SCCM Choosing Wisely KEG meeting February 17, 2021

Choosing Wisely in Critical Care: Successful Implementation of the Next Five

Speaker:
Lewis Kaplan, MD

Slides are available on SCCM Connect - Choosing Wisely KEG website

1. The Process of The Next Five – Convened multidisciplinary committee to start but also wanted to include the membership. Process of development followed a similar path as the "First Five" but differed in that the topics were offered up to the membership for a vote. Resulted in a "Next Five" that are embraced by a much broader group from multiple disciplines.

2. The Next Five:

1 Don't retain catheters and drains in place without a clear indication.

Patients in intensive care units typically require insertion of catheters and drains for fluid and medication delivery, pressure and flow monitoring, and fluid and gas evacuation. The majority of hospital-acquired infections and unintended safety events are associated with such devices. Daily assessment of need for invasive devices should be an essential element of critical care workflow, to reduce time of exposure by identifying the earliest opportunity for their discontinuation.

This concept is widely embraced but may meet resistance with certain specialties. This recommendation may be a little contentious for some; the wiggle room is in identifying a clear indication. Another layer to this recommendation was that removing the drain is key to stopping antibiotics ordered for the duration of drain placement.

2 Don't delay progress towards liberation from mechanical ventilation.

Although mechanical ventilation is frequently lifesaving, it is also associated with numerous complications. Discontinuation of mechanical ventilation support is frequently the rate limiting step in ICU discharge. Current guidelines recommend removing patients from mechanical ventilation support as soon possible, utilizing mechanical ventilation liberation and sedation interruption protocols in concert with structured multidisciplinary rounds.

This recommendation is generally well accepted. The focus here was for organizations to 1) empower other members of the team to initiate SBT ahead of rounds and 2) liberate patients from the ventilator as soon as ready (even if after-hours) as long as adequate resources are available and safely able to do so.

3 Don't continue antibiotic therapy without evidence of need.

In addition to employing microbe-directed therapy, a core principle of antibiotic stewardship is limiting antimicrobial therapy to the shortest effective duration. As a general rule, antimicrobials should be discontinued when the condition for which they were prescribed has been adequately treated, as one strategy to ensure access to effective antimicrobials, at a time when increased antimicrobial resistance represents a global health care challenge.

This was an easy one to embrace. Addresses the core statement and also provides support for building antimicrobial stewardship programs.

4 Don't delay mobilizing ICU patients.

Patients can develop significant muscle weakness and atrophy (including the diaphragm) during their ICU stay due to immobilization. However, multidisciplinary facilitated early mobilization has been shown to be safe in the ICU setting. Numerous, patient-centered, clinically meaningful outcomes are supported by early mobilization of critically ill patients.

Many places don't have enough PT staff to do this in a durable fashion. This recommendation supports both the notion of mobility as well as hiring practices for adequate number of PT to enable complex patients to ambulate and the support devices they need.

5

Don't provide care that is discordant with the patient's goals and values.

The condition of ICU patients is often uncertain and dynamic, which generates stress for ICU families and the care staff. Accordingly, eliciting and documenting desired care preferences helps ensure the provision of goal-concordant care. Patients, families and providers may participate as partners in shared decision-making to ensure that goals and values align with care that is offered and provided.

This is about goals and values, not preference. Takes time to discover and Palliative Care are very helpful to understand the goals. Often the way we explain things to patients may not be as granular as they need to truly inform whether this will be concordant or discordant with their wishes and values.

3. Discussion and Q&A
    a. What is Dr Kaplan's advice to address this on an everyday basis on every single patient?
        i. This must be part of how you deliver care; part of your checklist you consider every day. Consider laminated cards to make these visible and easily understood by everyone from the care team to support staff and family members. Work on these until they become second nature – a habit that is part of the workflow.
    b. Dr. Reddy shared a few of the Epic EMR tools they have developed at Cleveland Clinic:
        i. Quality audit list that is color coded to flag when devices have been in place too long. Additional info is available (ie, patient on a vasopressor) to add context to the appropriateness of the device.
        ii. They have team-based, cumulative line counts that gives an additional visual for the medical staff
        iii. They have created a checklist for the ICU to address each component of ICU Liberation
    c. Compared to the First Five, there were three of the Next Five that specifically address ICU Liberation. Was this discussed at length during development?
        i. They didn't draw from ICU liberation. He suspects part of the draw from ICU Liberation is how successful the initiative has been. In the First Five there was some hesitancy to be less provocative. There are great data for every recommendation in the Next Five. The ICU liberation studies are probably the best example of bundled care leading to an improved outcome that you will find anywhere.
    d. These elements should be built into the trainee education to also pass on in verbal reports so they are communicated consistently and also reinforce that these are valued aspects of care.
    e. How do others reinforce some of the Choosing Wisely recommendations so they are part of everyday care?
        i. Verbal communication and reinforcement (consider disseminating survey to determine who enforces this)
        ii. (EPIC) Have checklists built into the EMR similar to what Dr. Reddy shared. Go through checklist at the end of rounds, led by attending or fellow. Track compliance and report out at each ICU meeting.
        iii. Including family in rounds was effective (eliminated provider fatigue, prevented copy forward issues where due diligence not done before rounds)
        iv. They are creating virtual appointments to update family (text multiple family members at once, notify family they will round on the patient soon and provides a link for family to join)

v. Many of these decisions are nurse driven so there is a nurse leader who evaluates and sometimes unilaterally makes the decision to advise the bedside nurse to pull the urinary catheter and place an external device.

Feb 17th meeting attendees:

Jessica Mercer
Anita Reddy
Anne Rain Brown
Peter Lindbloom
Matt Tyler
Ally Hines
Bryan McGill
Kalpana Singh
Matt Siuba
Mais Yacoub
Amy Yeung
Russ Roberts
Maya Dewan