Instructor Manual

Teaching the Best Case/Worst Case-ICU Communication Framework

Overall Goals for Teaching Session

* Learners will describe the Best Case/Worst Case tool and your role as the Attending/Fellow Physician
* Learners will identify major events in the clinical course that change the best case
* Learners will translate clinical knowledge and prognostic information to BC/WC format for complex trauma patient cases
* Learners will use scenario planning during rounds to generate the patient outlook with a range of clinical trajectories including the best and worst cases
* Learners will demonstrate ability to communicate “what we are hoping for” and “what we are worried about” to patients and families to support shared decision making

Resources List

1. General resources:
   1. Classroom (virtual or physical) equipped to show PowerPoint presentation
   2. One coach (minimum) per every attending
2. Coach materials for training:
   1. Instructor manual (contains relevant information for cases)
   2. BC/WC ICU PowerPoint presentation
   3. Laptop
   4. Self-assessment (one per learner)
   5. BC/WC ICU evaluation rubric (one per learner)
   6. Pre-populated graphic aids (3-4)
   7. Blank graphic aids (3-4)
3. Learner materials for training:
   1. Learner manual
   2. Pocket Card (x2)

Teaching Session Flow

**Part 1 – Background (2 min, slides 1-2)**

1. (slide 1) Ask “what do you know about Best Case/Worst Case?”
   1. Explain how what they will learn today will be different/the same as what they already know/do.
   2. If they are not familiar with the original BC/WC, explain that it was developed as a way to help patients understand prognosis and the experience of life-limiting illness in the context of treatments, including surgery and life sustaining therapies.
   3. (slide 2) Explain how BC/WC ICU was adapted from the original BC/WC decision tool to fit the ICU environment.

**Part 2 – Introduce Best Case/Worst Case-ICU (3 min, slides 3-5)**

1. (slide 3) Show the blank graphic aid
2. Each column is a day in the ICU – each page contains 5 days
3. You will update this every day on rounds
4. (slide 4) Show the example of Yara Lopez (from the Whiteboard Video)
5. *This is an example of a trauma patient in the ICU who fell down some stairs and had a subdural bleed, serious facial fractures and a hip fracture. (for reference if learner asks for additional context- avoid spending too much time on this)*
6. Each day starts with the date and any Events that have unfolded in the past 24 hours that might change the Best Case story.
7. We use the first column to mark the date of admission to the ICU and we use the second column to mark the first day that you are rounding on the patient.
8. The Star represents where the Best Case is in relationship to the Worst Case – point to the left side of the page where there is a key to remember the relationship between the star and box.
9. The bullet points next to Best Case help the team and family members keep track of the big picture – and we’ll talk more about what that looks like (outlook) in a few minutes.
10. Point out that this patient’s Best Case story is getting less favorable over time.
11. The Worst Case might change based on Events as well, but for many ICU patients might be the same, indicated by the arrow.
12. If there are no events that change the Best Case story you can simply draw an arrow over to the next day.
    * 1. Many days of no change can be an Event in itself.
         1. Examples: patient stays intubated and unable to come down on ventilator support
      2. Lots of events happen in the ICU but the ones we mark at the top are ones that change the Best Case Story
      3. If there are questions about events, learners can reference this table on Page 8 of their Learner Manual:

A list of events that have been written

Description automatically generated

1. (slide 5) The flip side of the graphic aid can be filled out by family members/loved ones to reflect additional information about the patient.

**Part 3 – Explain the process in detail (5 min, slides 6-12)**

1. (Slide 6) First, we will go over the verbal piece (this is what you will be doing routinely on rounds), then we will go over what is written on the graphic aid (you might not do this routinely, but it is good to practice so you know all of the components and can help guide your residents/APPs as they fill it out).
2. You must first articulate how you think the patient’s course will unfold in the Best Case Scenario (or their Outlook).
   1. At the end of the systems-based patient presentation, whoever is presenting will cue you for the Outlook. The Outlook answers the question: How will this unfold if all goes as well as we might hope?
   2. (Slide 7) What we hope you will do is translate this information into a story
      1. Tell a story about what we are hoping for with a beginning, middle and end
      2. It should include information about additional treatments – eg ventilator, surgery, physical therapy
      3. Story should cover the anticipated amount of time in ICU, hospital, post-acute care
      4. Include details about where the patient would live after recovery (6-12 months from now)
      5. Describe functional status “after recovery”
3. (Slide 8) While you are telling this story, someone else on the team will be putting notes on the graphic aid – so we will talk about what information goes on the graphic aid.
   1. (Slide 8) Starting a new graphic aid
      1. Write the patient’s initials and room number in the upper right corner
      2. Write the date of admission and “admission” at the top of the first column.
   2. (Slide 9) Let’s say you are rounding for the first time on a patient on June 5th
      1. Write the date at the top of the second column
      2. Write the major events since admission: *Brain bleed, intubated* (for example).
      3. (Slide 10) After the Event is noted, the next step is placing the star – it represents where the Best Case is in relationship to the Worst Case. The star will go up or down depending on how things unfold over time.
      4. (Slide 11) As you are telling the story, the resident/APP will make notes on the graphic aid next to the Best Case star.
      5. You will also put something for Worst Case – so once you have finished telling the best case story, it is helpful to share what you are worried about with the team so they know what to include here for the worst case.
      6. Sometimes this includes the possibility that the patient will die from their injuries, but not always. It is important to be clear if that is a worry you have (remember this is the WORST case). Sometimes, the worst case might be something like: Many days in ICU. Stress of injury/illness is hard on the body. Gets sicker needing more treatments, machines, and life support.
   3. (Slide 12) You will do this everyday on rounds. If the there are no events that change the story, you can simply draw an arrow from the prior day to indicate this. To maintain consistency, we think it will be helpful to at least talk about the Outlook each day so that everyone is on the same page- but this may be the same as the day before & on these days we anticipate that the graphic aid would not take much time at all.

**Part 4 – Guided Practice using Case 1 (Laurel Rodgers) (5 min, slides 13-18)**

1. Let them know you will now be transitioning into the guided practice portion of training using the Laurel Rodgers Case (Slide 13)
   1. Tell them that the information on the slide is also in their Learner Manual on Page 4.

**Ask them to: TELL A STORY ABOUT THE BEST CASE**

**SCENARIO**

**TO YOUR INSTRUCTOR**

* 1. Listen to their story and prompt for any missing information using the Evaluation Checklist as a reference.

**Helpful Prompts/Questions**

To get them to elaborate on what happens in the interim... Okay, so it sounds like you think she’ll be able to go home – what happens in the interim for her?

Do you think going home will look the same for her as it was before?

“Walk it back” - what will it take for her to get to “x”?

If they ask, ‘how far out do you want us to go?’

To when you think the patient will be done recovering from this. This might be 6-12 months, maybe longer or shorter – and describe what that looks like, what they can do.

* 1. (slide 14) Based on your story, the resident/APP might write bullet points on the graphic aid. This is an example of what that would look like. This is also in the Learner Manual on Page 5.
     1. The bullet points we have might be different than what they shared – and that’s okay. The details of the story are less important than the overarching content – clinicians may have a slightly different story based on their experience and judgment.
  2. (slide 14) Talk over Worst Case – what do they feel comfortable writing on the GA?
     1. Point out the possible Worst Case Scenario at the bottom of the GA

1. (Slide 15) Now we are moving to Day 2 of Rounding for Ms. Rodgers
   1. Please read over the information on slide 15 (or in your Learner Manual on Page 5)
   2. (Slide 16-17) Has her Best Case changed? If so, how? (Ask them to talk you through this as they write on the graphic aid.)
      1. Slide 17 is for virtual training, with ability to move the star up and down, and write in the text box whatever they share with you.

**Ask them to: ADD EVENT, STAR, BEST CASE AND**

**ANY CHANGES TO WORST CASE ON GRAPHIC AID**

* 1. Listen to their story and review what they write down. Give them feedback on what they are doing well and what could be improved (if applicable).

1. (Slide 18) We will now watch a demonstration of Rounding Day 3 so you can see what this might look like when the team is present. As you watch, it would be helpful to imagine how this might work for you on rounds with your work flow. **START VIDEO AT 0:25 (AFTER INTRO)**
   1. Any questions/concerns about doing this with your team? Jot down anything they say here to inform our ongoing implementation efforts.

**COMPLETE THE GRAPHIC AID FOR**

**ROUNDING DAY 3 (OPTIONAL)**

**WORST CASE for 6/6**

**Part 5 – Evaluation using Case 2 (Colin Flaherty) (13 min, slides 19-29)**

1. (Slide 19) Now we are transitioning to the evaluation portion where you will take the lead.
   1. Here is the Evaluation Checklist I will be using as we go through the next Case. We will go over Rounding Days 1 and 2. You will also practice using the graphic aid with a family member that I will be portraying, but we will get to that in a few slides.
   2. Questions before we begin?
2. (Slides 20 & 21) Our next case is Colin Flaherty (this is also the name of a golf pro people might recognize). Please read the details on the slide or in your Learner Manual on Pages 6 and 7.
   1. (Slide 22) Now that you have read the introduction and systems-based presentation for Rounding Day 1.

**Ask them to: TELL YOU THE BEST CASE STORY AND COMPLETE THE GRAPHIC AID FOR ROUNDING DAY 1**

**WORST CASE for 6/6**

* 1. Listen to the story and review the graphic aid using the Evaluation Checklist.
  2. Share your feedback and answer any questions they have before moving on to Rounding Day 2.

**If they get a perfect score on the evaluation checklist for Rounding Day 1: Ask them if they would like to practice with Rounding Day 2. If not, you can skip to Slide 26 and use Day 1 for the roleplay. You will enter this score into the database.**

* 1. (Slides 23 & 24) Please read the information for Rounding Day 2 on the slides or in your Learner Manual on Pages 7 and 8.
  2. (Slide 25) Now that you have read the information for Rounding Day 2.

**Ask them to: TELL YOU THE BEST CASE STORY AND COMPLETE THE GRAPHIC AID FOR ROUNDING DAY 2**

**WORST CASE for 6/6**

* 1. Listen to the story and review the graphic aid using the Evaluation Checklist.
  2. Share your feedback and answer any questions they have before moving on to Updating the family.

1. (Slide 26) You will use the graphic aid to update Colin’s child (played by me). Before we do that, I just wanted to go over a few tips for using this with family members/loved ones.
   1. (Slides 26) As you know because you all do this a lot/are excellent communicators - breaking bad news helps prepare the family mentally for what comes next
   2. (Slide 27) It is helpful to frame the discussion as telling two stories
      1. “The graphic aid can really help orient them to how things might unfold over time.”
      2. “Hoping” and “worrying” helps to anchor the conversation and helps them know that you’re on their side.
   3. (Slide 28) The graphic aid stays in the room.
      1. Family can ask questions about what is on it.
      2. Family can use back-side of graphic aid to share important things about their loved one
   4. (Slide 29) You will now update Mr. Flaherty’s family member using the graphic aid. I will be playing the family member and paying attention to the elements on this portion of the Evaluation Checklist.

**Ask them to: USE THE GRAPHIC AID TO UPDATE CONNOR**

* 1. Pretend to be Connor and pay attention to the elements on the Evaluation Checklist.
     1. E.g. “Hi I’m Connor, are you Dr. X? Are you the doctor taking care of my dad? What is going on with him?”
  2. Share your feedback and answer any questions.

**Part 6 – Next Steps (2 min, slides 31-33)**

* 1. (Slide 30) “Just to summarize”: your role as attending/fellow
  2. Explain that you would like them to: Please use this for patients 50 years old and older whom you anticipate will be in the ICU for 3 or more days. This is NOT for people with isolated injuries who need to be in the ICU over night (e.g. isolated SDH). That said, if you want to use it for patients younger than 50 who you think are quite sick and will need 3 or more days in the ICU, that’s great, it will help to establish routine.
  3. (Slide 31) Timing for rollout, expectations: we are rolling this out now, we would really like you to get in the habit of using it every day on rounds, starting with your next time on service so that we can study the effects and everyone can get used to it and ask all their questions before we start collecting data (again).
  4. Set up time for check-in prior to the next time they rotate in the ICU.
     1. Tell them they will receive an email with refresher information prior to going on service.
     2. Make sure they know how to get ahold for the BCWC team (at UW and on-site).
        1. Share contact info for on-site team if they would like it.
     3. (Slide 32) End with any questions they have about the training and/or implementation process.
     4. Ask them to please fill out the self-assessment on your computer through the redcap link: <https://redcap.surgery.wisc.edu/redcap/surveys/?s=7A33XXTDJANHDE8P> OR hand them a paper copy to complete before they leave.

1. After the learner leaves..
   1. Enter their self-assessment into REDCap if administered on paper
   2. Record the higher score on the Evaluation Checklist (Colin Day 1 or 2) in redcap.
   3. Update the completion log in Box

**EXAMPLE ANSWERS FOR PRACTICE CASES**

# Laurel Rodgers

## Rounding Day 1

### Background

Ms. Laurel Rodgers is a 67 y/o female who presented to the ED as a level 1 trauma following a fall from standing. Bystanders report she was walking her dog when she fell, hitting her head on the concrete. She sustained extensive injuries, including a right subdural hematoma, multiple facial fractures, and multiple extremity fractures.

### Presentation

Ok, so by system for Ms. Rodgers…

**Neuro/Pain:** She has a right subdural hematoma seen on trauma head CT. Neurosurgery is following and wants a repeat head CT at 4 hours, which will happen in one hour. She has been sedated, so we will need to lighten her sedation in order to get a better neuro exam after she comes back from CT. For pain she has a fentanyl which appears to be working well.

**CV:** She has a history of afib, well controlled on 25mg metoprolol, currently in normal sinus rhythm. We’ll continue to monitor with telemetry.

**Pulm:** She is intubated and ventilated. Her gases are 7.4/40/25/98. PEEP is 8, tidal volume is 360, FiO2 is 50%, and rate is 10. Chest was clear on AM chest XR and her ET tube is in place. We’ll plan start trying to wean her vent when we get back from CT and do spontaneous breathing trials when ready—at least one each day.

**GI:** Abdomen is soft and non-distended. Trauma CT found no injuries. She has an NG-tube in place. No diet or tube feeds yet, but OK to give meds through the tube. Monitor for bowel movement.

**Renal/GU:** No acute issues or injuries. A foley was placed in the ED and she has been making good urine. We’ll continue to monitor and get the foley out as soon as we can.

**Heme:** Borderline anemic on labs this AM, but hemodynamically stable and no signs of bleeding except for her head. No transfusion needs at this time; continue to monitor. She takes warfarin at home; her INR in the ED was 4.0 and has since come down to 1.5 after she received 2 units of FFP for reversal.

**ID:** She’s been afebrile. White count is elevated likely secondary to trauma and not infectious, but we’ll continue to monitor.

**Endo:** History of hypothyroidism, 0.5 of levothyroxine. Continue for now.

**MSK:** For her facial fractures, plastics is consulted and they will see her in a few days to discuss operative treatment when the swelling goes down. She has a right arm and right hip fracture which orthopedics has evaluated and found to be non-operative. They are going to place a split today for her right arm.

**Prophylaxis:** Given her brain bleed we are holding anticoagulation and prophylaxis for now. We’ll keep her on a PPI for now while she is intubated.

**Outlook:** What is the Outlook?

### Best Case Sample Verbal Description

She will probably stay intubated while we finish up her CT scans. Hopefully her head bleed will be stable on CT, we can start weaning her sedation, and work to get her off the ventilator, maybe tomorrow morning or afternoon. During this time she'll get splints and some more X-rays from orthopedics and if she is doing well we can get her out of the ICU to a general care floor for recovery the rest of the week. She will go to the OR with plastic surgery likely the following week once her facial swelling is improved enough. Throughout this time she will start aggressive physical therapy, which will be difficult and painful, but if she does really well we can probably get her out of the hospital after a week and to a nursing home for more rehab for a few more weeks. I think she'll be able to go home, but she will probably need a good amount of help there for at least several months.

### Event

* Injured yesterday, intubated

### Star Location

* Around halfway between Best and Worst Case

### Best Case Sample Bullet Points

* Breathing tube out tomorrow
* Surgeries for her face
* Physical therapy, ~1 week in hospital
* Nursing home for ~2 weeks, then home with help for a few months

### Worst Case Sample Description

* Could get more sick and even die from injuries

RoundingDay 2

Update

We are here on rounds with Ms. Laurel Rodgers again – since we saw her yesterday, her head bleed got worse and she had to go to the OR to relieve the pressure.

Presentation

**Neuro/Pain:** For Neuro, she went to the OR this morning for decompressive craniotomy with neurosurgery due to worsening subdural hematoma with mass effect. She tolerated the procedure well and was returned to us this morning. Neurosurgery is involved for wound care and ICP monitoring. Pain appears well controlled.

*[skip the middle]*

**Prophylaxis:** So for prophylaxis we are continuing to hold anticoagulation, and we’ll continue her PPI while intubated.

**Outlook:** What is the Outlook?

Best Case Sample Verbal Description

Well, sadly she had this head bleed and surgery. Here’s what we are hoping for now. In the best case scenario her brain swelling improves and maybe we can be off of the medication that are keeping her blood pressure up by the end of today. Maybe by tomorrow morning we can test her movements and she won't have any lasting deficits from the worsened brain bleed. Hopefully we'll get her extubated over the next two days, after which she'll ultimately get to a regular hospital bed, start her rehab, and have more surgery to get her facial fractures fixed. I think she will be in the hospital for another two weeks after, and when she leaves she'll definitely need to go to a rehab facility for a month or two before going home where she will need a great deal of help, maybe indefinitely.

Event

Head bleed worse, needed brain surgery

Star Location

Lower than the day before

Best Case Sample Bullet Points

* Recover from brain surgery well, no deficits
* ICU ~1 week, breathing tube out
* Surgeries, rehab, hospital for ~2 weeks more
* Nursing home 1-2 months, home with lots of help

Worst Case Sample Description

Could get more sick and even die from injuries, may survive with significant deficits and be fully dependent on care.

Rounding Day 3

Update

Our next patient is Ms. Laurel Rodgers – since we saw her yesterday, she has been very agitated and has developed ICU delirium.

Presentation

**Neuro/Pain**: For neuro, her ICPs have remained stable and she hasn’t required any   
interventions since coming back from the OR yesterday. We were able to wean the   
sedation but she became very agitated. Labs are within normal limits and EKG doesn’t   
show seizure activity. She is CAM ICU positive, consistent with ICU delirium. We’ll   
continue to monitor this, try to regularize sleep/wake cycles, and try to consolidate   
medications to reduce the number of times she gets woken up and stimulated   
throughout the day.

**CV:** History of afib, continue 25mg metoprolol (home dose).

**Pulm:** She is intubated and ventilated. PEEP is 8, tidal volume is 360, FiO2 has been fluctuating between 50-60% since yesterday, desats when weaned further. She has not been able to complete a formal spontaneous breathing trial due to her agitation with weaning sedation.

*[skip]*   
**Prophylaxis**: Ok for prophylaxis we are still holding her anticoagulation until we get the   
OK from neurosurgery to restart. We’ll continue her PPI for now too.

**Outlook:** What is the Outlook?

Best Case Sample Verbal Description

I think, again, her outlook is a bit worse than initially predicted given her worsening delirium. She's been difficult to wean from the vent too. However, I think if everything goes well, we'll get her extubated tomorrow or the day after and hopefully with the tube out she will be less delirious. She'll stay in the ICU for another day or two after that as we get her respiratory status stabilized, and she'll go to a general care floor. If we're lucky, we won't have to readmit her to the ICU during the rest of her hospital stay, and she'll start the long journey toward recovery…lots of painful PT and OT work. I think she'll probably be in the hospital for another week or two, maybe three weeks after she leaves the ICU, and then she'll need to go to a nursing home for several months for more rehab. I am worried it's going to be very difficult for her to be independent and live by herself again, even if she does really well with PT and OT.

Event

Agitation, delirium (confusion)

Star Location

Slightly lower than the day before

Best Case Sample Bullet Points

* ICU until next week, breathing tube out
* General care, surgeries, hospital for ~3 weeks more
* PT, OT, nursing home several months
* Never independent again

Worst Case Sample Description

Could get more sick and even die from injuries, may survive with significant deficits and be fully dependent on care.

# Colin Flaherty

## Rounding Day 1

### Background

Mr. Flaherty is a 72 year old man with a history of hypertension who presented to the trauma bay last night after an MVC at highway speeds in which he was a belted driver involved in a collision with a semitruck. He was initially alert and oriented in the trauma bay, and the trauma team obtained a chest and pelvis xray notable for L rib fractures without pneumothorax. Prior to CT scan, he became hypotensive and lethargic; FAST revealed large amount of blood in L paracolic gutter so he was taken emergently to OR. He underwent exploratory laparotomy which revealed significant bleeding from the spleen; he underwent splenectomy and no other intra-abdominal injuries were identified. Once he was stabilized in the ICU, he underwent a CT pan scan to assess for other injuries. His only other identified injuries were L sided nondisplaced rib fractures 3-9. Overnight, he has not required additional blood transfusion and is not requiring any vasopressor support.

### Presentation

### **Neuro/Pain:** On propofol and fentanyl for pain and sedation; when paused he moves all extremities

**CV:** History of hypertension, takes lisinopril which we are holding.

**Pulm:** Ventilated on volume control setting with FiO2 40%, PEEP 5, TV 400, RR 16. AM CXR without pneumothorax, does show some L sided opacity consistent with pulmonary contusion. Anticipate SBT/extubation this morning.

**GI:** s/p splenectomy, NPO with OG tube in place while intubated. We will remove OG tube when extubates and start liquid diet.

**Renal/GU:** making adequate urine, Cr 0.9, remove foley catheter today. continue maintenance IVF while NPO.

**Heme:** Hgb stable this morning at 9 from 8 yesterday. Received total of 3 pRBC, 2 FFP, 2 plts yesterday. INR, PTT, TEG all within normal parameters this AM. Continue Hgb checks q6h until this evening, then can space to q12h.

**ID:** will need splenectomy vaccines prior to discharge

**Endo:** no history of DM, sliding scale insulin available for stress-induced hyperglycemia, has not required any doses

**MSK:** No acute issues.

**Prophylaxis:** If hgb remains stable at mid-day check will start lovenox for DVT ppx. On PPI while intubated, will discontinue if extubates today.

**Outlook:** What is the Outlook?

### Best Case Sample Verbal Description

We will work toward getting him off of the ventilator and taking the breathing tube out, hopefully later today. He will probably still have a lot of pain with breathing because of his broken ribs and we will want to make sure that he can get enough oxygen. If his pain is controlled and he is breathing ok he might leave the ICU tomorrow or the next day. His belly will also need time to recover after surgery; sometimes the intestines can take some time to wake up and start working after a big injury like this. He will probably be in the hospital for another week after leaving the ICU so that we can make sure his breathing and his belly is ok, and that his pain is controlled. He will work with our physical therapists and occupational therapists while he is here in the hospital. Depending on how much he is able to move around after this injury, he may need to go to a nursing or rehab facility for a week or two to get stronger; he also may need someone to live at home with him for several weeks while he recovers. I hope that in about two months he will mostly be able to take care of himself at home like he was before.

### Event

Injured yesterday, emergency abdominal surgery

### Star Location

Somewhere in upper half of chart, ~75%

### Best Case Sample Bullet Points

* Extubation today, ICU for 1-2 days
* Bowels begin to work in 1-2 days (may take longer because of bleeding and surgery on belly)
* Pain control, therapy in hospital for 1 week
* May require rehab stay for 1-2 weeks or additional support at home
* About two months before he is close to how he was before

### Worst Case Sample Description

Complications from his injuries (more bleeding, pneumonia, trouble breathing) could result in prolonged hospital stay or even death

### Rounding Day 2

### Update

Mr. Flaherty was extubated yesterday afternoon, though has struggled with pain control associated with his rib fractures and remains on BiPAP for oxygenation needs. During tertiary exam yesterday, the trauma team noted that Mr. Flaherty had significant bruising and swelling of his L knee and distal thigh. Xrays demonstrated a minimally displaced L distal femur fracture.

### Presentation

### **Neuro/Pain:** Scheduled tylenol, gabapentin, dilaudid PCA, lidocaine patches for pain control. Requesting a local block from anesthesia team to facilitate better pain control.

**CV:** History of hypertension, takes lisinopril which we are holding.

**Pulm:** BiPAP 12/6 50% FiO2. Wean as tolerated.

**GI:** s/p splenectomy, NPO due to aspiration risk as he remains on positive pressure. Passing flatus, no bowel movement.

**Renal/GU:** making adequate urine, Cr 0.8. continue maintenance IVF while NPO.

**Heme:** Hgb stable this morning at 9.2 from 9.0. No ongoing concerns for bleeding.

**ID:** will need splenectomy vaccines prior to discharge.

**Endo:** no history of DM, sliding scale insulin available for stress-induced hyperglycemia, has not required any doses

**MSK:** Orthopedic surgery consulted for L femur fracture; planning operative intervention later today vs tomorrow pending OR availability.

**Prophylaxis:** Lovenox for DVT ppx, will hold afternoon dose per Orthopedic surgery request.

**Outlook:** What is the Outlook?

### Best Case Sample Verbal Description

Like we expected, he is having difficulty breathing enough without significant pain. If we can get his pain under control, we can decrease the amount of support he needs from the breathing mask he has in place and he might be able to leave the ICU in 1-2 days. His belly still needs some time to recover. He will now also need surgery to fix his broken, probably today or tomorrow. After he has surgery on his leg, he will need to take special precautions to allow it to heal properly and this will make it hard for him to move around. He will most likely need several weeks or more at a rehab facility to recover from his leg surgery, even if his breathing and belly problems are doing fine. He will probably need at least two months to get back to taking care of himself – and he may not be able to move around as easily or independently as he was before.

### Event

Broken L leg

### Star Location

Slightly lower than previous day

### Best Case Sample Bullet Points

* Remain in ICU until respiratory status is improved
* Surgery for leg fracture
* Bowels begin to work in 1-2 days (may take longer because of bleeding and surgery on belly)
* In hospital for 1-2 weeks
* Will require rehab for several weeks minimum in order to recover from leg surgery

### Worst Case Sample Description

* Complications from his injuries (more bleeding, pneumonia, trouble breathing) could result in prolonged hospital stay or even death
* May not recover good function of leg or be able to walk independently

### Family Scenario

Mr. Flaherty’s child, Connor, flew in from Washington, DC, where they live when they heard that their dad was in the hospital. They are in the room and asking for an update from one of the physicians on how their dad is doing. Using the BC/WC-ICU graphic aid, help update Connor.