"Mind that ceiling!" A junior doctor's perspective on ceilings of care, evolving decisions for elderly patients

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Sepsis is a reversible cause of death. Ceilings of care should be set in advance for patients, but it should be an evolving discussion between all those involved. The objective of this clinical case report is to highlight the importance of identifying reversible causes in the elderly with multiple co-morbidities and empowering junior doctors to re-visit decisions made and escalate swiftly and appropriately.

An 84 year-old white female presented with 2 days of right calf erythema and right iliac fossa tenderness. Symptoms occurred following laceration of her right leg. She became unwell with nausea and vomiting. Abdominal computed tomography revealed reactive lymphadenopathy and blood cultures grew *Group A Streptococci*.

On admission to the ward, the patient agreed not to be resuscitated nor be admitted to the High Dependency/ Intensive Care Unit. She remained hypotensive despite 3 litres of intravenous crystalloid fluids. She maintained mental capacity and said "do whatever is best for me." With this, the junior doctor altered the recorded ceilings of care, referred to the intensivists for consideration of inotropic support. After 24 hours of intensive care, the patient was successfully stepped down to continue treatment for cellulitis on the ward until discharge home.

If the admission to the intensive care unit was delayed (due to senior doctors unavailable whilst attending emergencies) or cancelled due to the previously stated "ward base care only," the patient would have had a significantly different outcome. Decisions regarding ceilings of care should be re-evaluated on a regular basis to accommodate individual clinical pictures.

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