Deactivation of implantable cardioverter defibrillators towards the end of life

NELFT Policy Updated July 2020.

Developed from the national British Heart Foundation guidelines issued in March 2015

A partnership initiative with

Adapted for local use by

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Document Control Sheet

Procedure/Guideline title	Deactivation of implantable cardioverter defibrillators towards the end of life Includes Protocol for the Emergency Deactivation of an Implantable Cardiovertor Defibrillator (ICD) for terminally ill patients in the community who are too ill to return to hospital for the procedure			
Procedure/Guideline number	[leave blank]			
Assurance statement	NELFT as a Trust is committed in meeting its governance arrangements in running an efficient service. Assurance is given that patients will receive appropriate care and support in the community when they are coming to the end of life with an ICD in situ in the community			
Target audience (document relevant to)	Community Nursing staff, Heart Failure nurse specialists, Palliative Care nurse and medical specialists, General Practitioners Also relevant to hospice and care home staff Local hospitals will have their own policy, which includes thinking ahead, planning for future care including			
Links to other policies/guidelines	Advance Decision to Refuse Treatment and Advance Statement Policy Consent to examination and treatment policy			
Version control	Status	Version	Approval date	Review date
	Draft	1		

Deactivation of implantable cardioverter defibrillators towards the end of life

Introduction

Implantable cardioverter defibrillators (ICDs) can prolong life by terminating life-threatening cardiac arrhythmia (ventricular fibrillation [VF] and ventricular tachycardia [VT] in people at risk of cardiac arrest and sudden death. Some episodes of VT may be interrupted by the device delivering a burst of rapid pacing to the heart, but termination of VF and of some episodes of VT requires delivery of an electric shock to the heart.

Most ICDs also function as a pacemaker that will maintain heart rate in the event of spontaneous bradycardia. Some ICDs are combined as a single device with a biventricular pacemaker, used to synchronise contraction of the left and right ventricles (cardiac resynchronisation therapy [CRT]) and thereby reduce symptoms in some people with heart failure. These are referred to as CRT-D devices. The pacemaker and ICD functions of every device are programmable independently of each other. More recently a Subcutaneous Implantable Cardioverter Defibrillator (S-ICD) has been developed, which electrodes are placed just under the skin and not in the heart

As the indications for ICD implantation have expanded, the number of people with ICDs has increased progressively. As a result, more people have survived longer with ICDs and some of those people approach the end of their life, either due to progression of their heart disease to an advanced stage (usually advanced heart failure) or due to development of another irreversible terminal condition. Providing such a person with high-quality end-of-life care and allowing them a dignified death requires consideration and discussion of deactivation of the shock function of their ICD. When the ICD is not deactivated in this way the person may receive multiple painful or distressing shocks from the device during the last hours or days of their life. In some instances the device may delay the person's natural death with shock delivery that the patient would not have chosen to receive if they had been given a chance to discuss deactivation.

The purpose of this document

This document is provided as a guide for healthcare professionals caring for a person who is approaching the end of their life with an active ICD. It aims:

1. To promote high-quality care of patients who are approaching the end of life with an ICD in place by avoiding unwanted prolongation of life and the unnecessary distress that ICD shock therapy can cause in this setting
2. To outline the circumstances in which ICD deactivation should be considered and/or carried out as part of end-of-life care
3. To highlight the need for all doctors, physiologists, nurses and other healthcare professionals to consider and discuss ICD deactivation at the most appropriate time, preferably prior to a crisis situation
4. To explain the relationship between decisions to deactivate an ICD and anticipatory decisions about whether or not to attempt cardiopulmonary resuscitation (CPR)
5. To outline what to do when a patient with an ICD requires deactivation of their device
6. To promote and guide good communication and documentation in relation to discussions and decisions to deactivate an ICD.

Deactivation (and later reactivation) of an ICD may be needed in other clinical settings (e.g. during operations and other procedures). This document does not address those indications.

When to consider and discuss ICD deactivation

When people are approaching the end of their life their priorities for their care and treatment often change. The General Medical Council (GMC) recommends that people are given the opportunity to plan aspects of their care in accordance with their needs and preferences. In general it is recommended that such advance care planning be considered during the last year of life. However the variable certainty with which prognosis can be predicted accurately must be recognised, so that support is provided to patients and those close to them to help them deal with that uncertainty.

For people with ICDs (including cardiac resynchronisation therapy-defibrillator [CRT-D] devices) who are approaching the end of their life advance care planning should include opportunities to discuss their wishes in relation to deactivation of the shock function of their device. If attempted prolongation of their life by their device is no longer appropriate or a priority for them, deactivation of the shock function may spare them (and those close to them) the distress and indignity of ICD shocks that have no useful purpose.

In the majority of people approaching the end of life consideration of ICD deactivation should take place at a time that allows planned deactivation for those who want it. The objective should be to avoid a person entering their last few weeks or months of life, even acutely or unexpectedly, without a care plan or without their views about device deactivation being known. Whenever possible, this should be anticipated and undertaken by the healthcare team that knows the person and not left, for example, to a hospital acute admission team.

Explaining and deciding about ICD deactivation

Obtaining consent from a person for treatment requires provision to that person of sufficient, intelligible information to allow them to make an informed choice. The possibility of a later need to deactivate an ICD and the reasons for doing so should usually be explained as part of the informed consent process prior to implantation in anyone considering an ICD or CRT-D device. The extent of information and explanation about deactivation needed will vary on an individual basis. In exceptional circumstances the clinician seeking consent may consider that providing information and explanation about future deactivation may cause harm, in which case the withholding of information and the reason for it should be documented carefully.

Decisions about deactivation of any device should be shared decisions, with full involvement of the person themselves and of the healthcare team caring for them, and must be based on careful assessment of a person's individual circumstances at the time. People should be given all the information that they need, both by verbal explanation and using written or other media, to allow them to participate fully in shared decision-making. Discussion of deactivation of an ICD as part of end-of-life care should allow ample time and opportunities for explanation and for an agreed, shared decision when the patient is ready to make it.

When people lack capacity decisions must be made in their best interests, must be made according to the law in that jurisdiction and must involve those with legal power to make decisions on behalf of the person. The views of those close to the patient should be considered when making a best interest decision in such circumstances.

Some important points to explain to people about ICD deactivation

Deactivating your ICD will not cause death

Once your ICD has been deactivated if you have a heart rhythm change that could cause death your ICD will not deliver treatment for it

Deactivating the shock function of your ICD does not deactivate its pacemaker function

Deactivating your ICD will be painless

Near the end of your life your ICD may deliver shocks that are painful and distressing and are of no benefit

If your condition improves unexpectedly or you change your mind the ICD can be reactivated

It is best to think and decide about ICD deactivation in advance rather than in a crisis.

Who should discuss deactivation?

The person who initiates a discussion will often be a healthcare professional closely involved in the person's care, who knows them and their clinical and home circumstances. Helping patients with end-of-life care plans is always a sensitive process and requires healthcare professionals to be competent in undertaking such discussions.

It may be necessary to involve several members of the healthcare team and to have serial discussions with patients and those close to them before reaching a shared decision with which they are comfortable. The appropriate members of the healthcare team to contribute to this will vary. In the vast majority of cases in which deactivation of a device is considered during life the consultant or senior clinician responsible for management of the patient's device should be involved in the decision-making process but the degree of that involvement or its delegation will vary according to individual circumstances.

Depending on individual circumstances the healthcare professionals who initiate and undertake these discussions or provide support and information to patients and those close to them may include:

- cardiologists
- heart failure specialist nurses
- arrhythmia specialist nurses
- cardiac physiologists (especially those involved in device management)
- general practitioners
- non-cardiologist physicians or surgeons
- palliative care doctors or specialist nurses

Planned ICD deactivation

Planned deactivation (usually by a cardiac devices physiologist) should be the aim in the majority of people who require ICD deactivation. This is performed using the programmer that most patients will be familiar with from their routine review visits to the ICD clinic. It is a non-invasive and totally painless procedure that takes only a few minutes.

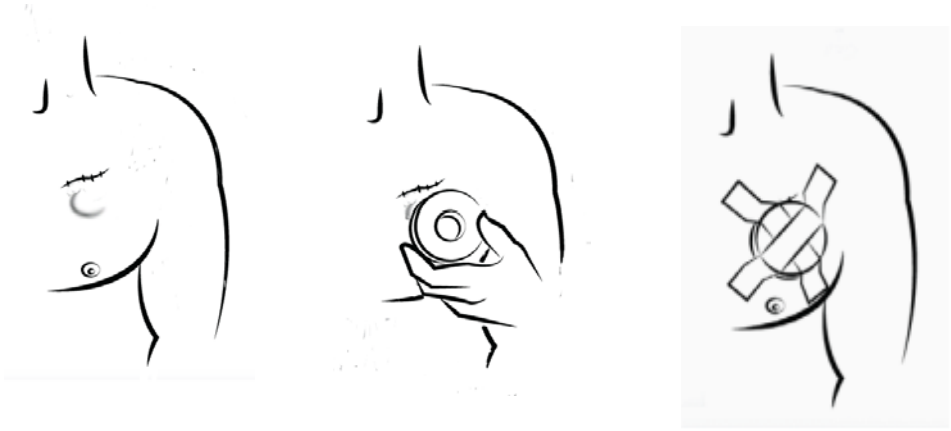
Some patients believe incorrectly that deactivation of the shock function of their ICD will cause their immediate death. It is important that they (and those close to them) understand that this is not the case, but that their ICD will no longer deliver shocks to treat a dangerous

heart rhythm that could cause their death. It is also important that they understand that their ICD can be reactivated (using a programmer in an equally simple and non-invasive way), should their condition improve unexpectedly or should they change their mind.

Whenever possible, planned deactivation is performed in the ICD department/clinic, usually during an outpatient visit, but if the patient is for any reason unable to attend the clinic it should be possible to arrange for deactivation in another setting, including their home. Where such arrangements are needed they should be planned with the ICD team. A flow chart for planned ICD deactivation is shown on page 7.

Emergency ICD deactivation

Situations may arise in which a patient is terminally ill, sometimes due to a sudden catastrophic event or sometimes where the question of deactivation has not been considered or determined in advance. In such situations, if urgent deactivation by a cardiac physiologist using a programmer cannot be arranged immediately, the ICD can be deactivated (after discussion and careful consideration of its consequences) by taping a ring magnet securely on the skin overlying the device.



Check your device. Locate a magnet.

Do be aware that it is not uncommon for people to confuse ICDs with pacemakers. Contact the patient's implantation centre (the place where the device was implanted and which conducts periodic reviews) to check the nature of the device/whether it is an ICD, and what type.

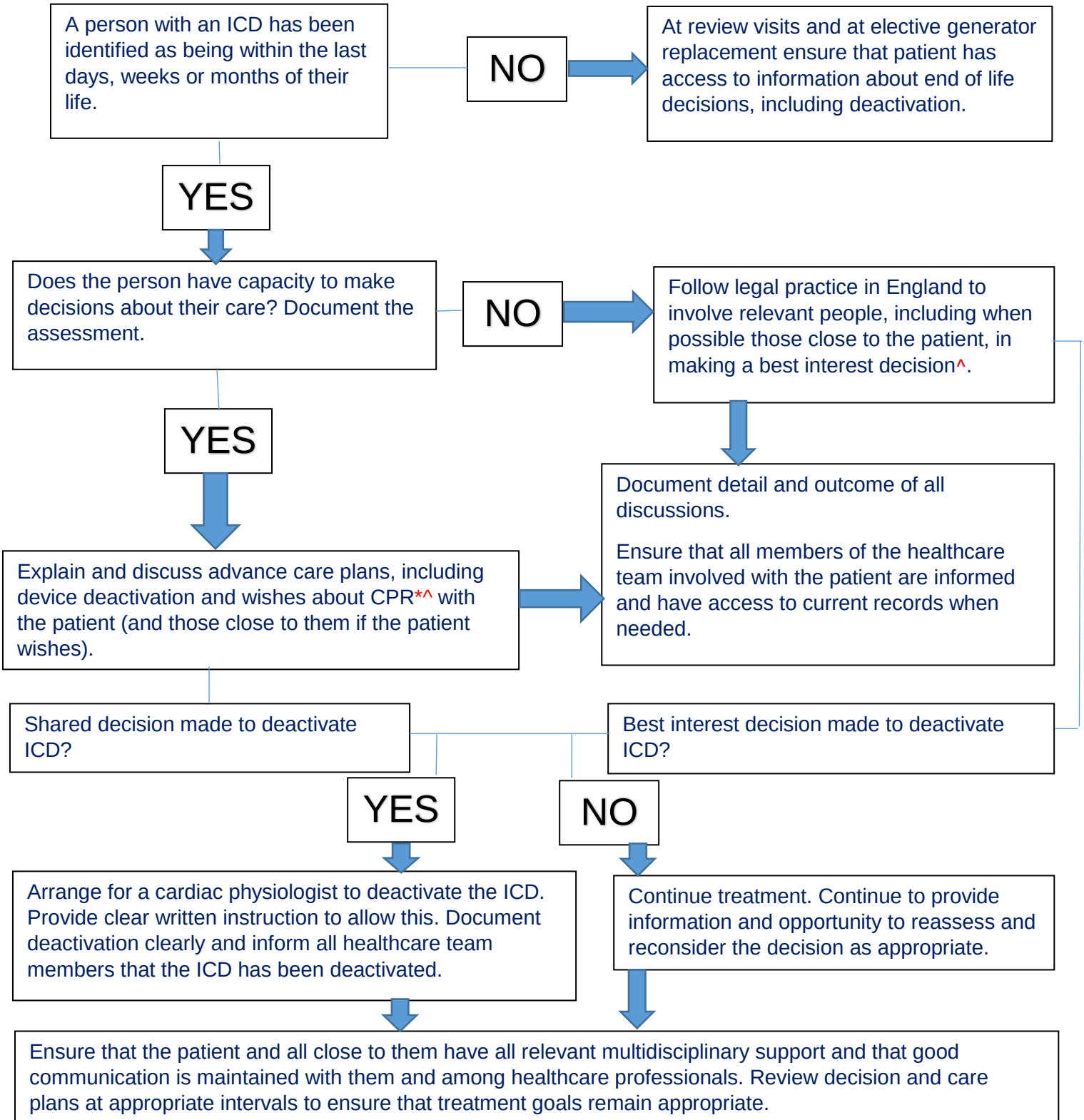
Devices from one manufacturer (Biotronik) will be inhibited by a magnet for only 8 hours, so with a Biotronik device (or if the manufacturer is unknown) the magnet must be removed for a few seconds and then reapplied every 7 hours. When a magnet is used for emergency deactivation, arrangements should be made as soon as is practicable for definitive deactivation, using a programmer.

Magnets for use in this way are available from the following places:

- in hospital departments such as Emergency Departments, Cardiology Departments and Cardiac Care Units
- In the community, at our local hospices – all happy to lend out
- In hub District Nurse centres.

A flow chart for emergency ICD deactivation is shown on page 8.

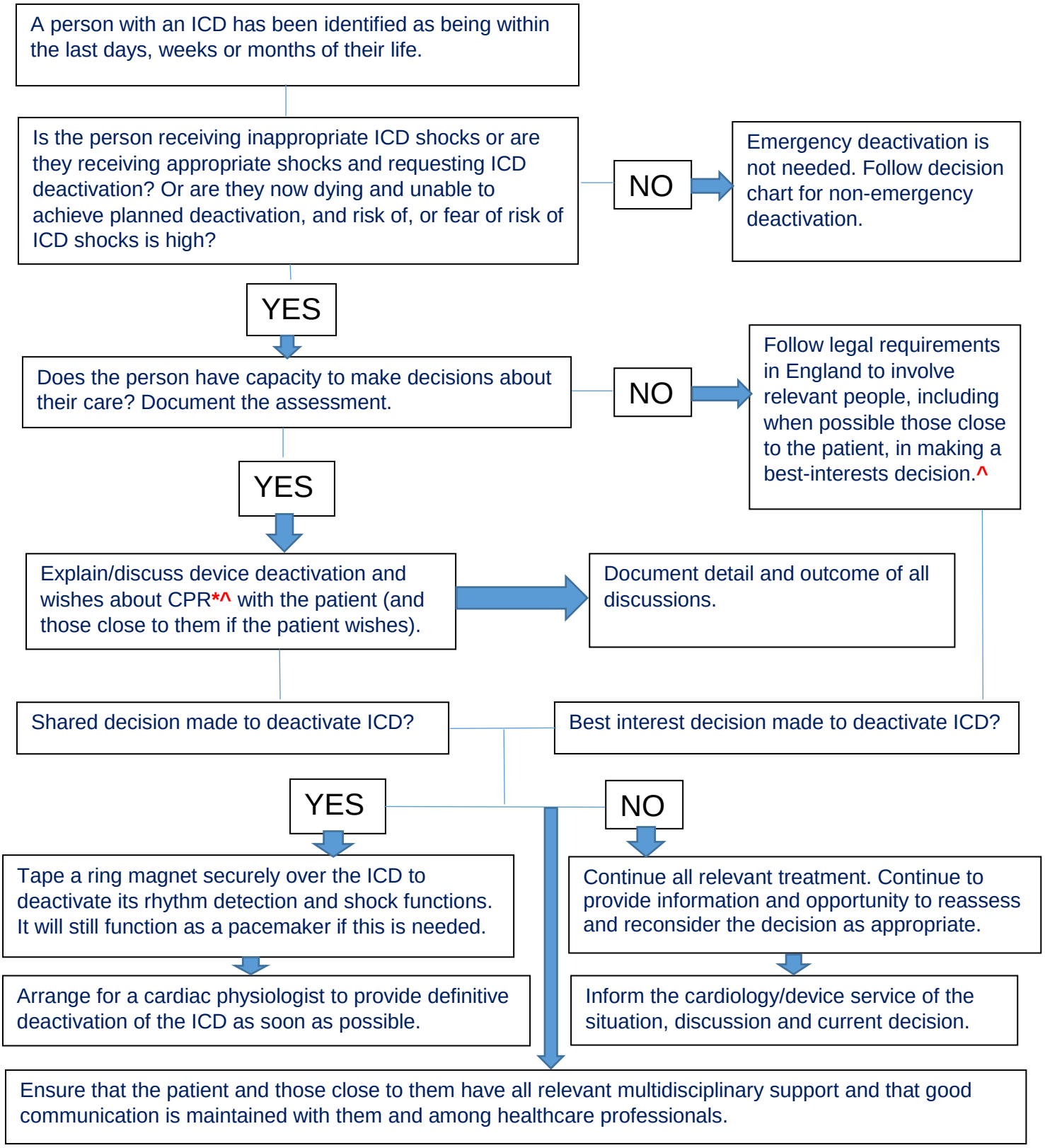
Decision chart for ICD deactivation towards the end of a person's life



* A DNACPR decision does not automatically warrant ICD deactivation and vice versa.

^ See 'Cardiovascular Implantable Electronic Devices in people towards the End of Life, during Cardiopulmonary Resuscitation and after Death' and 'Decisions relating to Cardiopulmonary Resuscitation' www.resus.org.uk

Decision chart for emergency deactivation



* A DNACPR decision does not automatically warrant ICD deactivation and vice versa.
^ See “Cardiovascular Implanted Electronic Devices in people towards the End of Life, during Cardiopulmonary Resuscitation and after Death” and “Decisions relating to Cardiopulmonary Resuscitation” www.resus.org.uk.

Ethical and legal aspects

Consideration of ICD deactivation can raise concerns similar to those associated with the withdrawal of other life-sustaining treatments, such as renal dialysis or mechanical ventilation, or associated with decisions relating to CPR.

Failure to give people information about their treatment choices breaches their human rights and breaches a fundamental principle of ethics, namely autonomy. Decisions about a person's treatment (including device implantation or deactivation) should be made jointly with any patient with capacity, following explanation of the balance of risks and benefits.

As people approach the end of their lives, especially if this is the first time that deactivation has been raised, such discussions are sensitive and often difficult for patients, for those close to patients and for healthcare professionals. This is not a valid reason to avoid discussions about these important decisions.

If a person with capacity requests withdrawal of treatment, despite being fully informed of the likely consequences, healthcare professionals must comply with that request, even when they consider the request unwise or illogical or when the withdrawal of treatment is contrary to medical advice,. Should an individual healthcare professional be unwilling to take action where there is a properly established decision to deactivate an ICD, it will be necessary to identify another healthcare professional to carry out deactivation.

Some people may be concerned that ICD deactivation could be interpreted as a form of assisted dying, and as analogous to voluntary euthanasia or assisted suicide. That is not the case. Voluntary euthanasia and assisted suicide each involve an active intervention that in itself causes the person's death. The courts have confirmed that, when death follows withdrawal of treatment, the person's underlying condition is deemed the cause of death. Such withdrawal will be lawful, provided that it follows from the person's competent refusal of treatment or, alternatively, is in his or her best interests. In such situations, the healthcare professionals are released from any duty to provide treatment.

Decisions about ICD deactivation and decisions about CPR

Decisions to deactivate an ICD and decisions about CPR attempts in the event of cardiorespiratory arrest are not the same. An assumption that having a DNACPR decision or being identified as dying automatically warrants ICD deactivation, or that ICD deactivation automatically warrants a DNACPR decision in every person is unethical. All decisions must be based on careful assessment of each individual situation.

In most cases, if there is an agreed decision with a patient or their representative that ICD shocks would present more burden than benefit, the same decision will be made about CPR, given that it is more traumatic and invasive, with less likelihood of a successful outcome. If it has not occurred already a DNACPR decision should be discussed at the same time as discussion of ICD deactivation. However, there may be occasional situations in which a person nearing the end of life will wish to be considered for CPR despite choosing to have their ICD deactivated, or having their ICD deactivated because it is delivering inappropriate shocks in the absence of ventricular arrhythmia.

Some healthcare professionals express a view that a DNACPR decision always implies that an ICD should be deactivated. For people with an ICD, a DNACPR decision or the recognition that they might be dying should trigger a discussion about ICD deactivation. However, some people choose not to have CPR attempted because of its trauma or relatively low probability of success, but wish to continue to receive treatment from their ICD for shockable ventricular arrhythmia. These choices must be respected and kept under review with the opportunity for decisions to be changed as the person's condition progresses.

Communication, documentation and care co-ordination

These are essential components of good medical practice. Failures of communication and documentation are common causes of complaint and litigation.

Good communication with patients and those close to patients should include provision of explanation and information, checking that these have been understood and answering any questions that people wish to ask.

Good communication among all members of the healthcare team (including usually the GP, the cardiology team and the palliative care team, and often other disciplines) as well as with the patient and those close to them is crucial to delivery of clear and consistent information and advice and ensuring that decisions are agreed and understood by all.

Details of discussions about ICD deactivation should be documented clearly in the person's health record. When an agreed decision is made to deactivate an ICD that decision and the reasons for it should be documented clearly. Documentation must provide all the information that the person (usually a device physiologist) who will carry out deactivation needs. An example of a form that may be used to achieve this is shown on page 10.

When an ICD has been deactivated it is crucial that this is documented clearly and communicated to all those who may need to know.

People with ICDs should carry with them current information about their device and, if it has been deactivated, this should be recorded clearly.

Further reading

Resuscitation Council (UK), British Cardiovascular Society & National Council for Palliative Care 2014. *Cardiovascular implanted electronic devices in people towards the end of life, during cardiopulmonary resuscitation and after death.* Available at: www.resus.org.uk, www.bcs.com and www.ncpc.org.uk.

General Medical Council 2008. *Consent: patients and doctors making decisions together.* Available at: www.gmc-uk.org/publications/standards_guidance_for_doctors.asp.
General Medical Council 2010. *Treatment and care towards the end of life: good practice in decision making.* Available at:
www.gmc-uk.org/publications/standards_guidance_for_doctors.asp.
The National Council for Palliative Care, Dying Matters and the British Heart Foundation 2014. *Difficult Conversations. Making it easier to talk to people with heart failure about the end of life.* www.ncpc.org.uk/sites/default/files/Difficult_Conversations_Heart_Failure_WEB.pdf

Appendix 1 – Deactivation Centre

Appendix 2 - Request for Deactivation of Implanted Cardioverter Defibrillator (ICD, SICD & CRT-D)

Appendix 3 – Mental Capacity Assessment and documentation

Appendix 4 – Care after death

Appendix 5 - Covid 19: additional service

Contact details of ICD centres to arrange deactivation

Planned ICD deactivation is done by a specialist cardiac physiologist placing a small communicating device attached to a programmer, over the ICD implant site (commonly in the left pectoral region), which deactivates the ICD within minutes. This is carried out at the ICD centres listed below. All patients should have a card/leaflet with details of their ICD, including the manufacturer and the hospital at which it was implanted. ICD deactivation should ideally be scheduled at the hospital where the ICD was implanted, but if this is impractical it can be carried out at King George Hospital and Queens Hospital. Have this information available before you call. Where implant details are not known, contact the hospital most conveniently located listed below:

BHR Hospitals
Queen's Reception - 01708 435497
Email - bhrut.queensheartrhythmdevices@nhs.net
King George Hospital
Reception – 020 8970 8254

St. Bartholomew's Hospital Reception – 020 3465 5855
Remote clinic room – 020 3465 6086 or 7083
Inpatient physiologist – 020 3765 8917 (try other numbers first)
Email - BHNT.bartscardiacdevices@nhs.net (will be changing soon)
Out of Hours – EP reg - 07810 878450

Basildon Hospital Reception – 01268 394516
Urgent Physiologist 01268 524900 bleep 6140 (Monday-Friday 9-5)
Email - btu-tr.essexcrm@nhs.net
Safe haven fax - 01268 394150, contact department to inform that fax is on its way and to confirm arrival
Out of Hours – EP reg - 01268 524900 bleep 9010

Guys and St. Thomas Hospital
Physiologist – 020 7401 9249
Email - gst-tr.cardheartdevices@nhs.net
Out of hours - EP reg - 020 7188 7188 Bleep 0100

Broomfield Hospital
Department - 01245 514185
It is possible to arrange deactivation for community patients who are able to travel to the local hospital by prior arrangement during normal working hours, but regrettably, we are currently unable to offer ICD deactivation in the patient's home.
Exceptionally during Covid times we may sometimes be able to arrange deactivation at home/in the hospice (see App 6).

Request for Deactivation of Implanted Cardioverter Defibrillator (ICD, SICD & CRT-D) for patients with capacity

P1 of 2

Full Patient Name			
Address			
		Postcode	
Date of Birth		NHS Number	
GP Details			
		Postcode	
REASON FOR DEACTIVATION REQUEST			
CLINICIAN REQUESTING DEACTIVATION			
Name			
Signature			
Date			
SENIOR CLINICIAN CONFIRMING AUTHORISING DEACTIVATION REQUEST (must be Consultant or GP)			
Name			
Signature			
Date			
Either		or	
Patients with capacity		Patients without capacity (see App 3 for capacity assessment)	
I understand the reasons for deactivating the ICD. I agree to the deactivation of the ICD. I understand that the decision to deactivate can be reviewed if necessary.			
Name		Name	
Signature		Signature	
		Relationship	
Date		Date	

Full Patient Name	

Date and time device of deactivation	
Any treatment that remains active?	

Name & Signature of health care professional deactivating the device

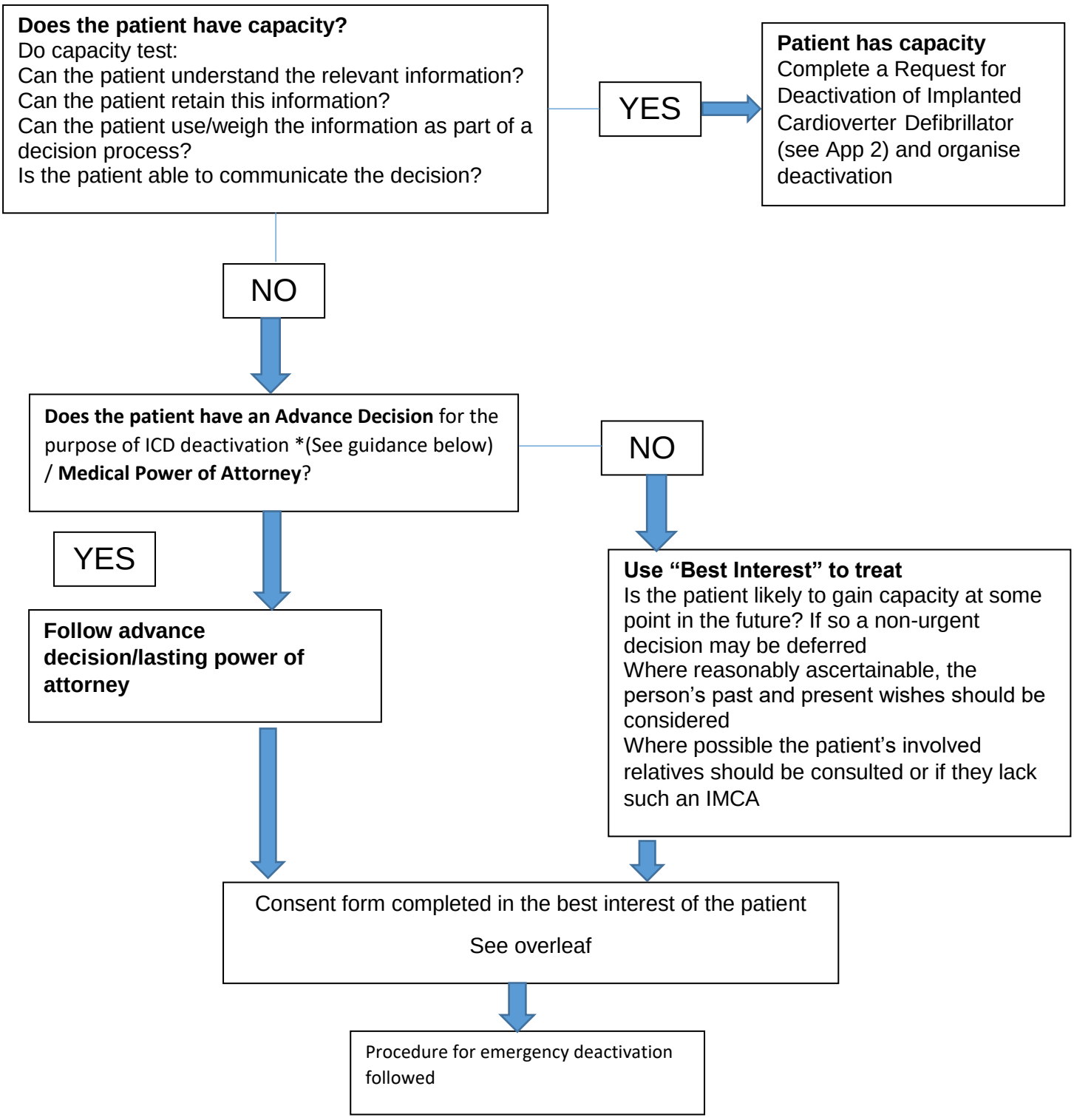
Name	
Signature	

Any Other Comments?	

Adapted from the ICD De-activation Policy developed by Surrey Cardiac Physiologists' Network, Western Sussex Hospitals NHS Trust,
and the Arrhythmia & Sudden Cardiac Death Working Group, and the Arrhythmia Alliance ICD deactivation leaflet www.arrhythmiaalliance.org.uk

Mental Capacity Assessment/documentation

(in practice likely only to be relevant to emergency deactivation)



Guidance for Advance Decisions to Refuse Treatment (ADRT) and Advance Statements and ICD deactivation

1 A valid ADRT can only be made by someone if: they have reached the age of 18; they have the capacity to make decisions relevant to the ADRT at the time it is made. If the ADRT applies to life-saving treatment it must also be in writing, signed and witnessed. It takes effect should the patient subsequently lack capacity. As such it is legally binding on a clinical team and must be followed unless there is explicit legal advice to the contrary.

2 An Advance Statement, unlike an ADRT, is not legally binding. It is a statement of medical preferences and should be taken account by doctors and other professionals when making a treatment decision.

3 Because ADRTs only apply to refusals of treatment they do not apply to decisions to deactivate an ICD, which is a withdrawal of treatment. In other words a patient cannot make a valid and legally binding ADRT to refuse to allow an ICD to be deactivated. If they could it would amount to a legally binding decision to have a treatment continued against clinical advice, which is not allowed in law.

4 It is possible that a patient may make an Advance Statement relating to an ICD. This is likely to be to say that in the event of being near the end of life they would like the ICD to be deactivated. Although not legally binding this is likely to confirm for the clinical team that the ICD should be deactivated.

5 It can sometimes be uncertain whether there is an ADRT or Advance Statement, or if so, whether it is legally valid or not. If there is any doubt immediately necessary treatment should be given to an incapable patient in their best interests whilst legal advice is sought.

If emergency deactivation is taking place at a weekend bank holiday or evening by a community staff nurse, the senior nurse on duty needs to be notified and involved in the deactivation.

Form overleaf.

Form for Deactivation of Implanted Cardioverter Defibrillator (ICD)

For patients who have lost capacity and can no longer contribute to the discussion of deactivation.

Full Patient Name .....Date of Birth……..

Address .....
.....
.....

GP Details .....
……
……..

Date/Time of request .....

Address patient is currently located at .....
.....
.....

Reason for request .....
.....
.....
.....

AUTHORISATION
Signature of authorising Consultant/Physician

.....

Best Interest Decisions
I understand the reasons for deactivating the ICD and that the decision to deactivate can be reviewed if necessary. I agree to the deactivation of the ICD.

Signature of patient carer/relative/next of kin/lasting power of attorney for health and wellbeing
.....

Date and time device is deactivated .....

Any treatment that remains active? .....
.....
.....

Signature of health care professional deactivating the device
.....

Any Other Comments.....
.....

Adapted from the ICD De-activation Policy developed by Surrey Cardiac Physiologists' Network, Western Sussex Hospital

Care after death

All ICDs deactivated using a magnet will require subsequent deactivation by a cardiac physiologist using a programmer prior to post mortem and burial or cremation. The ICD will also need to be removed prior to cremation (automatically done by the funeral home / undertaker).

1. Remove the magnet once death is certified and return to centre.

2. Inform the funeral home or mortician of the ICD status (whether or not it has been turned off). This must be noted in your death records book. Early notice to them will minimise delays in the funeral arrangements as post mortem and burial cannot be arranged until the ICD has been deactivated permanently. If the deceased person is to be cremated, the funeral home will remove the ICD beforehand as per standard practice.

3. Supply a Request for Deactivation of ICD Form if the ICD is still active (Appendix 2). This to help the funeral home/mortician team. Either the deceased person's next of kin or the funeral home can complete this form however, it will be more appropriate and less distressing for the funeral home to complete it, provided that they have access to the appropriate information contained on the patient's ICD ID card. Help them with any detail you can supply.

Ideally you will contact the implantation centre to let them know that death has occurred.

Contact your local ICD Centre (Appendix 1) should you need further guidance or have questions.

Appendix 5

Out of Hospital ICD deactivation during Covid-19

Under normal circumstances, patients in the community who need to have their ICD deactivated would be asked to attend one of the two hospitals in the trust.

There will be a need for patients to be seen in the community for this to be done, and therefore we need to put measures into place to ensure that this is safe for staff and patients.

Regardless of where the request comes from before the ICD can be deactivated the patient must have the following completed

- DNACPR form
- ICD deactivation form must also be completed. If needed email the GP/community team the hospital policy, the form is on page 14.

Guidance for anyone organising or undertaking a visit

The physiologist role is to carry out the deactivation and provide any technical information and advice that is required. The other health care professional meeting you at any location should be someone who knows the patient, their role in the visit is to support the patient and needs to be in a position to resolve any questions or issues the patient and their relatives may have.

Try and arrange any visits within normal working hours where this is not possible it should be completed as close to 9am or 5pm as possible.

- At least one senior member of staff within cardiology needs to know
    - The name of the patient you are visiting
    - The exact location of where you are going
        - Any changes with this needs to be reported back prior to visiting the patient
    - A mobile telephone for the member of staff undertaking the visit
- The member of staff undertaking the visit must have
    - A contact number/mobile number of at least one senior member of staff
    - Contact details/mobile number for the HCP they are meeting with
    - The name of the patient
    - The exact location of where the patient is
    - Appropriate PPE to take with them/ appropriate PPE on site for them to use
    - If they do not drive – Taxi to and from the venue needs to be arranged
    - Should not enter the home without the other health care professional or ensuring that they are already within the home. i.e. District Nurse, GP, Specialists Palliative Care Team CNS/RGN/Dr, Community Matron, Community Cardiac Nurse
- Check where any report should be sent to
    - Write on Solus
    - Record where the deactivation took place
    - Email the follow up hospital as we normally do
    - Email the GP/Hospice/ community team to update their records and Coordinate My Care (CMC) as appropriate
    - Don’t forget to record in the diary and the audit sheet please

Locations

Community patients (includes nursing/care homes)

We may also receive calls from the GP, community Matrons or our community HF colleagues.

Patient is able to travel

Is there a healthcare building (i.e. GP surgery) that is suitable for the patient to attend?

If so arrange to meet the patient here with another healthcare professional i.e. GP

Most places have staff parking, ensure that there is somewhere for you to park.

Patient is unable to travel

We will need to visit the patient at their home address, this makes ensuring that there is another HCP that can support the patient and their family whilst we are there even more important.

- Please ensure that you have all the relevant information as above
- Check if car parking is available
- Do not enter premises alone
- Ensure your senior member of staff is aware when you are going into the home and contact them again once you have left.

Hospice patients

Saint Francis hospice has a robust ICD deactivation policy and we have good communication links with them. The call for ICD deactivation may come from one of the consultants or from a nurse specialist.

Inpatients

- Arrange a time and to carry out the deactivation
- Make sure you know the location
- Sign in at the front desk
- Car parking is on site and is free

Outpatients

- If patient is well enough to travel to the Hospice arrange for a time and location to arrange for deactivation, another member of staff known to the patient should be with you.
- If the patient is not well enough then follow the guidance for the community.
- Check if car parking is available
- Do not enter premises alone
- Ensure your senior member of staff is aware when you are going into the home and contact them again once you have left.