Decision-making for ICU admissions
Trust training

Decision-making "table-top" simulation case.

Notes for trainers

This simulated case is provided to allow an in-depth worked example of the decision-support framework in practice.

To run this simulation you will need the following:

1. A copy of these notes
2. Completed referral form (an example copy is provided)
3. The summary of clinical records sheet
4. A copy of the additional information: this should not be haned out to the trainees: it is to provide information which is only given when specifically asked for.

The referral form is completed with only a bare minimum of information. This is to prompt thorough gathering of evidence and highlight the importance of all parts of the process in decision-making.

Running the session:

Distribute the referral form to group members and explain the following:

> **You have asked to see a patient on ward "X". The telephone referral is that this is an 81 year old man with a pneumonia who now has a low blood pressure. The referring junior doctor (a medical FY2) has asked for a review.**

Now provide the following information:

> **The hospital is full, with some patients waiting in the emergency department for a bed. There are no ICU beds immediately available: One bed may become available later if a ward bed can be found for a patient ready to be discharged. The ward the patient is currently on is well staffed by experienced staff (not agency staff); Critical care outreach is available 24 hours a day.**

Ask the group the following:

> **You attend the ward and locate the patient. Describe what you would do next.**

When the clinical records are mentioned provide the group with the summary of clinical records sheet. Explain the following:

A summary of the patient's case has been made by one of the medical junior doctors. There is no significant additional information available on the electronic records that is not here.

Once the group has read through the summary of clinical records and discussed the contents a little, ask them what they would do next:

So what do you want to do?

If necessary prompt the group towards discussing with the patient and his son in order to get more information and elicit the patient's wishes. Use the "additional information sheet" to provide information as requested by the group.

Once the group have gathered all the relevant information from the patient and his son, as well as the clinical record ask them to use the form to come to a decision regarding treatment for this man.

Ask the group to talk through their decision-making with reference to the form and the process they have used.

Summary of Clinical Records

81 year old man Referral from GP ?pneumonia.
Admitted yesterday, now on an acute medical ward.

Presenting complaint: Referred after a home visit from his GP due to breathlessness
Cough productive of brownish sputum.
Feeling hot and cold.
Poor appetite.

Past med history: Osteo-arthritis,
Hypertension,
THR 3 months ago: bleeding ++, pain ++. Prolonged rehab, pain team referrals (now on regular MST).
Discharged from rehab ward 3 weeks ago.
Weight loss since surgery: seeing community dietician

Social history: Retired
Lives with his wife, (PD)
Carers b.d.
Plays golf regularly. Decreased mobility since op. ground floor of house only.

Medication on admission: Bendroflumethiazide
Simvastation
Ramipril
Ensure
Paracetamol
MST
Oramorph
(NKDA)

On Examination: CVS: Shut down
Heart sounds are normal,
JVP not raised.
Resp: Creps at left base
Brown phlegm.
Abdo: abdomen soft, non-tender
No organomegaly or masses.
BS: +

Admission bloods: CRP: 122,
WCC: 18.0, Hb: 122, plt: 450.
Na: 122, K: 3.5, BUN: 14, Creatinine: 208
(4 weeks ago: BUN: 5mmol/l, Cr: 81micomol/l).
Other blood results are in normal limits.

Chest X-ray: Patchy consolidation at the left base.

Diagnosis: CAP + AKI

Rx: iv fluids (4000ml 0.9% saline in last 12 hours)
Antibiotics (co-amoxiclav 1.2g i.v. t.d.s. Clarithromycin 500mg i.v. b.d.)
Salbutamol nebs

Physiology on admission:
Temperature: 38.0
GCS: 15/15
SpO2 94% FiO2: 0.28 RR: 22
HR: 10 BP: 105/60

Current physiology
Temperature: 38.0
GCS: 14/15 (confused)
SpO2 92% FiO2: 0.6 RR: 27
HR: 105 BP: 90/55
u.o: 20ml/hr

ABG: FiO2: 0.6
pH: 7.31,
PaO2: 8.0
PaCO2: 3.4
lactate: 4.1
BE: -6.0

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Additional information to be provided if asked for by group

Social history:
A retired manager and company director, but prior to that had been in the army. (He was in fact one of the few surviving British veterans of the Korean War). He lives with his wife, who suffers from Parkinson's disease.

Since previous discharge he has been paying for two visits per day of help to look after him and his wife. He is able to walk around the ground floor of his house but cannot walk farther than this. He uses a stair lift to get upstairs. The lift was originally installed for his wife.

Examination:
He appears very thin. His BMI is about 18 (183cm tall, 61.5kg). He appears cold and shut-down, slightly clammy to touch. He is coughing up brownish phlegm.

Information from patient: (limited due to breathlessness and some confusion)
"Don't like the bloody food here"
"I just want to get better and go home"
"Who's at home with my wife?"

Information from family (son):
His wife is increasingly disabled with Parkinson's and memory problems. During the last year he has taken on a lot of care duties for her. He has two children, one of whom lives and works in the USA, his other son lives in Leamington.

He has been in very good health all his life and has found this last month or so difficult; He has "lost a lot of weight". He is still very sharp. He could complete nine holes of golf using a cart prior to THR, and that was just because his hip hurt.

He "can be difficult". "I think he just wants to go home, he hates being in hospital. If he needs more treatment so he can go home he'll be fine with that."

(On being pressed further about what his father would want he says "But he really doesn't like being messed around with. He has hated being this dependent, and if he got worse he'd be miserable")

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Affix patient sticker here

Hospital admission date: 16/03/2017

Date of assessment: 17/03/2017

Time of assessment: 09:30

Critical care Referral form

This form should be used to guide and record referral for critical care support. It is adapted from SBAR, and designed to support best practice in decision-making. It should not replace direct referrals and discussions.

Situation: *(reason for referral)*

81 year old man, left basal pneumonia, AKI
low BP (after 4000ml fluid iv)
Resp. failure.

Background: Patient's medical history and evidence regarding ability to recover from critical illness *(e.g: frailty score, trajectory of illness, physiological reserve, etc.)*

OA, HTN
Recent discharge after THR + rehab
Recent weight loss

Patient's values and wishes: *(What is important to the patient about outcomes of their care) ? Please note any ReSPECT form/ advance decision to refuse treatment.) Please document reasons if no information available.*

Patient confused—son thinks he would want everything done to get home

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

Recommendation

- ☐ To obtain a review to consider admission to ICU/HDU for full or limited organ support
- ☐ To obtain a review but not necessarily to admit to ICU/HDU
- ☐ For assistance with a specific therapy to be delivered outside ICU *(venous access, help with NIV etc. Please specify)*_____
- ☐ To obtain a review to plan care in the event of deterioration
- ☐ Other *(please specify)*_____

Has the patient or a person close to them been given an information sheet regarding referral to intensive care? ☐

Discussed with ICU team member: Name:_____

Role:_____ Date 17/03/2017 time: 09:30

Name:_____ Signature: _____

Role: Locum Registrar GMC number: _____

Discussed with consultant:_____

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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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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: _____