Short name: HASTY

Haven’t Thought of a Snappy Title Yet

MIRIAM DAVEY
POETICs 1, POETICs 2

- POETICs 1
  - Investigating assessment of clinical frailty

- POETICs 2
  - Carrying out a number of baseline assessments
  - Follow up after 30 days and 6 months to assess vital status
POETICs 2 - baseline

Demographics – age, gender, habitat, & reason for ICU admission;

IQCODE

SOFAs score

KATZ score

Clinical frailty score

CPS – Co-morbidity and Polypharmacy score

ICU interventions
POETICs 2 – follow up

30 days.....Alive/Dead?

6 months.....Alive/Dead?
Is this enough?

MY QUESTION....TO KNOW HOW THEY ARE AFTER THE PERIOD OF CRITICAL CARE; KNOWING VITAL STATUS SIMPLY ISN’T ENOUGH!

HOW ARE ELDERLY ICU PATIENTS AFFECTED BY THEIR CRITICAL CARE EXPERIENCE; IF WE COULD PREDICT THIS, WOULD WE DO IT DIFFERENTLY?

SHOULD WE HAVE A TOOL TO GUIDE THE DECISION TO ADMIT ELDERLY PATIENTS TO ITU OR TO GUIDE THE LEVEL OF ESCALATION OF INTERVENTIONS?
SERVICE USERS SAY THAT **QUALITY OF LIFE** TAKES PRECEDENCE OVER SIMPLY SURVIVING.

RESPONDENTS HAD A GOOD UNDERSTANDING OF CRITICAL CARE, BUT VERY LITTLE AWARENESS OF THE LONG-TERM RISKS, AND THE PROBABILITY THAT IF THEY SURVIVED, THEY WOULD NOT RETURN TO BASELINE FUNCTION AND HEALTH.
The objective of this pilot study is to illicit the degree to which a critical care episode leads to deterioration in the components which affect everyday function, with a view to a larger scale study, potentially resulting in change of practice.

I hope the future brings a structured approach to decision making regarding admission of elderly people to ICU.
HASTY compared to POETICs 2

POETICs 2
- Baseline assessments
- Follow up of vital status at 30/7 and 6/12

HASTY
- Baseline assessments
- Repeated baseline assessments at 3/12
After all, we know already….

THAT THE RATE OF RISE IN THE ELDERLY POPULATION WILL DOUBLE BY 2050; ALONG WITH A PREDICTED RISE IN THE INTENSITY OF INTERVENTIONS (NGUYEN ET AL, 2011); WITH SUCH DEMAND ON THE MOST EXPENSIVE BEDS IN HEALTHCARE, CLINICIANS FIND THEMSELVES IN AN UNCOMFORTABLE DILEMMA ETHICALLY; EVIDENCE SUGGESTS THAT ESCALATED LEVELS OF INTERVENTION HAVE POOR OUTCOMES, HIGH MORTALITY, LONGER HOSPITALISATION, DETRIMENTAL IMPACT ON MOBILITY, FRAILTY, COGNITION AND MORBIDITY (NGUYEN ET AL, 2011; BOUMENDIL, 2012; HAAS ET AL, 2015; CHIN-YEE ET AL, 2017).
The first published discussion of medical ethics dates back to 1803;

After years of unethical research which resulted in the Nuremberg Code in 1947, in 1998 Good Clinical Practice (GCP, 1998) guidelines became the ethical and scientific quality standard for clinical research; compliance with GCP assures participants that their rights, safety and well-being are protected, and that outcomes of clinical trials are trustworthy (Medical Research Council, 1998);

The foundations of GCP are Beauchamp and Childress’s four pillars of respect for autonomy, beneficence, justice and nonmaleficence; adherence to the principles by clinical research staff is essential to ensure ethical integrity in research (Morrow, 2015).
Ethical framework, continued

As well as the obligation to uphold the ethical principles, we must adhere to the Nursing and Midwifery Council (NMC) code with specific reference to the standards regarding prioritising people, acting in best interests, effective practice, preserving safety, and promoting trust (NMC, 2015).

If values of common morality were transposed to clinical research, there would be careful adherence to the protocol to prevent risk to participants, honesty and transparency, and showing respect to participants’ decisions, sometimes bearing a degree of risk, and made altruistically.

Scrutiny by the ethical review committees is the most robust way of ensuring adherence to ethical principles.
Ethical Considerations & Challenges

- There are many ethical challenges, but the biggest are related to informed consent and participants' vulnerability.
- Critically ill patients are vulnerable in research because they are incarcerated and dependant on clinicians (Blackwood, 2006; Morrow, 2015).
- The family is in state of anxiety and vulnerability, and studies revealed that relatives make different decisions from those that would be made by patients (Blackwood, 2006; Ecarnot et al., 2017; Karlawish et al., 2009; Duffet et al., 2011).
- Proxies cannot know the patient's wishes in a situation but must form an opinion based on their best interests; however, where there is equipoise, this is not always clear (Emanuel et al., 2000).
- Weighing up the risk-benefit ratio is a harsh judgment for a relative who must process unfamiliar information (Emanuel et al., 2000; Antonelli et al., 2008; Morrow, 2015).
- Morrow (2015) highlights the risk of pressure on the relatives by the ICU team during their decision-making, however unintended, and describes the role of the ICU research team as twofold, both clinician and researcher, creating potential bias.

IRAS application and REC review aim to mitigate the multitude of ethical implications in researching vulnerable groups.
FUNDING?

Application for a small amount of funding has been made to ICU steps, who have a budget for supporting post graduate research aimed at benefitting ICU patients.
Ultimately....
Less of this:
And more of this:
References


Gillett (2015) states that outcomes for participants in research are somewhat better than patients who are not, and that patients in ICU’s where research is delivered experience better outcomes; in a systematic review Fernandes et al (2014) found that even in the worst-case scenario, patients are not harmed by participation.

A powerful statement!

Thank you for listening.
Miriam Davey
miriam.davey@nhs.net