Palliative Care Team
Lead, End of Life Care
Facilitator, Critical Care
Sister and Matron

Stakeholder involvement:
Hospice at Home Service,
GPs, District Nurses and
Community End of Life
Care Facilitators

RESULTS

Strengthened links between Critical Care Specialist Palliative Care (SPC)

Greater SPC support for patients and families on Critical Care

Individualised End of Life Care Plan empowers staff to provide excellent end of life care to all their dying patients and allows further auditing of our performance

Critical Care staff have better awareness and understanding of both general end of life care and Specialist Palliative Care

Positive feedback from families & community colleagues

Successfully carried out one more withdrawal of life support at home and have discharged two others directly from Critical Care to their own home for end of life care

Schwartz Round



CHALLENGES

Increasing awareness amongst
Critical Care consultants body

Identifying potential patients at an
early enough stage

Gaining support of local GPs and
District Nurses

PLANS FOR THE FUTURE

Regular Specialist Palliative Care
involvement at Critical Care MDTs
to improve on current weekly
ward rounds

Specific validated bereavement
survey

Patient and family information
leaflets



FEEDBACK

**“Outstanding example
of excellent partnership
working and
communication”**

**“So impressed by the
motivation of everyone
involved to give the
best care to this entire
family”**

