Worcestershire Acute Hospitals NHS Trust

GUIDELINES FOR THE LIMITATION OF TREATMENT FOR ADULTS REQUIRING INTENSIVE CARE

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

This guideline is for use by the following staff groups:

Group 1 Critical Care Medical/Nursing staff

Lead Clinician(s) Dr Mike McAlindon	Consultant in Anaesthetics & ICM
Approved by Intensive Care Forum on:	13th October 2025
Approved by Medicines Safety Committee on: *Where medicines are included in document.*	N/A
Review Date: This is the most current document and should be used until a revised version is in place	13th October 2028

Key Amendments

Date	Amendment	Approved by
8th October 2019	Document extended with no changes as part of Disease Management section in critical care	Dr Nick Cowley/ Dr Andy Burtenshaw
24th February 2022	Document edited by owner to include RESPECT form	
14th October 2022	Document reviewed with no changes	Intensive Care Forum
23rd September 2025	Document edited to reflect processes relating to ICCA (ICU EPR)	Dr Mike McAlindon

INTRODUCTION

This guideline is largely transcribed from the document “Guidelines for limitation of treatment for adults requiring intensive care” published by the Intensive Care Society. The authors of the source document were S.L. Cohen; J.S Bewdley; S. Ridley; D. Goldhill; and the Members of the ICS Standards Committee.

For the purposes of this guideline, an adult is defined as age 18 years old and over.

In light of the SUDIC policy all patients admitted to critical care who are under the age of 18 are to remain under the care of a Consultant Paediatrician.

This guideline does not apply to patients under 18 and all withdrawal decisions in this age group should be guided by the Consultant Paediatricians in consultation with advice from the Regional Paediatric Intensive Care Unit.

These are basic guidelines solely intended to provide a framework for approaching a highly sensitive subject.

Further documents are available from the British Medical Association and the General Medical Council.

All medical treatment must be founded on compassion and the best interests of the patient. Good communication, collaboration and agreement between colleagues, patients and families are essential.

Accurate documentation of these aspects of care is essential from a governance point-of-view. A significant proportion of hospital deaths occur within a critical care environment and these deaths need to be properly managed. Studies on end of life decisions show the vast majority of deaths in the ICU occur following decisions to withhold or withdraw treatment. Death needs to be a managed process in the ICU.

Competent adults have an absolute right to refuse treatment, even if that refusal results in their death. The vast majority of ICU patients are not competent but occasionally have valid advance directives. The assessment of competency should include an assessment of mental capcity in accordance with the principles laid out in the mental capacity act code of practice, noting specifically the principles of the 2 stage test. In particular, it may be necessary to carefully consider the impact of medication, sleep deprivation or other features of critical illness on a patient's capacity to make life-determining decisions.

Many factors are involved in making decisions to withhold or withdraw therapy. The decision is normally taken after consultation with other members of the nursing and medical team. Ideally, there should be consensus among the entire clinical team who have been heavily involved in the patient's care, that it is appropriate to withhold or withdraw aggressive treatment. Usually two or more senior doctors, one of whom must be an ICU Consultant, will agree on the decision.

Unanimity is desirable but may be unobtainable. The final decision and responsibility for that decision is vested in the consultant in charge of the ICU, but it is essential that the views of the family are taken into consideration and attempts are made to avoid conflict at this sensitive time. The nurses may be more familiar with the family and the patient's views, which if known, are of paramount importance. Usually, in ICU patients, these views are not available. A recent Swedish study demonstrated that the general public wanted the patient and family to be involved in such decisions, with only 5% supporting a physician only approach. We do not know British patients' views on this subject, but the law allows a competent and experienced physician to make the decision.

In the UK, with the exception of Scotland, there is at present no established role for surrogate decision makers, although their input might be helpful in making decisions for patients who are not competent. In England and Wales, no adult can give consent on behalf of another adult; however Scotland passed a law encompassing surrogacy in April 2001.

Uncertainty in prognosis in critical illness may lead to problems in communication with patients, family and caring team. There is increasing societal awareness of medical matters.

Decision-making should be open and accountable to the patient, family and all concerned. All discussions and decisions should be recorded in the notes.

The legal issues surrounding treatment limitation are discussed in the BMA booklet on withholding and withdrawing life-prolonging treatment. The second edition also gives specific guidance on the Human Rights Act that came into force in October 2000. The spirit of the Act aims to promote human dignity and transparent decision making, and it is these principles that should be applied in decisions to limit intensive are treatment.

DETAILS OF GUIDELINE

Principles:

Medical treatment should only be withdrawn on clinical grounds because the treatment will not benefit the patient or the expected benefits are outweighed by the burdens of treatment. Every withdrawal decision should be made upon its own merits and must not be made on the basis of either cost or medical convenience

The need for an ICU bed for another patient should not be a reason for withdrawing support.

There is a need to know, if possible, the wishes of the patient and their treatment goals. If the patient is not competent to communicate their wishes, their family and friends should be consulted. Attempts must be made to discover the patient's wishes in this situation. Advance directives, if available and relevant, may be helpful. In the case of incompetent patients without family or close friends, the doctor has the responsibility of determining the best interest of the patient. Ultimate responsibility remains with the consultant in charge of the ICU.

When patients are admitted to the ICU there needs to be a clear management plan encompassing the limits, if any, of invasive interventions. This plan requires accurate documentation and regular review.

Limitation of treatment should be regarded as a formal ICU procedure subject to the same preparation, thought, care and consent as for any other aspect of care.

A RESPECT form should be completed for each patient admitted to ICU. This form contains a summary of diagnosis, prior planning, personal preferences and clinical recommendations for emergency care and treatment. Further detail can be provided on the RESPECT form concerning interventions that are and interventions that are not appropriate. The RESPECT form incorporates sections stating whether CPR attempts are or are not recommended.

Details of treatment limitations and CPR recommendations are also documented on the Philips IntelliSpace Critical Care and Anesthesia (ICCA) EPR.

Ethics:

Almost all ethical authorities agree that there is no moral difference between withholding and withdrawing treatment. In practice though, many doctors feel more comfortable with withholding, rather than withdrawing treatment. When outcome is uncertain, it is worth considering a trial of intensive care treatment on the understanding that it will be withdrawn if ineffective.

Some doctors and nurses, as well as patients, may have conscientious objections to treatment withdrawal. Their views should be respected and they should be allowed not to participate in such procedures if these are against their principles. They should, however, be prepared to transfer care to other clinicians.

Training:

Training in communication skills and in breaking bad news for all ICU personnel should be improved with the emphasis on the importance of good contemporaneous written records.

Communication & Records:

Good communication with the patient and/or family as well as all colleagues in the caring team and the referring clinicians is essential. If the patient is competent, the patient's wishes and preferences for treatment must be obtained.

Methods of Withholding & Withdrawing:

It is the duty of the consultant in charge of the ICU to recognise a dying patient and to know when palliative care should over-ride more aggressive treatment. There needs to be agreement among patient, family and the entire caring team, especially in the case of the patient who is not competent, but the ultimate responsibility for the decision should rest with the ICU consultant in clinical charge. The significance of poor prognostic factors must be explained. Families may need time to come to terms with their impending loss.

In the cases of disagreement, either among the family or physicians, or between them, suitable second opinions may provide objective assessment and support.

Basic Guidelines for Withdrawal of Life-Sustaining Treatment (WLST):

Patients and families should be given the maximum possible access and privacy at this time. If possible a side room should be made available otherwise the bed space curtains should remain drawn and unnecessary monitoring and alarms removed.
It is important to communicate to all of the unit staff that a highly-sensitive stage of patient care is unfolding and extraneous noise on the unit should be kept to a minimum. Signs and candles are available on both units to facilitate this communication.

The patient's management should continue to be compassionate and caring. To this end, it is important to relieve the patient's pain and distress. Suitable drugs might include potent opioid analgesics such as diamorphine or benzodiazepines such as midazolam. Such drugs are often given by infusion. The dosage needs to be adjusted to relieve the patient's suffering but not to intentionally hasten death.

Treatments aimed at primarily maintaining organ function but which may prolong death should be withdrawn. Examples may include vaso-active drugs, antibiotics and intravenous fluids. Respiratory support may be withdrawn. This may involve reducing fractional inspired oxygen concentration towards 21%, lessening the ventilatory support and eventually where appropriate extubating the patient. Adequate analgesia and sedation are essential, but paralysis must always be avoided.

It is vital that whichever drugs or combination of drugs are used, the aim is to relieve the patient's pain and distress. Clinicians need to ensure that the drugs and the doses they use could not be regarded as excessive by others responsible for similar patients. Euthanasia is illegal in the United Kingdom and plays no part in the withdrawal of treatment from critically ill patients.

REFERENCES

The document "Guidelines for limitation of treatment for adults requiring intensive care" includes this list of suggested further reading.

1) British Medical Association. Withholding and Withdrawing Life-prolonging Treatments. 2nd Edition. BMJ Books, 2001

2) Brett S. Ethical Questions for the New Millenium. In: Vincent J-L (Ed) Yearbook of Intensive Care and Emergency Medicine 2001. Springer-Verlag, 2001:708-716
3) Sjokvist P, Nilstun T, Svantesson M, Berggren L. Withdrawal of life support – who should decide? Differences in attitudes among the general public, nurses and physicians. Intensive Care Medicine. 1999; 25:949-54

4) Consensus report on the ethics of foregoing life-sustaining treatments in the critically ill. Crit Care Med. 1990; 18:1435-39

5) British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing. Decision relating to Cardiopulmonary Resuscitation. 2002. http://www.web.bma.org.uk/ap.nsf/Content/cardioresus

6) General Medical Council. Withholding and withdrawing Life-prolonging treatments: Good Practice in Decision Making. 2002. http://www.gmc-uk.org

7) Luce JM, Prendergast TJ. The changing natures of death in the ICU. In: Curtis JR, Rubenfield GD. Managing Death in the Intensive Care Unit. Oxford University Press, 2001:19-29

8) Vincent J-L. Foregoing life support in western European intensive care units: The results of an ethical questionnaire. Crit Care Med. 1999; 27:1626-33

MONITORING AND COMPLIANCE

This section should identify how the Trusts plan to monitor compliance with and the effectiveness of this Treatment pathway. It should include auditable standards and/or key performance indicators (KPIs) and details on the methods for monitoring compliance

What	How	Who	Where	When
These are the 'key' parts of the process that we are relying on to manage risk.	*What are we going to do to make sure the key parts of the process we have identified are being followed?*	*Who is responsible for the check?*	*Who will receive the monitoring results?*	*Set achievable frequencies.*
Two consultant decision to use $ECCO_2R$	Audit	Dr Bhardwaj	ICU Forum	Annually
All $ECCO_2R$ patients included in ELSO registry	Audit	Dr Bhardwaj	ICU Forum	Annually
Each patient should have complete sets of observations and a NEWS score calculated	Compliance with NEWS will be monitored by audit of patient observation charts	Ward Managers	Director of Nursing, Matrons	Weekly
Transfers from critical care should avoided between 22:00 and 07:00	Compliance with avoidance of out of hours transfers will be monitored via ICNARC data	ICNARC clerk	Consultant Clinical Lead ICU	Monthly
Patients transferred from critical areas should have a formal documented structured handover of care	Compliance with transfer documentation will be monitored by audit of patients notes	Outreach Team/FY1	Matron for ICU Clinical Director	Once Yearly
Critical Care Nutrition guidelines	Observation and chart reviews	Sr Julie Share, Nutrition Link Nurse Critical Care ALX, Sr Andrea Carn, Nutrition Link Nurse, WRH		Six monthly intervals
Management of patients with tracheostomy tubes	Audit	Critical Care outreach teams and physiotherapists at Alex and WRH		All tracheostomy patients

Contribution List

This key document has been circulated to the following individuals for consultation:

Name	Designation
Dr Steve Digby	Consultant, Intensive Care Medicine
Dr Steve Haynes	Consultant, Intensive Care Medicine
Dr Philip Harrington	Consultant, Intensive Care Medicine
Dr Edwin Mitchell	Consultant, Intensive Care Medicine
Dr Jeremy Thomas	Consultant, Intensive Care Medicine
Dr Gavin Nicol	Consultant, Intensive Care Medicine
Dr Stephen Pearson	Consultant, Intensive Care Medicine
Dr Laura Kocierz	Consultant, Intensive Care Medicine
Dr Sian Bhardwaj	Consultant, Intensive Care Medicine
Dr Laura Tulloch	Consultant, Intensive Care Medicine
Dr Philip Pemberton	Consultant, Intensive Care Medicine
Dr Shiju Mathew	Consultant, Intensive Care Medicine
Dr Nick Fitton	Consultant, Intensive Care Medicine
Dr Nick Cowley	Consultant, Intensive Care Medicine
Dr Olivia Kelsall	Consultant, Intensive Care Medicine
Dr Gareth Sellors	Consultant, Intensive Care Medicine
Dr Andrew Burtenshaw	Consultant, Intensive Care Medicine

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Name	Directorate / Department
Dr Mike McAlindon	Consultant & Clinical Director, Critical Care
ICM Forum	Approved by ICM Forum 13th October 2025
SCSD Critical Care Directorate Governance Meeting	Approved by Critical Care Directorate governance meeting 15th October 2025

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

NHS Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form

Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	Dr Mike McAlindon, CD for ICM

Details of individuals completing this assessment	Name	Job title	e-mail contact
	Dr Mike McAlindon	CD for ICM	michaelmcalindon@nhs.net
Date assessment completed	25/11/25		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	Title: **GUIDELINES FOR THE LIMITATION OF TREATMENT FOR ADULTS REQUIRING INTENSIVE CARE**			
What is the aim, purpose and/or intended outcomes of this Activity?	Updated guidance.			
Who will be affected by the development & implementation of this activity?	×	Service User	×	Staff
	×	Patient	❑	Communities
	×	Carers	❑	Other _____
	❑	Visitors	❑	

Is this:	× Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	ReSPECT process/guidance.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	ICU Forum, MDT input.
Summary of relevant findings	Guideline approved.

Section 3
Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		X		
Disability		X		
Gender Reassignment		X		
Marriage & Civil Partnerships		X		
Pregnancy & Maternity		X		
Race including Traveling Communities		X		
Religion & Belief		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sex		X		
Sexual Orientation		X		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				

When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	With guideline update.

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Dr Mike McAlindon
Date signed	25/11/25
Comments:	
Signature of person the Leader Person for this activity	Dr Mike McAlindon
Date signed	25/11/25
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.