Limitation of Treatment Communication Sheet

Patient Name:	MRN:	Date of Birth:
Clinical Lead:	Next of kin/contact details:	

This document may be revised at any time if the clinical situation or wishes of the patient and/or family change. Please complete the review box on the back of this page.

Ensure you consider the following:

- **Individualised patient care is the priority, which can be altered, amended or withdrawn at any time depending on the clinical situation.**
- **Every effort should be made to involve the patient in this process. The discussion with the patient and/or family regarding what is planned is documented (date: _____).**

1. Full organ support is inappropriate as specified below (please tick):

- Not for advanced respiratory support (including CPAP and NIV) ☐
  OR
- Not for intubation and ventilation (but CPAP and NIV is permissible) ☐
- Not for inotropes or vasopressors ☐
- Maximum dose of vasopressors ☐ dose:_____
- Not for renal replacement therapy ☐
- Not for escalation above current treatment ☐ (please specify):

These limits of treatment do not exclude the use of medical management including hydration, feeding, antibiotic therapy and pharmaceutical management of illness.

2. Documentation

Please document why limitation of treatment is appropriate (please continue on reverse if required):

Please document the date, time and who were present at the conversation with the patient or the next of kin:

- Has a DNAR been discussed and completed? ☐
- Have relevant members of the ICU team been informed of this decision? ☐ Names:

- The parent team are aware and are in concordance with this decision (if appropriate) ☐

Review of decision:

Review Date (specific):
Review Interval (specify): daily ☐ every two days ☐ other:
Review if situation changes (specify and date):

Two Consultants in charge CTITU (NAME/SIGNATURE):
Doctor completing this form (NAME/SIGNATURE):
Nurse receiving form (NAME/SIGNATURE)
Date and Time:

Cardiothoracic Intensive Care Unit: Limits of Treatment Communication Sheet

Withdrawal of Treatment Communication Sheet

Patient Name	MRN:	Date of Birth:

Recognition of the dying patient is difficult, especially in intensive care. Complete this document when a decision has been made between the senior members of the multi-disciplinary team and the patient and/or the patient's next of kin to withdraw active treatment. Monitor for signs that may indicate an improvement in the clinical condition necessitating a revision of this process.

1. Ensure you consider the following:

- **Every effort should be made to involve the patient in this process to individualise care. Discuss with the patient and/or family any particular requests regarding timing, environment or religious/spiritual beliefs and the possible duration of the dying process.**
- **Consider palliative care referral**
- **<u>All</u> patients should be assessed by the Specialist Nurse for Organ Donation (SNOD) who can be contacted via a 24 hr team pager, regarding the potential for tissue or organ donation.**

2. Documentation

Please document why withdrawal of treatment is appropriate (continue on separate sheet if needed):

Indicate that the following people have been involved and are in agreement regarding withdrawal of treatment (if appropriate):

- Patient/Next of kin/family ☐ Consultant of primary team ☐ ICU multi-disciplinary team ☐

3. Date and Time withdrawal of treatment is to commence:

4. Details of how withdrawal is to be conducted:

- Leave current airway in situ ☐
- Wean to Room air ☐
- Turn of ventilator support ☐
- Maximum vasopressor/inotrope therapy □ dose:
- Wean/stop vasopressor/inotropic support (delete/specify below as appropriate) ☐
- **Continue:** Nutritional support (NG) ☐ and/or IV or SC maintenance fluids ☐ for hydration. Continue routine aspiration of NGT and prokinetics ☐
- **Medication** such as analgesics, anxiolytics, anti-secretory medicines and anti-emetics should be considered. **Discontinuation of medications** such as antibiotics, hypertensive medications, and anticoagulation may be appropriate ☐
- **Remove all invasive lines** if causing discomfort. ☐
- **Monitoring:** silence all alarms and avoid non-invasive blood pressure monitoring. ☐
- **Ensure the patient and family** are aware of the timing of withdrawal, the possible duration of the dying period and the methods of symptom management during this period. ☐
- **Free text entry detailing process of treatment withdrawal:**

Two Consultants in charge on CTITU (NAME/SIGNATURE):
Doctor completing this form (NAME/SIGNATURE):
Nurse receiving form (NAME/SIGNATURE)
Date and time:

Cardiothoracic Intensive Care Unit: Withdrawal of active treatment