

## Supplementary Material 20 – Evaluation tool user FAQs

### **ICU Decision Making Evaluation Tool FAQs**

#### **What if I can't find a review?**

You will likely see occasions where there is no ICU review documented. For example, sometimes patients are so critically ill that there is no time for doctors to write in the notes and they forget to do so retrospectively. In these cases, put No in 'Record of ICU review in notes', and move on to the next set of notes after you have documented the location from which the referral came, and whether they were admitted or not.

#### **How can I tell where in the hospital a patient came from?**

When you see the notes, in the section just before the ICU admission (if there is one), you should be able to discern whether they are Emergency Department notes, ward notes, or theatre/anaesthetic records. This indicates where the referral was made. You may also see written 'Referred to ICU' or something similar.

#### **How do I identify the record of decision-making for ICU admission?**

After a patient is referred to ICU they should be assessed by a member of the ICU team. This will usually be a registrar or consultant but may be any of the following people: ICU Consultant, Anaesthetist consultant on call, ICU SHO, ICU Registrar (this may also be documented as ST3-7). The decision whether to admit or not is usually made at this point and documented at the end of their entry in the notes. This entry should be treated as the record of the decision-making process.

#### **What counts as a description of evidence for system failure?**

An organ system is usually assessed by the measurable parameters such as pulse and blood pressure for the cardiovascular system or the oxygen saturations or respiratory rate for the respiratory system. However we would count 'qualitative' descriptions if they convey a specific system failure

(e.g. no urine output, awake and alert). The word 'stable' is difficult to interpret and should not be used as a description of a system.

### **What counts as a description of 'capacity to recover'?**

Capacity to recover in this case specifically refers to a patient's capacity to recover *from their critical illness after treatment in ICU*. E.g. a doctor might write "Patient has poor baseline respiratory function and therefore would be unlikely to recover from ventilation", or "This woman has an excellent pre-morbid health and there is no reason she should not benefit from ICU".

### **What counts as evidence of frailty?**

Clinical frailty scores exist, but are not widely used in ICU referrals. However, just writing 'frail' is not good enough to score a point when describing capacity to recover. So they must evidence their assessment of 'frailty', and they can do that by describing how well a patient can carry out activities of daily living by themselves. Or using a frailty scale.

### **What counts as an interpretation of 'capacity to recover'?**

To score 2 marks in question 4 the notes entry should record a statement on how likely (or not) a patient is to recover from their critical illness *and* explicitly link this in the text to the description of factors that might affect capacity to recover. For example: "Mr Jones has a very poor exercise tolerance and this indicates a poor likelihood of him recovering from this critical illness".

To score 1 mark a judgement on capacity to recover should be made but this is not linked specifically to the evidence: e.g.: "Mrs Jones has a reasonable chance of a good recovery if admitted to ICU".

### **How do I interpret a description of information about patient's wishes?**

To score 2 marks a notes entry should include quotes and/or multiple sources of information. To score 1 mark a simple single description of patient wishes is sufficient.

### **What counts as a 'quote' about patient values and wishes?**

A quote in this instance doesn't have to have quotation marks around it, it must just demonstrate that it is the words of the patient. For example: "Mrs Smith has said that she would want to come to ICU for ventilation".

### **What counts as balancing of benefits and burdens?**

To score two marks there should be explicit balancing documented i.e. there should be a benefit and burdens (or lack thereof) documented that together forms a description of the reasoning used. If the benefits and burdens are both present but the reasoning is absent, this is implicit balancing and scores 1 mark. Just presenting one side of the argument (benefit or burden) scores zero points

### **What person or team might be specified in the 'need for review'?**

Often a patient who has been referred to ICU but not admitted will have a follow up review by the Critical Care Outreach Team (if there is one at that Trust). The records may say "Contact Outreach to review tomorrow". Alternatively, they may specify a person at ICU to be asked to review, or just the ICU team generically, or they may state that e.g. the surgical or medical team need to review the patient.

### **What does 'functional status' mean?**

Functional status refers to the ability to carry out ADLs (activities of daily living). These include e.g. getting washed and dressed, toileting, and feeding oneself, but could also include e.g. going shopping for food. The inability to carry out ADLs does *not* necessarily mean that a person cannot recover from a critical illness, which is why it is not acceptable *on its own* as a rationale for non-admission. If functional status is part of an overall assessment of capacity to recover then it may be included but the standard of reasoning should be high.