Although considerable effort is being directed at providing patients and their families with a “good death,” most patients in intensive care units, if given the choice, would prefer to die at home. With little guidance from the literature, the palliative care committee of an intensive care unit developed guidelines to get patients home from the intensive care unit to die. In the past few years, the unit has transferred many patients home with hospice care, much to the delight of their families. Although several obstacles to achieving this goal exist, the unit has achieved success in a small-scale implementation of its Going Home Initiative. (Critical Care Nurse. 2011;31[5]:46-57)
trillion or 17.6% of the gross domestic product of the United States. The cost of caring for patients in ICUs in the United States has been estimated as 15% to 25% of all US hospital costs and from 1% to 2% of the gross national product. By 2019, these costs are expected to increase to 6% of the gross national product, an incredible 38% of the total US health care costs.

In the context of high mortality, resource utilization, and financial burdens to patients’ families, discussions about a patient’s future quality of life and withdrawal of life support are becoming more common both in the United States and across the globe. End-of-life care in the ICU has become an integral component of contemporary critical care practice. Providing such care requires technical competence, excellent communication skills, emotional and cultural sensitivity, and a desire for shared decision making.

Considerable effort is being directed to providing critically ill ICU patients a “good death” in the units. However, most patients, if given the choice, would prefer to die at home. Although dying at home was a common phenomenon at the end of the 19th century, we could find no contemporary initiatives focused on getting patients home from the ICU. Consequently, our ICU palliative care committee (PCC) sought to provide patients a peaceful death both in the unit and perhaps at home. We embarked on developing a process for getting patients home to die.

The Going Home Initiative

Our PCC consists of numerous staff nurses, an intensivist, a clinical nurse specialist, an interfaith chaplain, a social worker, and 2 hospice nurses. We embrace the notion that providing a peaceful death in all possible circumstances requires a focus on the desires of each patient and the patient’s family and assessment by a multidisciplinary staff.

To achieve our goal of a peaceful death in the unit, we instituted comfort care guidelines. These strategies help all unit health care providers become familiar with best practices in withdrawal of life support. The guidelines include principles for withholding and withdrawing life-sustaining treatment and information for comfort before extubation; liberalization of visitation; and suggested levels for analgesia, sedation, and ventilator support. We have received many notes of appreciation from patients’ families indicating that the families are grateful for such supportive care.

Some families in our unit asked to take their loved ones home to die. These requests had surfaced for years. Unfortunately, we had no process to facilitate this type of request. We talked about these anecdotal requests in our PCC meetings. We quickly realized that if we were to consider ourselves true advocates for providing comprehensive end-of-life care, we needed to explore this compelling option.

Literature Review

Much of the literature on hospice is on providing care for a terminally ill patient in the patient’s home. However, little information is available on taking a critically ill patient home to die, and none is evident in the US literature. We found 8 descriptive case study
articles on end-of-life care at home in other countries (Table 1).

The type and number of patients in the samples studied varied. One article was about bringing neonates home to die; all the other articles were about adult ICU patients who wanted to die at home. In some studies, only 1 patient was taken home to die; in other studies, 10% to 44% of ICU patients were transported home to die.

Results also varied. Although all the patients wished to die at home, some articles emphasized that transferring patients home to die was based on religious or cultural beliefs, such as Muslim religious values or Maori, Polynesian, or Chinese cultural perspectives.

Conclusions were consistent. Patients’ families were overwhelmingly pleased with the support in bringing their loved one home to die, whether this satisfaction was based simply on having their loved one at home or on cultural or religious beliefs. Both patients’ families and health care providers were comforted by the experiences.

Although these articles gave little insight into the process of bringing patients home to die, the evidence suggests that both patients’ families and health care providers found the experience positive, particularly in the context of compliance with the patients’ desires or religious or cultural beliefs.

### The ICU Context

Our Beacon award–winning unit at Baystate Medical Center in Springfield, Massachusetts, is a 24-bed, level I trauma, medical, surgical, noncardiac ICU. We admit a mean of 1600 patients annually, the mean length of stay is 5 days.

#### Table 1 Literature review: getting patients home to die

<table>
<thead>
<tr>
<th>Author/year of publication/country of origin</th>
<th>Sample</th>
<th>Method</th>
<th>Results</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawdon et al/1994/New Zealand</td>
<td>3 intensive care neonates</td>
<td>Case examples</td>
<td>Life support withdrawn at home</td>
<td>Families were pleased with the nursing support and ability to have the infants die in familiar surroundings</td>
</tr>
<tr>
<td>Mann et al/2004/New Zealand</td>
<td>17 adult ICU patients</td>
<td>Case examples</td>
<td>Life support withdrawn at home</td>
<td>Maori and Polynesian families reported the process as a positive experience</td>
</tr>
<tr>
<td>Ryder-Lewis/2005/New Zealand</td>
<td>14 adult ICU patients</td>
<td>Case examples</td>
<td>Life support withdrawn at home</td>
<td>Families were pleased with support and care; found the experience highly valuable</td>
</tr>
<tr>
<td>Beuks et al/2006/the Netherlands</td>
<td>2 adult ICU patients</td>
<td>Case examples</td>
<td>Life support withdrawn at home</td>
<td>Experience was comforting for families and caregivers</td>
</tr>
<tr>
<td>Kallel et al/2006/Tunisia</td>
<td>1 adult ICU patient</td>
<td>Case example</td>
<td>Life support withdrawn at home</td>
<td>The patient was allowed to die in his own bed as he wished, without suffering and with all the Muslim religious and cultural rituals</td>
</tr>
<tr>
<td>Boussarsar and Bouchoucha/2006/Tunisia</td>
<td>10% of the adult ICU patients’ deaths</td>
<td>Case examples</td>
<td>Many patients sent home to die consistent with the wishes of families and patients</td>
<td>Families were grateful that the medical team complied with family/patient’s religious beliefs</td>
</tr>
<tr>
<td>Huang et al/2009/Taiwan</td>
<td>26-44% adult ICU patients (2003-2007)</td>
<td>Case examples</td>
<td>Consistent with the Chinese belief system</td>
<td>Process allowed family to be together at home at the time of death; families were grateful that the medical team complied with family/patient’s Chinese cultural traditions</td>
</tr>
<tr>
<td>Kumar et al/2009/Great Britain</td>
<td>1 adult ICU patient</td>
<td>Case example</td>
<td>Life support withdrawn at home</td>
<td>Patient died a peaceful death on her own terms at home as she desired; family was pleased with support</td>
</tr>
</tbody>
</table>
and approximately 250 patients die each year. ICU mortality is 17%.

Of those patients transferred out of the unit, 93.7% are designated to receive full resuscitation; the remainder are classified as do not resuscitate, comfort measures only, or limited interventions. The patients who receive comfort measures only (ie, making the patient comfortable) and limited interventions (ie, no escalation of interventions that will not benefit the patient) account for almost all of the deaths that occur between ICU discharge and hospital discharge (Thomas Higgins, MD, oral communication, November 9, 2009). A small percentage of patients have extremely poor prognoses and little hope of survival. Although these patients do not require the technical skills of ICU personnel, but do need family support, they are transferred to a step-down unit or to the unit where they eventually die.

Unit’s Plan for Change: Program Development

Within the context just described, the PCC wanted to offer alternatives for a peaceful death for patients and a positive end-of-life experience for the patients’ families. We sought to base this program on the best available evidence and on assumptions based on our beliefs and the processes needed to transport a patient home to die (Table 2).

Table 2: Going Home Initiative assumptions

| If possible, patients who wish to spend their final days at home with their families should be able to do so. |
| We would partner with the local hospice for a smooth transition into the home. Because of limited resources (ambulance service could not transport a ventilator patient home without a respiratory therapist and because we had no available respiratory therapists), patients would have to be extubated and their condition physiologically stable enough to sustain the ambulance ride home. |
| A family support mechanism would have to be in place at a patient's home. In other words, the family would need to provide care for the patient on a 24-hour basis or contract with an agency to provide care. Do not resuscitate/intubate or comfort measures only, if not already in place, would be instituted. |

With these assumptions in mind, we began to think about our typical unit process for transferring patients to other facilities. We hoped that these insights would help us plan for transferring patients home to die. We understood that transferring any patient from our unit to another facility incorporated 3 distinct stages: discussion about leaving the unit, leaving the unit, and discussion after the transfer.

Discussion About Leaving the Unit

Before a patient is transferred to another facility, the bedside staff nurse, the attending physician, the clinical nurse specialist, and the patient’s family discuss the physiological readiness of the patient to leave the unit. Although most ICU patients are transferred to another acute care unit in the hospital, some patients are transferred directly from the ICU to another facility. If transfer to another facility is a possibility and the patient and his or her family concur with the decision, the social worker and/or the case manager discuss transfer possibilities for placement. For example, the following questions are considered:

- Is the patient returning to a nursing home or moving to a subacute facility for additional care (with or without hospice)?
- Is the patient well enough to return directly home (a rare circumstance)?
- Does a match exist between the patient’s needs and the support provided by the accepting facility?
- Do any insurance issues exist that need to be resolved?

With these basic conversations complete and agreed upon among the health care provider, the patient, and the patient’s family, plans for transfer are operationalized, tentative plans made for engaging the ambulance, and the day and time for transfer determined and scheduled.

Leaving the Unit

On the day of transfer, if needed, the staff nurse, the attending physician, and the case manager confirm plans for transfer to the accepting facility. With discharge notes written, the accepting facility waiting for the patient, and the ambulance time confirmed, the patient is ready to be transferred.

Discussion After the Transfer

Little discussion occurs in our unit after a patient is transferred to another facility. Occasionally, we hear about how a patient and the patient’s family were doing, through communication with either the family or the accepting facility. The family might write a note to the unit, usually because the family members were grateful for the care the patient received. The case manager or social
worker, our facility liaisons, or hospice nurses might talk with the bedside nurse or the clinical nurse specialist about a transferred patient. Rarely did we contact a patient’s family about the patient’s condition after transfer.

The Going Home Initiative

In developing the Going Home Initiative, we knew that the discussion about leaving the unit for home would be more complex than a discussion about transfer to another facility. We were dealing with patients who wanted to go home to die, not be transferred to another facility. These patients are often in an unstable condition and receiving mechanical ventilation. We did not know if we could transfer a patient home while he or she was receiving mechanical ventilation and intravenous medications (analgesics or vasopressors) or whether a hospice organization would accept such an acutely ill patient. We did not know how patients’ families might react to the possibility that their loved one might die during the ambulance ride home. If we could find answers to some of these questions and partner with local hospice organizations, we thought we might be able to move ahead.

We considered our typical process of transferring patients to other facilities and how we might transform the normal transfer process into a workable process to get patients home to die. We ultimately developed the Going Home Initiative, a 3-part algorithm to guide us in getting patients home to die. Similar to our processes for transferring patients to other facilities, the Going Home Initiative included 3 phases: the workup, the day of transfer, and contact with the patient after transfer (see Figure).

**Workup**

The workup, or the discussion and planning phase before transfer, was focused on 3 key factors that a patient’s bedside nurse, the clinical nurse specialist, and the intensivist would analyze. We needed to understand if getting a patient home was a possibility at all. First, did the patient want to go home to die? Second, was the patient in a sufficiently stable physiological condition to endure an ambulance ride home? Third, could the patient’s family care for him or her at home? For example, many patients wanted to go home to die, but if a patient was being treated with vasoactive medications and intravenous analgesics and/or could not be weaned from mechanical ventilation for the trip home, we did not have the resources to get the patient home, despite his or her wishes. Additionally, although...
many families want to fulfill the wishes of their loved one to die at home, many of the families do not have the financial resources to provide home care by outsiders or the skills to provide the care themselves around the clock for their loved one.

Occasionally, these 3 factors would align, and we were able to honor a patient’s wishes. For example, if a patient expressed a desire to go home to die, his or her physiological condition was stable enough for a trip home, and the patient’s family was willing and able to provide care, we might be able to fulfill the patient’s wishes. In these instances, we contacted the local hospice or visiting nurse association (VNA) to have an intake visit with the patient and the patient’s family. During this visit, the hospice nurse would discuss the services that hospice could provide the patient and begin planning to get the patient home. The bedside nurse or the clinical nurse specialist would be in contact with the hospice nurse by telephone if further planning was needed.

For example, Mr D was a 74-year-old man with end-stage chronic obstructive pulmonary disease who desperately wanted to go home to die. His wife and his family wanted him home where he could be with them and sleep in his recliner in the living room by the picture window, which looked out onto his front yard. Mr D was in a stable physiological condition and was extubated 11 days into his ICU stay. His family was able to care for him at home. We moved ahead to contact the local hospice (located 1½ hours from the hospital). After the intake visit with Mrs D, plans began to fall into place to get Mr D home. Mrs D contacted her husband’s primary care physician to be sure that the physician would accept the patient back into the community under these circumstances. The physician had a history of working with hospice and accepted responsibility for Mr D’s care at home. The case manager talked with the family to begin arranging for the ambulance and for needed supplies at home.

Day of Transfer

With the basic mechanisms in place, the case manager arranged with the family for arrival of the ambulance. Concurrently, hospice arranged for a hospital bed at Mr D’s home and for any other equipment needed for patient care and comfort when Mr D was transferred home. Simultaneously, the bedside nurse and resident discussed plans for completing the discharge note and the need for medication orders. We discovered that hospital orders for pain medications and oxygen are in effect for a patient until the patient arrives home. Once the patient entered the house, orders from the primary care physician provided for the patient’s needs. The hospice nurse took over the care of the patient and the patient’s family at that moment. Timing of the patient leaving the hospital and arrival at home was critical for the patient and his family. The hospice nurse needed to be at the house to accept the patient.

In Mr D’s situation, plans for the ambulance were discussed with Mrs D. Because the family lived a substantial distance from the hospital, timing was critical. Mrs D decided to ride behind the ambulance to their home; her daughters were at home with the hospice nurse ready to welcome their father. Orders were written on the hospital end, and the primary care physician had written orders to guide the hospice nurses’ use of medications. All was in place, and the process worked smoothly.

Contact After Transfer

The clinical nurse specialist has regular contact with a patient’s family during the planning and implementation of the transfer home. After transfer, the nurse contacts the family directly or the hospice nurse to see how the patient is doing and how the processes worked for the family and patient. The clinical nurse specialist keeps records of these processes and the family’s reactions to the initiative so that further discussion can ensue in the PCC meeting. If problems arise, the committee discusses the challenges and adjusts the processes of the Going Home Initiative. On the whole, this practice has been successful.

For instance, Mr D arrived home as planned. He died 2 days later in his favorite recliner by the picture window in his living room surrounded by his wife, daughters, and grandchildren. His wife wrote us, “My husband died at home yesterday. You gave us the greatest gift we could have wished for. Thank you.”

Realization of the Going Home Initiative

As we developed the Going Home Initiative, we presented our ideas to our unit-based clinical practice committee and discussed the program with all staff members at our annual validation program. Because our staff nurses are intimately aware of patient-family dynamics, we needed
the nurses’ committed support for this program to succeed. We were fortunate to have committed PCC members on both day and night shifts.

We also needed a commitment for support from our group of intensivists and house staff. Our PCC intensivist proposed the idea to ICU physician colleagues and to the rotating, incoming house staff at the monthly ICU orientation. The algorithm for the Going Home Initiative helped everyone realize the potential benefit of the program, and everyone volunteered commitment to the project.

To provide support 24 hours a day, 7 days a week, our clinical nurse specialist and an intensivist were willing to be called at any time for support and clarification of the processes. PCC members supported other staff nurses if the Going Home Initiative was implemented when the committee members were in the unit. The following case example exemplifies the common approach to our guidelines.

**Case Example**

Mr H, a 92-year-old man, was admitted to the ICU after a massive stroke. Without further long-term care, he had little hope of survival. He was receiving mechanical ventilation and was unresponsive to stimuli but had spontaneous breaths greater than the ventilator settings. His wife, daughter, and 3 granddaughters were at his bedside.

Mr H was truly the patriarch of his family. His wife of 50 years understood his strong role in guiding the family. His grandchildren stated that he had always been there to support them because their mom had a busy schedule as a pediatric oncologist.

His physician daughter adored her dad and did not want him to suffer. Because of her medical background, she knew that he would never want to have a tracheostomy or tube feedings or be placed in a nursing home if he could not live life interacting with his family.

**Family Discussion and Hospice Intervention**

After a short time, the potential need for a tracheostomy, tube feedings, and long-term placement arose. The family members talked among themselves with the attending physician, the bedside nurse, and the clinical nurse specialist. Mrs H and the daughter knew that Mr H would want to go home to die if he had no hope for a quality life. The family requested that Mr H be extubated. After extubation, he breathed on his own, and his condition remained stable. We called hospice for an intake visit to see if the family members’ desires to have him home to die could be fulfilled. The hospice nurse looked forward to working with the family, and the family had the resources to provide care for Mr H at home. However, a small problem arose. Although Mrs H had a primary care physician, Mr H had never had a private primary care physician.

Mr H’s daughter called her mother’s primary care physician to see if this physician might care for her dad after his arrival home. The primary care physician did not respond. The family was concerned that they might never get Mr H home. Although discussing a patient’s care was not part of the normal role of the clinical nurse specialist, late in the day, the nurse called the hospital geriatrician, who happened to be the hospice’s physician director. The geriatrician accepted Mr H as a patient. The family and the ICU staff were overjoyed.

The case manager and the social worker set up an ambulance for a late afternoon arrival. Discharge plans and orders were completed. Hospice arranged for home equipment, and the geriatrician was ready to accept this elderly man home. The ambulance arrived at 5 PM, and Mr H was transported safely home. He died 2 days later, with his family present.

**The Family’s Response**

The clinical nurse specialist spoke to hospice and Mr H’s daughter the following week. Hospice was pleased that getting Mr H home to die went smoothly and that he had a peaceful death. The daughter said that Mr H’s family could not have asked for more. We were able to fulfill his last wishes.

**Critical Care Patients Sent Home to Die**

Since 2009, we have transferred 7 patients home to die (Table 3). Five were men. Ages ranged from 55 to 76 years, with a mean of 66 years. During this time, a total of 456 patients died in the ICU or were moribund when transferred to another unit in the medical center. Thus, 1.5% or 7 of 456 dying patients were able to make this transition. The majority (86%) had pulmonary dysfunction as the primary diagnosis. Chronic comorbid conditions were common, including chronic obstructive pulmonary disease, hypertension, coronary artery disease, and diabetes mellitus. The mean ICU length of stay...
before discharge was 9 days. All patients survived transport home, and time to death varied from approximately 8 to 48 hours.

The clinical nurse specialist called hospice personnel (not the patients’ families) to understand the dying experience at home without interfering with the families’ time. The nurse documented the hospice nurses’ descriptions on the unit data sheet used to track these patients. Informal surveys of patients’ family members and VNA personnel indicated that symptom relief was good; we received no reports of inadequately treated pain or dyspnea. Many patients had said that they were happy to be going home. Families also reported, usually through written notes to the ICU, that the experience of having their loved one die at home was extremely gratifying. ICU nurses, visiting nurses, and hospice staff consistently provided positive feedback on the experience of fulfilling patients’ wishes.

Our process also resulted in considerable cost savings. The ICU length of stay of the patients in our unit who went home to die was shortened by at least 1 to 2 days, saving approximately $4050/day in room costs and cost per unit of service. In other words, we saved 10 ICU patient care days at $4050/day, for a potential saving of $40,500 for these 7 patients alone.

### Obstacles Encountered

We did, however, discover obstacles that prevented some families from taking their loved ones home to die. Primarily, these barriers included patients’ unstable condition, disagreements among family members, and lack of resources to support some families and patients through the dying process (Table 4).

Most commonly, patients whose hemodynamic status was stable still required ventilatory support. These patients could not be safely extubated in the hospital and survive the trip home. We did not have the resources to transfer patients who would then be extubated at home. Our local VNA and hospice did not have the resources to extubate patients in home at the time the patients returned home.

Despite frequent and consistent communication among staff and patients’ family members, some families did not understand the emotional support needed to sustain caring for their loved ones at home. At times, family members desired to have their loved ones transferred home and had support mechanisms in place. When the transfer was imminent, a key family member might suddenly decide to keep the patient in the hospital.

### Table 3 Patients transferred home from a level I, medical-surgical, noncardiac intensive care unit

<table>
<thead>
<tr>
<th>Case no.</th>
<th>Age</th>
<th>Sex</th>
<th>Admitting diagnosis</th>
<th>Comorbid diseases</th>
<th>Days in unit</th>
<th>Hours to death after discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>74</td>
<td>Male</td>
<td>Cerebrovascular accident, respiratory failure</td>
<td>Coronary artery disease, hypertension, chronic obstructive pulmonary disease</td>
<td>11</td>
<td>&lt;48</td>
</tr>
<tr>
<td>2</td>
<td>61</td>
<td>Male</td>
<td>Pneumonia, acute respiratory failure, dehydration</td>
<td>Coronary artery disease, thyroid problem, cerebrovascular accident, dementia; mentally delayed</td>
<td>12</td>
<td>~48</td>
</tr>
<tr>
<td>3</td>
<td>76</td>
<td>Female</td>
<td>Respiratory failure</td>
<td>Diabetes mellitus, mentally delayed</td>
<td>8</td>
<td>~24</td>
</tr>
<tr>
<td>4</td>
<td>55</td>
<td>Male</td>
<td>Respiratory failure</td>
<td>Metastases, non–small cell cancer</td>
<td>4</td>
<td>&lt;24</td>
</tr>
<tr>
<td>5</td>
<td>55</td>
<td>Female</td>
<td>Hypotension</td>
<td>Diabetes mellitus, hypertension</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>6</td>
<td>73</td>
<td>Male</td>
<td>Pancreatitis, chronic renal failure</td>
<td>End-stage chronic obstructive pulmonary disease</td>
<td>12</td>
<td>48</td>
</tr>
<tr>
<td>7</td>
<td>70</td>
<td>Male</td>
<td>Respiratory failure</td>
<td>Metastatic lung cancer</td>
<td>5</td>
<td>8</td>
</tr>
</tbody>
</table>

* For each patient, hospice was called, the patient’s family was pleased with the care and support, and the patient had a peaceful death.

### Table 4 Obstacles preventing patients from getting home to die

- Unstable hemodynamic and respiratory conditions
- Disagreements among family members about handling the death of the loved one at home
- Lack of family resources to support the care for the dying loved one
- Community resources or lack thereof
that he or she would not be able to cope with the scenario of the loved one dying at home in the family member’s presence. Clearly, for the process to unfold as planned, all participants had to share the common goal.

Some families were excluded from the initiative because they were simply physically and/or emotionally unable to provide the necessary care until their loved one died. Others were under the impression that either hospice or the VNA could provide 24-hour care. Neither hospice nor the VNA provides 24-hour physiological support in our area. The family members themselves would have to provide care or hire health care providers. These home care resources are expensive and finite. For instance, Mr Z wanted to go home to die, but after many surgeries, his care was complex. Although he was extubated, his family could neither emotionally nor financially afford to provide the complex care needed. Mr Z died in the ICU with his family at his bedside.

Finally, the logistics of a home transfer are individual and dynamic. Hastening the implementation is difficult, and sometimes a patient died in the ICU before all parties were prepared to transport the patient home. Hospice intake visits, preparation of the home, and logistics were frequent sources of frustration to our staff because the process did not move as quickly as we wished despite everyone’s desires. For instance, Mr L had end-stage chronic obstructive pulmonary disease. Both he and his wife discussed his going home to die because they had had a wonderful previous experience with hospice. Hospice nurses talked with Mr L and his wife, the decision to go home was made, and plans were completed to get him home to die. Unfortunately, he died at 3 AM on the day we were to transport him home.

An Alternative to Going Home to Die

When a transfer home was not realistic, patients’ families were comforted with our holistic and compassionate approach to end-of-life care and were grateful to us for providing privacy and a peaceful death. Our nurses are excellent communicators, families remain at the bedside as family members feel the need, and our spiritual services and social worker are attuned to provide support for these patients and the patients’ families. Finally, we may provide a home-like environment in the patient’s room. We provide a soft glow light in the room and other materials (quilts, pillow cases) to make the room less like a hospital room.

For example, Mr T, who had an anoxic brain injury, could not go home because his sons who would provide the care lived too far away. We discussed what Mr T would like if he died at the hospital. The sons understood their father’s desires, which had a Japanese cultural perspective. Mr T would want a picture of his mother dressed in her kimono, soft lighting, and music. As life support was withdrawn, we stood around his bed in our stocking feet because we were on “hallowed” grounds according to the sons. Mr T died peacefully an hour after life support was withdrawn.

Conclusions and Future Thoughts

As the focus of patient care shifts from cure to comfort, and with a shortage of beds for incoming, more severely ill patients, patients are often sent to hospital units or palliative care services. Reconciling the focus of aggressive interventions of an ICU culture with futile care and the desires of a patient’s family for a peaceful death remain compelling issues for further exploration and discussion, especially in more than a single ICU.

Currently, we are attempting to address some unresolved systems issues to improve our process; we hope to expand patient eligibility in the future. First, we are addressing the need to accelerate the timing of hospice or VNA referral. Since May 2010, we have had 2 hospice nurses located at the hospital, and they are available at any time. Second, we are working on implementing a systematic tool to improve the identification of patients for home transfers. Third, we developed 2 questionnaires on improving end-of-life care. One focuses on the needs of patients’ families; the other, on the needs of the health care staff.

In our review, we found that communities and hospitals in other countries allow patients receiving mechanical ventilation to die at home. Their success has been equal to ours. Since November 2010, our local VNA and hospice accept patients being treated with mechanical ventilation and extubate the patients at home when the patients and the patients’ family members are ready.

In closing, we have made strides to provide patients with a peaceful
Critical Care Nurse

...death at their home. In our experience, transferring patients home to die has been limited, but overwhelmingly positive. We achieved success in the small-scale implementation of our Going Home Initiative. With our simple algorithm, the process works well for a small subset of ICU patients.

References

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by patients, family, physicians and other care providers. JAMA. 2000;284:2476-2482.


1. Among patients for whom a decision is made to withhold and/or withdraw life-sustaining therapy, how many die in the intensive care unit (ICU)?
   a. 11%  
   b. 20%  
   c. 32%  
   d. 60%

2. What is the estimated total cost of caring for patients in ICUs in the United States today?
   a. 1%-2% of the gross national product (GNP)  
   b. 5%-6% of the GNP  
   c. 15% of the GNP  
   d. 30%-32% of the GNP

3. Which of the following is a reason that end-of-life discussions are becoming more common in the ICU?
   a. Low mortality rates  
   b. Decreased resource utilization  
   c. Increased quality-of-life issues

4. Which of the following items is required for staff who provides end-of-life care in the ICU?
   a. Unilateral decision making  
   b. Excellent communication  
   c. Culturally insensitive view  
   d. Emotional lability

5. At which of the following stages of transfer from the ICU do insurance issues need to be resolved?
   a. Requesting to leave the unit  
   b. Discussion about leaving the unit  
   c. Leaving the unit  
   d. Discussion after leaving the unit

6. At which of the following stages of transfer from the ICU does confirming the ambulance transport occur?
   a. Requesting to leave the unit  
   b. Discussion about leaving the unit  
   c. Leaving the unit  
   d. Discussion after leaving the unit

7. Which of the following conditions would enable a palliative care patient in the ICU who wishes to go home to die to be included in the Going Home Initiative?
   a. Receiving continuous mechanical ventilation  
   b. Having a family that could provide 24-hour care at home  
   c. Receiving continuous intravenous analgesia  
   d. Receiving titrated vasoactive drugs

8. Which of the following was the most common diagnosis for the patients in the Going Home Initiative?
   a. Hypotension  
   b. Stroke  
   c. Pancreatitis  
   d. Respiratory failure

9. Which of the following is an obstacle to going home to die?
   a. Unstable hemodynamics  
   b. Family in agreement with the plan  
   c. Community resources in place  
   d. Family available for 24-hour care

10. According to the palliative care going home algorithm, the multidisciplinary palliative care committee should review the data during which of the following phases?
    a. Working phase  
    b. Day of transfer  
    c. After transfer phase

11. What benefit did the hospital realize by instituting the Going Home Initiative?
    a. Decreased length of stay in the ICU  
    b. Increased hospice revenue  
    c. Increased transport ventilator equipment

Test answers: Mark only one box for your answer to each question. You may photocopy this form.

1. q a  2. q a  3. q a  4. q a  5. q a  6. q a  7. q a  8. q a  9. q a  10. q a  11. q a

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