Supporting implementation of NICE Critical Care Guidelines (NG159)
https://www.criticalcarenice.org.uk/patient-information

SUPPORTING CLINICAL DECISION MAKING

As the health service sees increasing numbers of patients presenting with coronavirus it is clear that all parts of the nation’s health service will be under enormous pressure. Patients may potentially deteriorate quickly, and early decisions will need to be made about what treatments they would benefit from, and in which setting they would best be cared for as outlined in NICE 159.

This guidance is intended to bring together resources to support clinicians who are making decisions about care and treatment, and who are having conversations with patients and families in these difficult situations. The guidance is focussed on the following areas:

1. Making decisions around escalation of treatment
2. Involving others in decision-making
3. Supporting good communication with patients and their families

The guidance involves links to resources which may help, and you can adapt for local use. They are not new and have been widely used in the NHS.

MAKING DECISIONS AROUND ESCALATION OF TREATMENT

Making difficult decisions is not a new problem, it is a daily experience for patients, families and doctors every day in the NHS. The process of decision making with patients and families, is a part of Good Medical Practice as defined by the GMC, and is an integral part of determination of best interests as outlined in the Mental Capacity Act. In order to ensure fair access to intensive care during the COVID-19 pandemic, a structured approach should be used to making such decisions.

Resources are only one factor in ethical decisions, and so a transparent process is needed regardless of the extent or lack of resource. Decisions to escalate, limit or withdraw treatments should not be seen in isolation, but as a series of interdependent decisions in a patient’s care. The resources highlighted here seek to achieve this goal. While the contexts maybe different, the following structure should help support both the clinician and patient in decision making, whatever the setting:

1. Ensure you have a shared understanding of what the problems are (e.g Covid is suspected; known heart disease requiring frequent hospital admissions with limited exercise tolerance, this means the patient is at high risk of severe illness and may die).
2. Discuss what the likely outcomes are. Try to help the patient identify which outcomes are most important to them and their family.
3. Be clear about what treatments are being proposed or available. If a treatment is not considered sufficiently beneficial to be offered, this will need communicating carefully and compassionately.

4. Agree the proposed treatment plan and care you will be organising, for example treatment on the ward, treatment on intensive care, or links to palliative care.

5. Include discussion of specific treatments that are important to the patient, e.g CPR.

Following the discussion, ensure that decisions, including CPR, are documented in an easily recognised format (e.g. ReSPECT, TEP, DNACPR plus ACP). This will help guide your fellow clinicians in an emergency situation, and some patients may already have such decisions documented which you should take account of.

INVOVING OTHERS

The conversation above assumes a patient with capacity to be involved in the decisions made. Where the patient lacks capacity, the clinician must try to contact those close to them, where practicable and appropriate, in order to make a decision for the overall benefit of the patient (including contacting a legal welfare proxy if applicable).

Professional guidance recommends important best interests decisions (ICU admission, withdrawal of life sustaining therapies, DNACPR etc) should be shared between at least two senior clinicians. This can be difficult at times of extreme clinical pressure, suggested mechanisms to ensure this can be achieved will be shared here soon.

DECISION MAKING FRAMEWORKS

These frameworks, tools and templates can all be adapted by teams to suit their population, workforce, and the changing circumstances. We will be adding best practice examples and further resources as they are developed and become available.

*Warwick Model*

Developed by the University of Warwick from observed best practice, this model draws on the ethical framework of accountability for reasonableness. It focuses on gathering the right information about the particular situation to inform reasoning and to recommend treatment. It also guides the implementation, communication and on-going review of the patient. Resources are available in the following links and can be adapted for local use:

1. [COVID-19 decision-making e-ICM module available on this site](https://example.com)
2. Decision-making structure: [credit card reminder](https://example.com)
3. Decision-making documentation  
   a. Referral form (information from referrers to help choose best treatment)  
   b. Decision-form (documentation to guide and document escalation decision)  

MORAL Balance  
An ethical framework to support bedside decision making, based on the four pillars of medical ethics, and designed to help clinicians apply them rapidly. Developed as part of NHS Blood and Transplant’s Deceased Donation Course for ICM trainees, but applicable widely. The framework has been taught to more than 300 ICM trainees over five years, and recommended in the FICM’s Care at the End of Life guidelines.  

1. BJA Education Article describing framework & application  
2. BJA Education Podcast, further discussion of application  
3. Website - www.moralbalance.org inc. framework, video lectures and case examples  
4. Documentation template - to help application and documentation  

SUPPORTING GOOD COMMUNICATION WITH PATIENTS AND THEIR FAMILIES  
Clinicians will have conversations with patients in multiple settings: primary care, virtual clinics and during acute admissions. Isolation and illness may mean the patient is without their family, for support and to help advocate their wishes if capacity is lost. Clinical teams may need to use telephone/electronic communication, recognising the conflicts with confidentiality. Organisations should develop local policy for telephone conversations.  

We have suggested some short resources to support good communication practice:  

1. Communication in Acute Settings  
2. ABCDEs of Good Communication  
3. RED MAP guide for professionals  

SUPPORTING PRE-EMPTIVE DECISION-MAKING OUTSIDE ICU  
During the COVID 19 emergency it will be necessary to build confidence and capability in doctors with a wide range of expertise and experience to share decision making. Opportunities should not be missed to gather information and make decisions when patients are able to participate in the process. Patients may deteriorate quickly, and decisions made in an emergency situation can be considerably more difficult. These resources are designed to help teams deliver this:  

The ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process has been developed based on best evidence of how to support conversations and make sure that patients get the treatment that they want and would benefit from. It has been developed with input from clinicians from many
different specialties, patient groups and others, and the support of the Resuscitation Council UK.

The ReSPECT process creates personalised recommendations for a person’s clinical care and treatment in a future emergency in which they are unable to make or express choices. These recommendations are created through conversations between a person, their families, and their health and care professionals to understand what matters to them and what is realistic in terms of their care and treatment.

ReSPECT is designed to be able to cross care settings, working in primary care, and in ward and critical care environments. Draft text for organisation email (can be adapted for local use).

REFERENCES


