Tests, treatments and procedures at risk of inappropriateness in Italy

that Health Professionals and Patients should talk about.

Five Recommendations from the Italian Association of Critical Care Nurses – ANIARTI (FNOPI Professional Society)

1	**Don't replace regularly the mechanical ventilator circuits to reduce the risk of VAP (Ventilator Associated Pneumonia)**
	Routine replacement of the mechanical ventilator circuits is not recommended. These should only be replaced if they are visibly dirty (with plenty of moisture and / or secretions). VAPs produce increased morbidity and mortality and rise the costs for hospitalized patients in intensive care (ICU) with the presence of endotracheal tube (ETT). Routine replacement of the ventilation circuit does not decrease the risk of infection. Effective interventions to reduce VAPs can be inserted in a "bundle" (combination of preventive strategies) which considers: keeping the patients' head elevated at least 30 ° (compatibly with any constrained position due to functional limitations); hygiene of the oral cavity with an alcoholic solution of chlorhexidine mouthwash to 0.12% at least every 6 hours; hand hygiene of healthcare workers; use of ETT with subglottic suction lumen; early extubation and mobilization.
2	**Don't routinely use personal protective equipment (gowns, masks, hats, gloves, ...) for the access of family members in ICU**
	The infections related to care practices are an important cause of morbidity, mortality, prolonged hospital stay and have a significant economic impact. Patients admitted to intensive care units (ICU) are at high risk of acquiring infections due to reduced immunity (eg. trauma outcomes, corticosteroid therapy), and frequent exposure to invasive procedures. The entry of family members in ICU highlighted the importance of controlling any infectious risk, but the use of personal protective equipment is not effective in limiting bacterial colonization, infections and patients' mortality. However, hand hygiene before and after entering the unit is essential to prevent infections.
3	**Don't perform endotracheal aspirations at regular intervals but according to early indicators of retention of bronchial secretions.**
	Endotracheal suctioning of secretions through a ventilatory prosthesis (orotracheal or tracheostomy tube) is not a riskless procedure. Despite international literature is lacking both on the ways and on the times of suction, since long ago the main recommendations are that the procedure should be carried out with the minimum frequency or when clinically indicated by the presence of secretions in the ventilatory prosthesis. The early indicators for the diagnosis of bronchial secretions retention are: change in the volume flow loop (presence of a "saw tooth" track); presence of coarse crackles (detectable by dedicated tools); increase in peak pressure in volumetric ventilation or decreased current volume in pressometric ventilation, arterial desaturation. In the absence of these indicators do not perform "routine aspirations."
4	**Don't replace peripheral venous catheters at regular intervals but based on clinical evaluation.**
	The routine replacement (or at regular intervals) of peripheral venous catheters has a lower cost-benefit than a replacement following clinical criteria. The decision to replace the peripheral venous catheter should be based on the assessment of the patient's conditions; the vascular access site; the skin integrity and used vein; the duration and type of prescribed therapy; the integrity, patency and stability of the device; the fastening dressing. Replacement strategies of the catheters as clinically indicated reduce costs and inconvenience for patients without increasing the risk of phlebitis. Potential complications such as phlebitis, occlusion and accidental catheter removal are related to other risk factors.
5	**Don't maintain routine preoperative fasting since the midnight preceding the elective surgery.**
	Even today, in many surgical units patients are invited to fast solids and liquids since the midnight preceding surgery, even though it is shown that this practice does not reduce the possibility of aspiration into the airway in case of general anesthesia. Indeed, scientific literature shows that drinking water before surgery produces significantly less gastric volumes in patients not considered at risk, defined class 1 (healthy patient) or 2 (mild systemic disease) according to ASA (American Society of Anesthesiology) classification. For these reasons patients ASA I and II and patients not affected by diseases impacting the digestive function (obesity, gastroesophageal reflux, diabetes) can take clear liquids up to two hours before surgery (water, tea, chamomile tea, black coffee ... i.e. anything that has the effect of "transparency"). To help patients in medication intake in the immediate pre-operative, you may administer up to 30 ml of water. If the surgery is postponed, the opportunity of administer some water to avoid excessive thirst and dehydration should be considered. Adults undergoing emergency surgery should be treated as if they were on a full stomach. The caring approach must be interdisciplinary and involve all persons appointed to manage the "preoperative fasting"

Please note that these items are provided only for information and are not intended as a substitute for consultation with a clinician. Patients with any specific questions about the items on this list or their individual situation should consult their clinician.

Released: 1 October 2016

How this list was created

ANIARTI (National Association of Critical Care Nurses) accepted the invitation of Slow Medicine and the National Federation FNOPI and was involved along with other scientific companies and professional associations - for what concerns their area of professional expertise - in the identification of care procedures at high risk of inappropriateness, as required by Slow Medicine as a part of the project "Doing more does not mean doing better- Choosing Wisely Italy". Alike for other associations, the National Council established a working group which, after identifying the procedures that best meet the criteria of "DON'T DO" for risks of inappropriateness, conducted a review of the literature to prove the lack of efficacy or the risk of harm to patients for widespread practices in Critical Area. The methodological approach was organized by the Academy of Nursing Sciences (ASI).

Sources

1	1. Levy MM. A new definition of ventilator-associated pneumonia: far from perfect, better than before. Ann Am Thorac Soc. 2013 Dec;10(6):644-5. 2. Rosenthal VD, Bijie H, Maki DG, Mehta Y, Apisarnthanarak A, Medeiros EA, et al. International Nosocomial Infection Control Consortium (INICC) report, data summary of 36 countries, for 2004-2009. Am J Infect Control 2012;40(5):396-407. 3. Eom JS, Lee MS, Chun HK, Choi HJ, et al. The impact of a ventilator bundle on preventing ventilator-associated pneumonia: A multicenter study. Am J Infect Control. 2014 Jan;42(1):34-7 4. Mietto C, Pinciroli R, Patel N, Berra L. Ventilator Associated Pneumonia: Evolving Definitions and Preventive Strategies. Respir Care. 2013 Jun;58(6):990-1007
2	1. Mongardi M, Melotti R, Sonetti S, Moro ML. Il rito della "vestizione" per l'accesso dei visitatori nelle Unità di Terapia Intensiva: revisione della letteratura ed indicazioni operative. Scenario. 2008;25 (3): 30-34 2. Webster J, Pritchard MA. Gowning by attendants and visitors in newborn nurseries for prevention of neonatal morbidity and mortality. Cochrane Database Syst Rev. 2003;(3):CD003670. 3. Malacarne P, Corini M, Petri D. Health care-associated infections and visiting policy in an intensive care unit. Am J Infect Control. 2011 Dec;39(10):898-900. 4. World Health Organization. WHO Guidelines on hand hygiene in health care. First Global Patient Challenge: Clean Care is Safer Care. Geneva, Switzerland: World Health Organization, 2009
3	1. American Association for Respiratory Care. Clinical practice guideline. Endotracheal suctioning of mechanically ventilated patients with artificial airways: 2010. Respir Care. 2010; 55(6):758–764 2. Lucchini A, Zanella A, Bellani G, Gariboldi R, Foti G, Pesenti A, Fumagalli R. Tracheal secretion management in the mechanically ventilated patient: comparison of standard assessment and an acoustic secretion detector. Respir Care. 2011 May; 56(5): 596-603 3. Pedersen CM, Rosendahl-Nielsen M, Hjermind J, Egerod I. Endotracheal suctioning of the adult intubated patient-what is the evidence? Intensive Critic Care Nurs. 2009; 25(1):21-30.
4	1. Tuffaha HW, Rickard CM, Webster J, Marsh N, Gordon L, Wallis M, Scuffham PA. Cost-Effectiveness Analysis of Clinically Indicated Versus Routine Replacement of Peripheral Intravenous Catheters. Applied Health Economics and Health Policy, 01/2014 2. Infusion Nurses Society (INS), Infusion Nursing. Standards of practice, Revised 2011. Journal of Infusion Nursing. 2011; 34: 1-110. 3. Healthcare Infection Control Practices Advisory Committee (HICPAC). Guidelines for the Prevention of Intravascular Catheter-Related Infections. Atlanta, CDC and Prevention, 2011 4. Rickard C, Webster J, Wallis MC, Marsh N, McGrail M, French V, Foster L, Gallagher P, Gowardman J, McClymont A, Whitby M. Peripheral intravenous catheters can be left in situ until clinically indicated for removal: Randomised controlled trial. Australian Critical Care. 2012; 25(2):125. 5. Wallis MC, McGrail M, Webster J, Marsh N, Gowardman J, Playford EG, Rickard CM. Risk Factors for Peripheral Intravenous Catheter Failure: A Multivariate Analysis of Data from a Randomized Controlled Trial. Infection Control and Hospital Epidemiology, 2014; 35(1):63-68.
5	1. Brady M., Kinn S., Stuart P. Preoperative fasting for adults to prevent perioperative complications (Review). Cochrane Database of Systematic Reviews. 2003, Issue 4. Art.No. CD004423. 2. Soreide E., Eriksson L.I., Hirlekar G., Erikosson H., Henneber W., Sandin R., Raeder J. Pre-operative fasting guidelines: an update. Acta Anaesthesiol Scand 2005; 49.1041-1049. 3. Westby M, Bullock I, Gray W, Lardner-Browne C, Rashid R, Perioperative fasting in adults and children, Clinical Practice Guidelines, Royal College of Nursing, 2005;1-14

Slow Medicine, an Italian movement of health professionals, patients and citizens promoting a Measured, Respectful and Equitable Medicine, launched the campaign **"Doing more does not mean doing better- Choosing Wisely Italy"** in Italy at the end of 2012, similar to Choosing Wisely in the USA. The campaign aims to help physicians, other health professionals, patients and citizens engage in conversations about tests, treatments and procedures at risk of inappropriateness in Italy, for informed and shared choices. The campaign is part of the Choosing Wisely International movement. Partners of the campaign are the National Federation of Medical Doctors' and Dentists' Orders (FNOMCeO), that of Registered Nurses' Orders (FNOPI), the Academy of Nursing Sciences (ASI), National Union of Radiologists (SNR), Tuscany regional health agency, PartecipaSalute, Altroconsumo, the Federation for Social Services and Healthcare of Aut. Prov. of Bolzano, Zadig. www.choosingwiselyitaly.org; www.slowmedicine.it

ANIARTI is a professional association which, since 1981, promotes and enhances the culture, the skills and the practicality of critical care nurses throughout the national territory. The critical area is the set of intensive intra- and extra-hospital structures and the totality of situations characterized by the criticality and instability of the patient and by the complexity of nursing care. Critical care nurses ensure timely, intensive and continuous care to any person in situation of instability and/or life-threatening, also using complex technological instruments and devices. Aniarti aims at improving the quality of nursing care.

www.aniarti.it