ROYAL COLLEGE of PHYSICIANS of EDINBURGH

Evening Medical Update: Hurdles in the High Dependency Unit
Tuesday 29 September 2020

Escalation decisions – when to, when not to – Dr Lewis Gray

Given the increasingly older population, should we start to admit somewhat complex and frail patients to level 2/3? How would we assess their reserves?
Yes. For those with reasonable reserves and reversible illness, age should not be a barrier and level 2 care (increased nursing and medical staff ratios, invasive monitoring, High-flow oxygen therapy) is usually effective and well tolerated.

However – it is worth bearing in mind that the majority of formulae for mortality / morbidity prediction in critical care admissions include age as a factor, and most patients in their 80's and 90's have accumulative comorbidity +/ - frailty.

If unsure – a discussion with HDU, patient, treating team and a trial of therapy (with or without treatment limitations at this stage) may be appropriate.

If a medical consultant cannot make a decision regarding escalation due to reasons such as patient and family choices – how useful will it be to get an opinion from ICU?
Patients may be offered critical care therapies, just as they may be offered other therapies in hospital (e.g. radiotherapy, antibiotics, surgery) if these are indicated for their disease process and there is a reasonable chance that these therapies may work to make the patient better.

If a patient is not appropriate for critical care treatment (frailty, multiple comorbidities, terminal illness for example), it is the case that critical care treatment will not improve their outcomes, or return them to a reasonable functional independence or quality of life.

Critical care should not be offered where it is not appropriate.

Once critical care therapy is offered, a patient has a right to refuse it.
A medical consultant has the same information required to make an escalation decision for a patient that an ICU consultant has. Most of the time this will not require a second opinion, but occasionally it will. It would be very reasonable to ask the opinion of critical care, especially in grey area cases.

What CFS score would you deem 'high'? From a geriatrician point of view acutely we address CFS 5 and above for CGA review.
Depends on the scoring system used.

If Rockwood clinical frailty scale – 5/6 or above suggests significant frailty, and less likely to benefit (but not an absolute rule) from critical care. Needs appropriate scoring i.e. baseline levels of functioning, taking into account medical problems.

Some ITU teams have stopped taking referrals except from consultants 24/7, and this affects timely assessments and interventions. What are your thoughts on this practice?
This has probably evolved due to difficulties with inappropriate referral, over or under referral?

Anyone competent to make a referral, with clear information, should be able to make one. This should be facilitated, as timely assessment and admission is thought to help in those that will benefit from ICU care.

If it is a complex, tricky scenario, is it appropriate to ask the HDU to come and assess the patient and to give an input on whether the patient is for ITU or not?
Yes. We should be more than happy to help. This should be a discussion about the relative risks / benefits of admission to critical care. Honest and up-front information with regards most likely outcomes if critical care admission and therapy occur.

Ethical principles of autonomy, justice, beneficence and non-maleficence should be considered on an individual basis.

Post ICU discharge – outcomes and experience – Dr Monica Trivedi

Our island hospital air stabilises and transfers level 3 patients to the nearest ICU. Any tips for following them up in the way you describe?
I would suggest:

1. The discharging Unit should be sending you or the patient a discharge summary in a timely manner so that you have a good idea of how complex and how long the ICU stay was, and any major events- particularly delirium, VTE, arrhythmias which may recur. It would also be helpful to have input from Physio, OT, SLT etc. about progress in hospital, goals and ongoing plan.
2. Phone call to patient soon after returning home to check whether they are coping and whether appropriate rehab /care is in place if needed.
3. Phone call or face to face meeting at around 3 months to check for physical, emotional and cognitive recovery- you could use the PICUPs tool as a template or develop a checklist for a nurse led clinic. What patients appreciate most is the opportunity to talk about what happened and get advice on their general physical and emotional rehabilitation.
4. Develop links with community services – best done through AHPs such as Physio and Dietician. Mental health support is the most frequently needed service, and referral pathways differ in different areas.

It would depend on local circumstances whether this process is best led by GP or local hospital, but would probably need some coordinated input from both.

How do you ensure that patients continue to get the support they need after ICU discharge, and that they get involved in the decision of their care?
We start the post ICU process from the time of step down to the ward, with Clinical Nurse Specialists seeing the patients after step down and prior to discharge home, documenting progress, goals and support needs. We have colleagues in Physiotherapy, Dietetics, Speech and Language Therapy handing over individualised plans from ICU to ward to community, which we plan to formalise as a "Rehab Prescription". Our Psychologists also follow patients up on the ward and sometimes after discharge. The Follow-up Clinic appointment at 3 months is a useful time to check how well this has worked in practice and make additional or repeat referrals as needed. For the most complex patients, referral to Rehab Medicine at this point ensures longer term follow up.
We discuss escalation plans with patients when they come to hospital, and where there are worsening long term health issues we may discuss future goals of care at the time of ICU discharge.

How do you involve the family of a patient in hospital with COVID to help with reducing the effect of delirium, especially when they are waking up from sedation?
This has been a huge challenge over recent months, and not just for COVID patients as all visiting has been dramatically reduced for infection control reasons.
We have used Skype and FaceTime very regularly to allow patient and family interaction in many situations- letting families see a loved one on a ventilator, at end of life care, and definitely to reassure delirious patients. Both patients

and relatives have fed back that they found this very helpful. We were lucky to get a charitable donation to purchase several iPads to facilitate this.