Choosing Wisely®

An initiative of the ABIM Foundation

Society of Critical Care Medicine

The Intensive Care Professionals

Choosing Wisely for Critical Care: The Next Five

1 Do not leave lines, tubes or drains in ICU patients that have not been evaluated at least once daily and judged to provide continued patient benefit.

Patients in intensive care units often require invasive lines (access) to be inserted and maintained for medication delivery, fluid administration, monitoring and life support. The majority of hospital-acquired infections and unintended safety events are due to line and drain placements. Reducing time to exposure by assessing continuous need and opportunity for discontinuation of invasive access is in the best interest of the patient (11, 12).

2 Do not delay mechanical ventilator weaning unless there is clinical evidence of need.

Patients can linger on mechanical ventilation with invasive tubes for periods longer than necessary, particularly when processes for spontaneous awakening and breathing trials and weaning protocols are not implemented consistently. Most ICUs assess mechanical ventilation needs daily; however, opportunities for discontinuance can present throughout the day. Where it is safe and can be accomplished, current guidelines recommend removing patients from mechanical ventilation as soon as it is safe to reduce pain, reduce patient anxiety, minimize exposure to infection and to promote liberation as a standard practice (13-16).

3 Do not delay discontinuation of antibiotics in culture negative and asymptomatic patients with sterile cultures beyond 48 hours.

SCCM fully supports the CDC's call for hospitals to implement antibiotic stewardship programs to avoid harm to patients from the misuse of antibiotics. Given SCCM's prominence as a clinical practice guideline producer, SCCM encourages informed consideration of antibiotic use and continuation in all related published guidelines (17-19).

4 Do not delay mobilizing patients beyond 48 hours from ICU admission for patients who passed mobilization safety screening.

SCCM has supported early mobility in ICU patients since 2013 when the first SCCM Clinical Practice Guidelines for the Management of Pain, Agitation, and Delirium in Adult Patients in the Intensive Care Unit were published (20-22). The evidence for mobilizing patients who pass safety screens is growing as provided in the subsequent 2018 PADIS guidelines (13). SCCM's ICU Liberation Campaign has reinforced safe mobilization as a method to help reduce sedatives, encourage reduction of ICU related delirium and support strength maintenance and building in this vulnerable patient population (23-26).

5 Do not provide care that does not align with the documented patient's and family's goals, values and preferences for healthcare.

Five million persons are admitted annually to intensive care units in the United States annually and 20-40% require mechanical ventilation or other life support [https://www.sccm.org/Communications/Critical-Care-Statistics]. One in five adults die during a hospitalization that includes ICU admission, and 25% of total healthcare costs are expended on the 6% of people who die each year (27). Accordingly, consideration for documented care wishes is crucial (28). Condition of ICU patients is often uncertain and dynamic, which adds stress to the families and the care staff. Early goal-oriented care discussions with the family were reported to reduce ICU admissions and over-all hospitalizations near the end of life (29). SCCM encourages ICU clinicians to consider each patient's religious and cultural standards and to have open communications with patients and their families as early as possible in the ICU stay. Establishing goals of care is a crucial component in the decision-making process aligning care with desired outcomes wherever possible.

This recommendation recognizes the importance of empowering and engaging the family in the care plan. For possible additional rationale, Recommendation 5 mirrors element "F" in ICU Liberation (ref), as part of a bundle of 6 usual care element for critically ill patients (23). This approach to care is associated with improvements in multiple patient-centered, clinically meaningful outcomes for critically ill patients.