SOCIETY OF CRITICAL CARE MEDICINE (SCCM) OFFICIAL GUIDELINES

Caring for Older Adults in the ICU

An Evidence-to-Practice Blueprint for Geriatric Critical Care

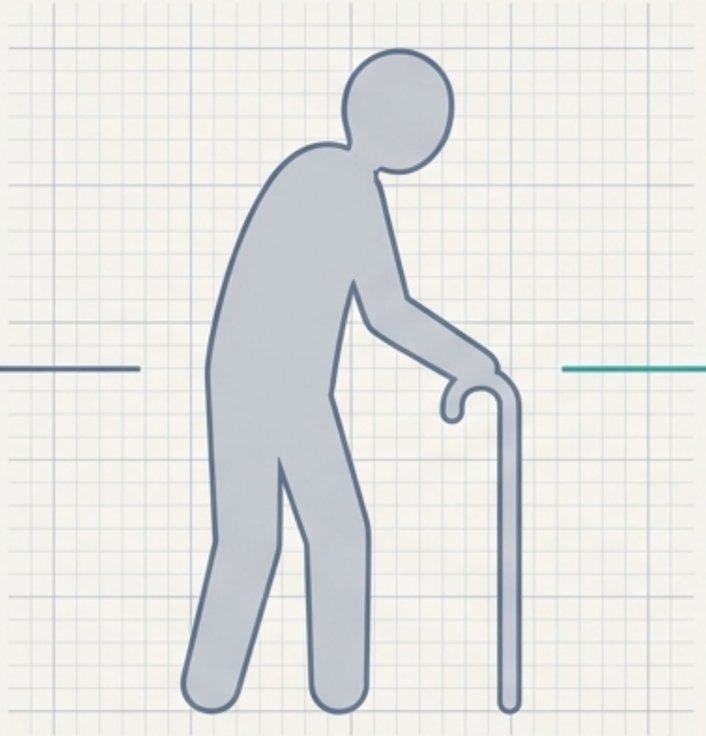
Based on the expert consensus of a 22-member interprofessional panel
(DOI: 10.1097/CCM.0000000000007085)

The Paradigm Shift in Geriatric Critical Care

Traditional ICU Focus

Survival at All Costs

Metrics focused strictly on mortality, mechanical ventilation duration, and acute stabilization.



Older Adult Priority

Maintaining Functional Independence

Older adults rank this over survival. Metrics must account for cognitive preservation, avoiding polypharmacy, and limiting immobility.

Older adults (≥65) have incurred more than 50% of all ICU days for the past 25 years.
Frailty is a stronger determinant of outcomes than chronological age.

Evidence-to-Decision Methodology

The Panel

The Panel

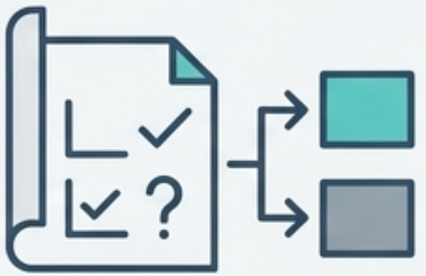
22-member interprofessional ACCM panel (physicians, nurses, pharmacists, therapists, patient rep)

The Filter (GRADE & EtD)

The Filter (GRADE & EtD)

Systematic reviews using GRADE methodology and the Evidence-to-Decision (EtD) framework to balance desirable vs. undesirable effects

The Output



The Output

5 prioritized PICO questions leading to 2 conditional recommendations and 3 "no recommendation" statements

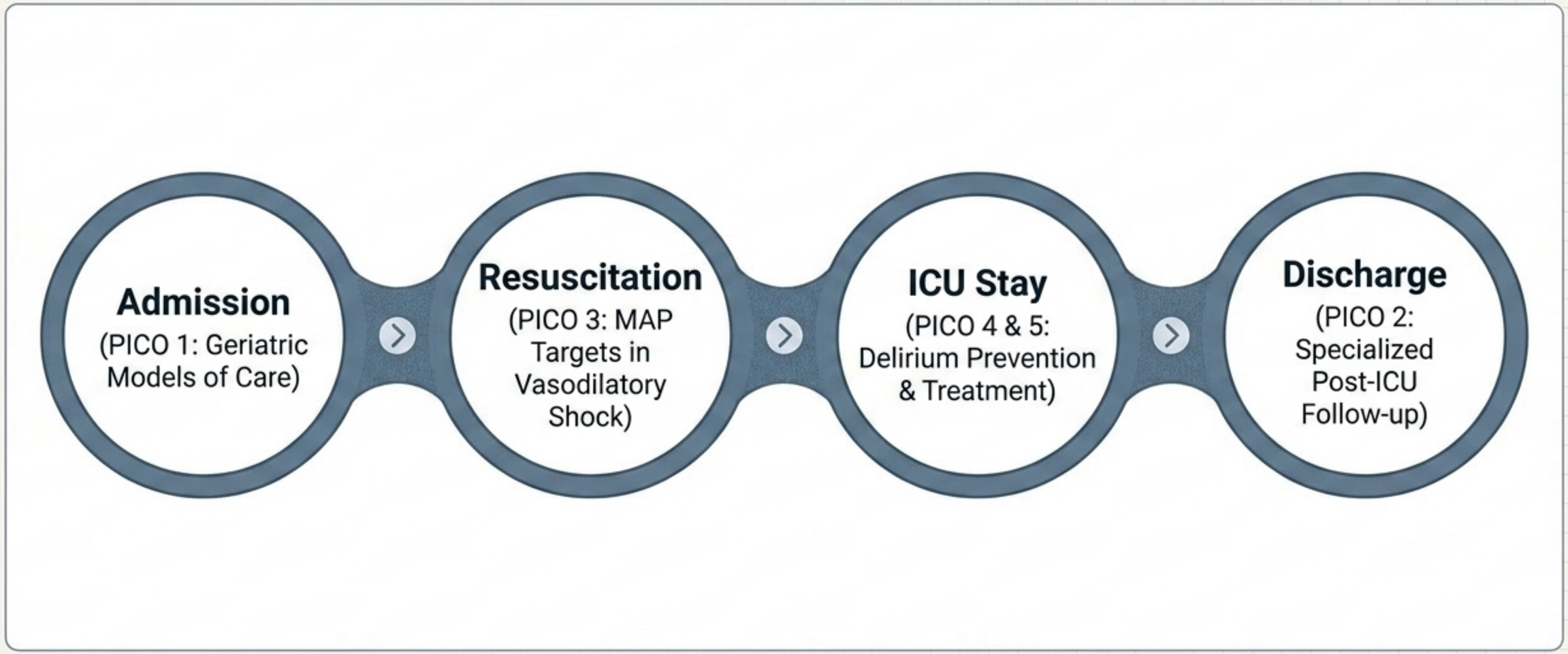
How to Read the Recommendations

Target Audience	Strong Recommendation ("We recommend")	Conditional Recommendation ("We suggest")
For patients	Most want this.	Majority want this, but many would not.
	(Note: No strong recommendations were made in this guideline).	
For clinicians	Should be standard of care/quality indicator.	Requires shared decision-making aligned with patient values.
For policymakers	Can adapt as policy.	Requires substantial debate; policies will vary.

The SCCM Geriatric ICU Guidelines at a Glance

Clinical Domain	Intervention	Recommendation	Certainty
Admission	Geriatric Model of Care	Suggest (Conditional)	Very Low Certainty
Hemodynamics	Lower MAP Target (60-65 mmHg)	No Recommendation	Very Low Certainty
Neurological (Prevention)	Antipsychotics for Prevention	Suggest Against (Conditional)	Very Low Certainty
Neurological (Treatment)	Antipsychotics for Treatment	No Recommendation	Low Certainty
Post-ICU	Specialized Follow-up Clinic	No Recommendation	Low Certainty

The Older Adult’s Critical Illness Pathway



The following slides trace this pathway, applying the GRADE recommendations sequentially to clinical practice.

VERY LOW CERTAINTY

SUGGEST

We suggest a geriatric model of care for all older adults admitted to the ICU.

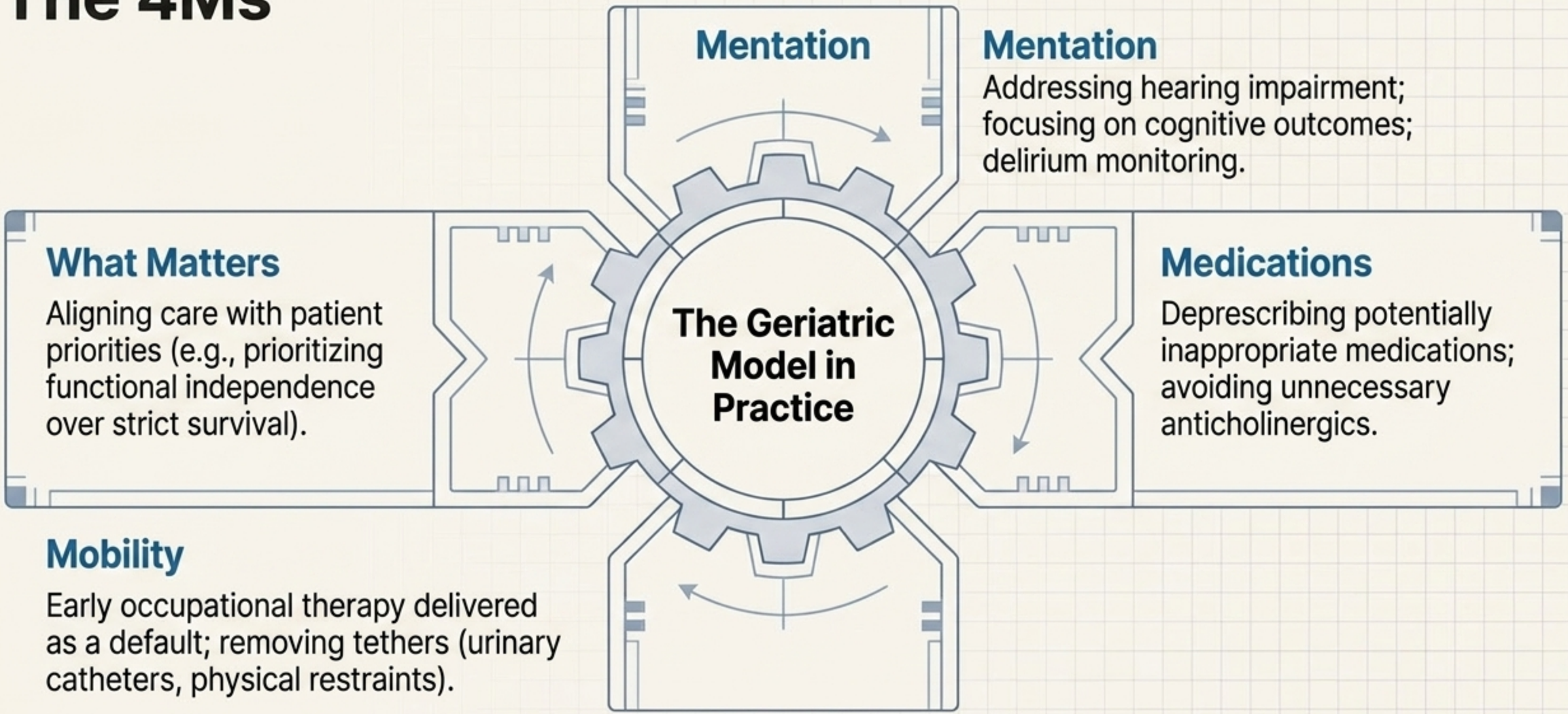
The Why (Evidence)

While direct RCT evidence shows uncertain effects on mortality (RR 0.40) or long-term ADL performance, indirect evidence from trauma/surgical units indicates small-to-moderate desirable effects.

The Nuance (Context)

Outcomes like mortality and length of stay may be less important to older adults than living independently and cognitively intact. Implementation of these models poses trivial risk of harm.

Operationalizing the Recommendation: The 4Ms



VERY LOW CERTAINTY

NO RECOMMENDATION

For vasodilatory shock, we make no recommendation regarding targeting a lower MAP (60-65 mmHg) vs. usual care (>65 mmHg).

The Why (Evidence)

A single RCT in older adults showed uncertain effects on 28-day mortality (RR 0.94) and quality of life.

The Nuance (Context)

Lower targets meant less vasopressor exposure (fewer central/arterial lines). It was cost-effective at 90 days (70% probability) but attenuated at 1 year (40%). Undesirable effects were likely trivial, but insufficient evidence prevents a formal recommendation.

The MAP Target Trade-Off

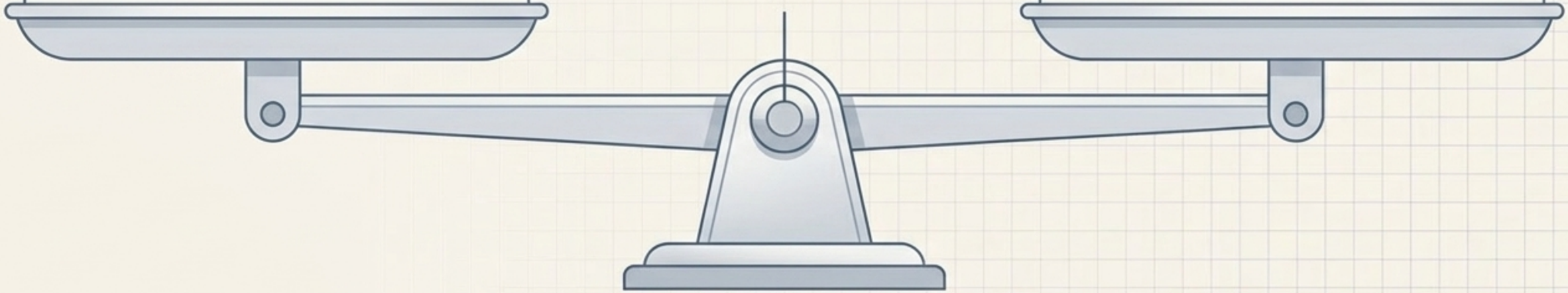
Lower Target: 60-65 mmHg

- Less vasopressor exposure, fewer central lines, fewer arterial lines, potential cost savings at 90 days.

With only one trial published, the evidence weight cannot tip the scale to a formal recommendation, leaving practice to clinical discretion.

Usual Care: >65 mmHg

- Aligns with standard clinical comfort zones; avoiding potentially deleterious hypoperfusion in unstudied subgroups.



The Antipsychotics Paradox (Delirium in the ICU)

Suggest Against | Very Low Certainty

Prevention

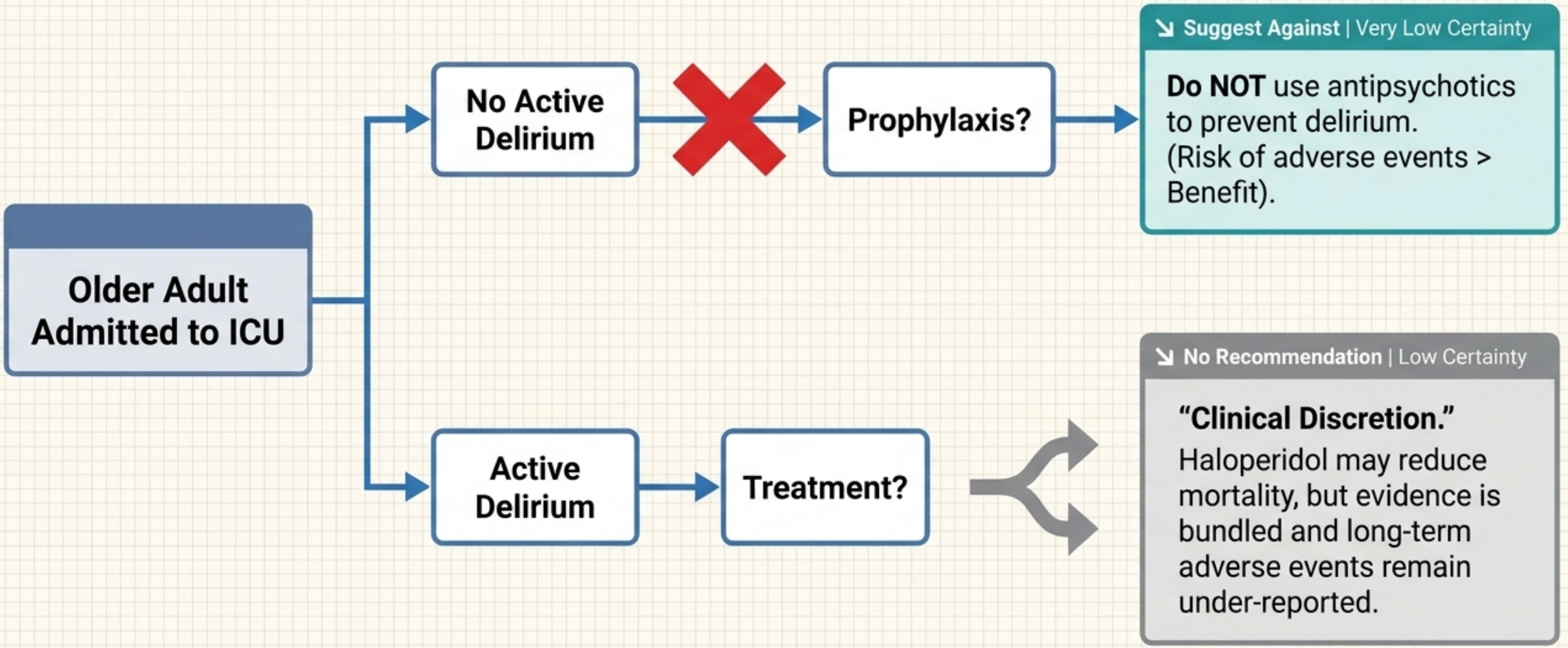
Prophylactic use (haloperidol/quetiapine) showed NO difference in delirium- or coma-free days. Panel cited high concern for inappropriate continuation post-discharge and known adverse events in older adults.

No Recommendation | Low Certainty

Treatment

Haloperidol for *active* delirium showed a possible reduction in mortality (RR 0.84). However, effects on hospital length of stay and mechanical ventilation were uncertain, and interventions were bundled in trials, confounding the mortality benefit.

Navigating Delirium Care



LOW CERTAINTY

NO RECOMMENDATION

We make no recommendation regarding specialized post-ICU outpatient follow-up.

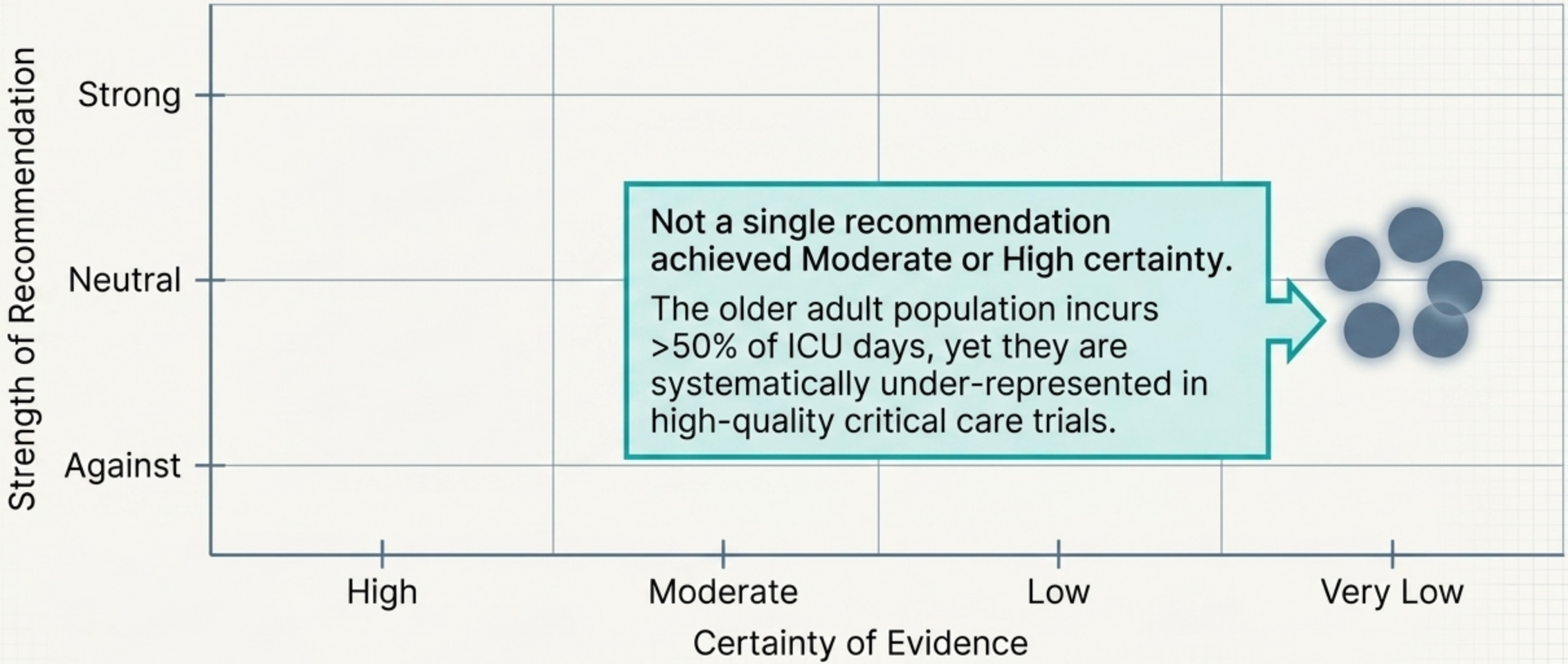
The Why (Evidence)

Subgroup data from 5 RCTs showed uncertain effects on mortality (RR 1.07), health-related quality of life (SF-36, EQ-5D), and anxiety/depression symptoms.

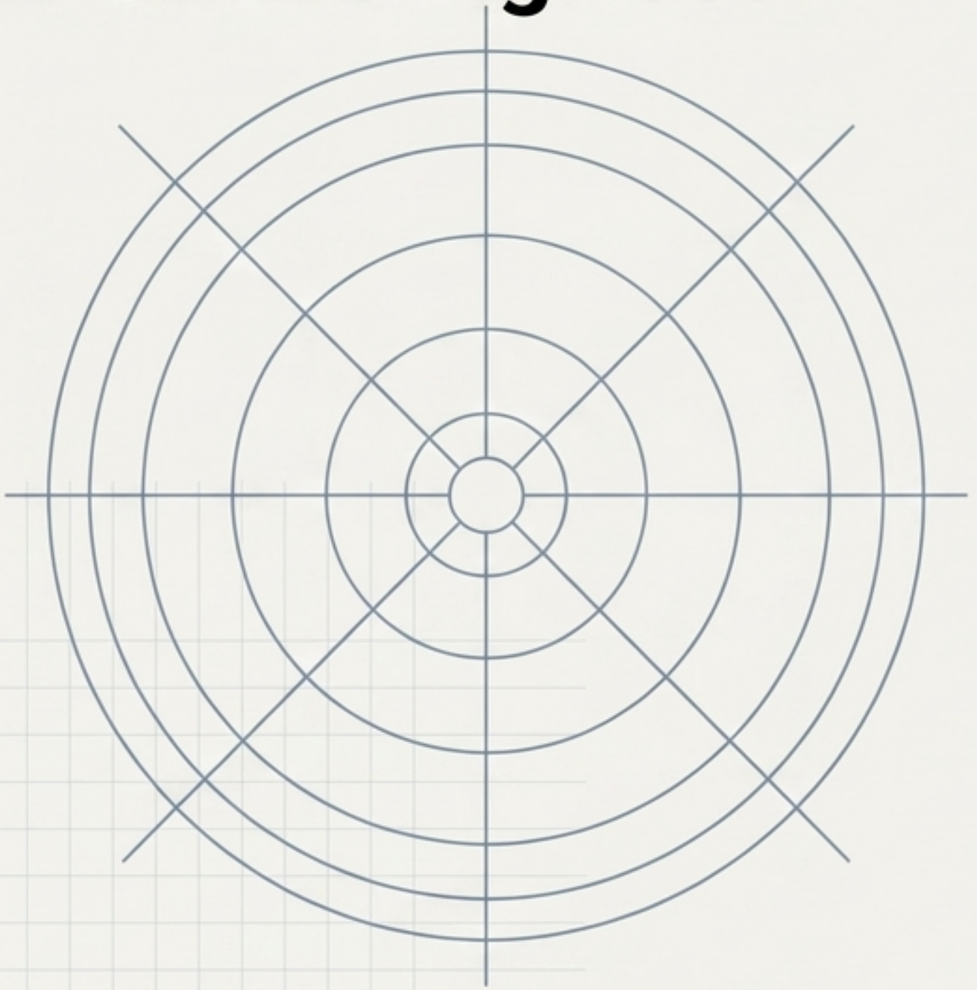
The Nuance (Context)

Multidisciplinary clinics are highly heterogeneous and potentially resource-intensive. Current studies failed to measure outcomes most meaningful to older adults, such as return-to-home and restoration of independent function.

The Synthesis: A Massive Certainty Gap



The Geriatric Critical Care Research Agenda



1. Redefining Outcomes

Future trials must develop a core outcome set prioritizing what matters to older adults: cognitive preservation, long-term functional mobility, and community independence (not just 28-day mortality).

2. Dedicated Demographics

Need large-scale RCTs *exclusively* enrolling older adults, specifically parsing out subgroups with biological or social frailty.

3. Unbundling Interventions

Studies must isolate specific variables (e.g., precise 4Ms adherence, unbundled antipsychotic use, specific MAP targets) rather than relying on heterogeneous care packages.

SCCM Guidelines on Caring for Older Adults in the ICU (2026).