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INTRODUCTION:

Intensive Care Services is an ever-growing specialty, follows the highest standards of care, and utilizes the best equipment and technologies. Despite such advances, some patients do not respond to the best available critical care support. Continue to treat such patient will not benefit them and would occupy vital resources at times. It would be inhumane to the patient and would become futile.

1. Purpose of Policy:

It is to identify those patients who are admitted to Intensive Care Services but are not responding to full critical care support and when mortality is inevitable. The Scope of the Policy is for all patients admitted to Intensive Care Services in Riyadh Military Hospital:

- GICU
- New ICU
- SICU
- Mobile ICU
- LTVU and Weaning Program
- Transplant ICU
- Trauma ICU
- Solid Organ Transplant ICU


2. Definitions:

2.1 Withdrawal of Critical Care Support:

Is to stop any active cardiopulmonary, hemodynamic, biochemical, dialysis support and to stop hemodynamics, biochemical and blood count monitoring.

2.2 Withdrawal of Critical Care Support Orders:

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It is the order written by the intensivist when he feels critical care support is no longer effective and futile.

2.3 Decision to Sign a Withdrawal of Critical Care Support:


It is the Critical Care Team's decision made in liaison with the Primary Team.

2.4 Withdrawal of Critical Care Patient either:

2.4.1 Patient whose recovery is deemed by current scientific evidence to be impossible. The following situations may be used as examples:

- Advanced late stage cancer
- Irreversible multi organ failure
- Advanced chronic liver disease
- Advanced congestive heart failure
- Advanced pulmonary disease
- Advanced dementia
- Severe brain damage
- Inoperable malformations that are incompatible with life
- Irreversible or untreatable fatal neuromuscular disease
- Diagnosed Brain Stem Death (the Saudi Centre for Organ Transplant (SCOT) guidelines (dated 18/06/1414) should be followed (Appendix IV and V).
- Untoward effects or drugs
- Severe multiple trauma.
- Conditions which have been associated with an extremely low chance of survival for example:
 - o Inoperable congenital heard diseases
 - o Fatal Chromosomal anomalies
 - o Fatal neuromuscular disease

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OR

2.4.2 Failure to respond to Respond to Critical Care Support

2.5 FOR (Failure of Resuscitation)

Failure of resuscitation (FOR) is the patient who was admitted to intensive care and required full supportive measures and fails to respond to it.

2.6 No Further Resuscitation (NFR) Order

No Further resuscitation is an order made by the consultant intensivist in charge of ICU team for patient who failed the full critical care resuscitation.

2.7 Active Management

This includes inotropic support, renal dialysis haemofiltration, blood and blood products, TPN and ventilator support. Limit care to include sedation and analgesia IV fluids, O₂ therapy, feeding and personal hygiene.


2.8 Basic Care

A patient, in whom aggressive treatment is meaningless, i.e. seems to delay death rather than prolong life. His/her basic care must include sedation & analgesia, IV fluids, maintenance of a free airway with room air, enteral feeding and personal hygiene.

2.9 No Escalation of Therapy Order

3. Policy:

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3.1. Patient who fulfils the criteria outline in section 2.4.1 and 2.4.2 will be a candidate for the following orders:

3.1.1. No Further Resuscitation (NFR)

3.1.2. No Escalation of Therapy (NET)

3.1.3. Withdrawal of Critical Care Support (WCS)

3.2. These decision has to be made by Intensivist consultant in charge of the patient with

3.3. The decision to have these orders is considered based on individual cases and should consider the family of the patient.

4. Procedure:

4.1 The patient has been identified as being appropriate for status, based up on the accepted definition (Section– 2), the treating physician (Consultant in-charge) must document and sign in the progress notes his/her reasons for reaching this decision to describe:


4.1.1 The patient condition with emphasis on the natural history of the disease treated or untreated.

4.1.2 The quality of life if the patient undergoes CPR.

4.1.3 The unavailability of therapy that can improve the patient’s survival with improved quality of life.

4.1.4 Description of the patient’s decision making capacity. Or the patient is not responding to the maximum support of either individually or in

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combination of the following:

- Hemodynamic support
- Ventilatory support
- Cardiac support
- Hematological support
- Renal support
- Hepatological support
- Neurological support
- Anti-microbial support
- Anti-cancer support

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4.2 The treating physician (consultant in-charge) will write NFR, WCS or NET in capital letters on the order sheet and then the patients file should be marked with appropriate letters (NFR, WCS or NET) sign that will be obvious to all health care providers working in the hospital.


4.2.1 No Further Resuscitation (NFR) order: means that patient will not receive CPR in case of cardiac arrest.

4.2.2 No Escalation of therapy (NET): mean that patient will not have any augmentation of the current therapy such as the level of mechanical ventilation support, the level of hemodynamic support drugs, the start of new support modality such as renal or liver dialysis. Though the basic care of the patient .should continue to ensure the comfort and freedom from pain for the patient.

4.2.3 Withdrawal of Critical Care Support (WCS): means that all the artificial support of the patient will be removed in the following way:

4.2.3.1 Mechanical ventilation setting will be set at minimal

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support, ie SIMV 4, PS of 6 to 10, PEEP 0, FIO2 21%.

4.2.3.2 All hemodynamic support drugs will be tapered off over the next two hours.

4.2.3.3 Discontinuation of all renal or liver dialysis if the patient is already on.

4.2.3.4 No more radiological examination or blood work.

4.3 Every aspect of therapeutic regimen is determined by the criteria of overall welfare and comfort of the patient.

4.4 Certain procedures may cease to be justifiable and thus be contraindicated.

4.5 It is important that the consultant in-charge specify for nursing and junior physicians what modalities of treatment will be excluded.

4.6 The relative should be told of the poor prognosis and their contribution to the discussion. If any, should be considered and recorded.


4.7 The relative should not be involved in the decision making process for the FOR including connection and disconnection of the ventilator as such decisions do not fall within their areas of expertise (Fatwa Resolution no.12086) (Appendix I).

4.8 The documentation must clearly indicate that the decision has been explained to and understood by the patient and/or the most appropriate family member

4.9 Approach Patient's Family

4.9.1 The treating physician (consultant intensivist in-charge) must discuss in depth of how and why withdrawal of Critical Care Support has reached with either the patient who has decision making capacity or with most appropriate responsible family member, if the patient is lacking decision making capacity. He/she should clearly indicate in

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simple language, all the reasons for reaching this decision and emphasize that further medical and or surgical intervention would not alter the inevitable outcome.

- 4.9.2** The treating physician (consultant intensivist in-charge) should to approach the discussion with honesty, sensitivity and compassion in order minimize situations in which the patient and/or relative insists, in the face of all evidence to the contrary, that a full code be undertaken.

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