INSERT LOGO

TO BE COMPLETED BY ICU TEAM

Affix patient sticker here

Hospital admission date: _____

Date of assessment: _____

Time of assessment: _____

Assessment number_____ *(for repeat assessments)*

Critical Care: Decision-support Form

This form can be used to guide and record the decision-making process regarding the critical care support a critically ill patient should receive. It is designed to support best practice in decision-making.

Evidence*: Clinical* *(factors in patient's acute condition and long term health relevant to decision about escalating treatment)*

Evidence: Ability to recover from this critical illness based on evidence *(e.g: functional reserve, trajectory of illness, exercise capacity, dependence, self-reported QoL, frailty score)*

Evidence: Patient values and wishes *(what is important to the patient with regard to their treatment and the potential outcomes? Please note ReSPECT form/advance decision to refuse treatment if available.) If no information is available please say why.*

Please document source of this information:(patient, family or someone close to patient, advance care plan etc)

_____

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Developed in conjunction with University Hospitals Coventry and Warwickshire NHS Trust

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Balancing burdens and benefits of escalating treatment (based on the evidence in section one)

Benefits of intensive escalation of treatment for this patient *(what good may be achieved and what harms avoided? How likely is this?)*

Burdens of intensive escalation of care for this patient *(what harms are likely to occur due to escalating care)*

Recommended treatment *(summary of goals and focus of care, and actual therapy patient is to receive)*

Can this care safely be delivered outside ICU/HDU?

☐ Care required can only be delivered on ICU/HDU

☐ Care required can be delivered outside ICU/HDU and resources are available to do this safely

☐ Care required could be delivered outside ICU/HDU but resources are not available to do this safely

Arrangements for ongoing care/review

☐ Patient will be admitted to ICU/HDU.

☐ Patient to stay on ward with ongoing ICU or critical care outreach review.

☐ Patient to stay on ward. If patient's condition changes and further advice is required please contact ICU team.

Individuals contributing to decision-making

Patient *(please state if no involvement and reason for this)*: _____

Person close to patient: _____

Name: _____

Relationship to patient: _____

Nature of involvement: _____

ICU team

Name: _____ Signature: _____

Role: _____ GMC number: _____

Referring team

Name: _____ Signature: _____

Role: _____ GMC number: _____

Further information available: see notes entry dated: _____

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