Direction of Care

Priority level 1

- Critically ill, unstable patients
- Require life support for organ failure and intensive monitoring. This includes high flow nasal cannula (HFNC), non-invasive (NIV) or invasive ventilation, renal replacement therapy, invasive haemodynamic monitoring and other interventions
- Do not have limitations of treatment
- High likelihood of benefit

Priority level 2

- Acutely ill but relatively stable
- Require intensive monitoring and/or therapies, who can be managed in a ward with close monitoring or intermediate care facility, e.g. high dependency unit
- Admit to ICU if early management fails to prevent deterioration, or there is no intermediate care facility in the hospital.

Priority level 3

- Have advanced co-morbidities
- Acutely ill with high risk for further deterioration
- Require some intensive monitoring and/or therapies. They may be managed at a ward level or intermediate care facility, e.g. high dependency unit.

- All cases with priority level 1 should be actively resuscitated regardless of the status of ventilator or ICU bed availability.
- In the event of ventilator and ICU beds constraint, patient in priority level 2 should be properly assessed and repeatedly discuss the outcome with ward consultant/specialist and family/relatives.
- For a patient with priority level 3, it would not be in the best interest of these patients to receive non-beneficial intervention that is invasive and prolonged if further deterioration occurs. Such patients need to be identified early for limitations of treatment. A discussion on this needs to be followed through by the primary team with families (and patients where possible). This is important to address expectations, elicit preferences and clarify resuscitation status. These patients may be treated with the best ward care alongside palliative care principles.