Alberta Health Services
Critical Care Strategic Clinical Network™

Delirium News

Winter 2017 Critical Care SCN

Photo credit: Jeanna Morrissey

ICU Delirium LS #4!

Date: May 1st, 2018, Edmonton AB

Featured expert speakers:

Dr. Margaret Herridge

Dr. Herridge is an intensivist at the Toronto General Hospital and a professor of medicine, critical care, and pulmonary medicine at the University Health Network. Her extensive area of academic focus includes research on long-term patient outcomes after critical illness. Dr. Herridge is the director of the RECOVER Clinical and Research Program for patient and family-centered care after critical illness.

Dr. Christopher Grant

Dr. Grant is a Clinical Assistant Professor of Physical Medicine and Rehabilitation at the Cummings School of Medicine, University of Calgary. His practice includes inpatient care at the Foothills Medical Center and Peter Lougheed Centre, and research interest focuses on critical care rehabilitation. He currently directs the ICU Recovery Clinic for Calgary, a clinic that helps people heal from difficulties associated with stays in the ICU.

Karen Choong

Dr. Choong joined the Division of Critical Care in the Department of Pediatrics at McMaster University in 2003. Her current academic area of focus is around acute pediatric rehabilitation in critically ill children, including efficacy of rehabilitation on patient-important short and long-term outcomes.

Inside this issue:

Learning Session #4: Announcements

Stop thief! Stealing ideas that could get you ahead of the game

Unit Success Stories

"Ask an Occupation Therapist" blog

Causes of agitated behavior: you want me to try what?

New AHS Delirium website

What's COOL this winter?

Have a few minutes to spare? Check this out!

In 8 min: PBS News: **Why a stay in the ICU can leave patients worse off** (featuring Dr. Wes Ely)

https://www.youtube.com/watch?v=iKB5dPZU6CI

The top “steal ideas” from LS#3

Site	Poster topics they shared:	How this relates to our Provincial Delirium Framework:
Rockyview General Hospital ICU	Mobility, creative “Brain Games”	Bundle “D”: Assess, Prevent, and Manage delirium
Red Deer Regional Hospital	Sound board: Minimizing noise in ICU	Bundle “D”: Assess, Prevent, and Manage delirium
Foothills ICU	FMC Rounds Checklist and reports, Rehab calendar	All bundles: Incorporates daily communication about every patient regarding pain, agitation, and delirium best practice

Visit https://www.albertahealthservices.ca/scns/Page13419.aspx for all LS#3 posters!

Unit Success Stories

PLC ICU

Goal: Timely extubation of patients who have successful SBTs

Strategy: Extubation Bullet Rounds—coming soon!

Lead: Maria Brix, Unit Manager

What are they working on now?

One of the challenges that the PLC ICU had with "liberating" their patients from mechanical ventilation was that often patients passed their SBT but had to wait for unit rounds to receive order for extubation. This led to delaying extubation for patients who were ready.

Strategy: Bullet rounds *only for extubation.* Start at 0800 with RT, MD, charge RN and bedside RN.

What will be reported in Extubation Bullet Rounds?

- SBT time (when they passed)
- Tobin score
- Cough
- Cuff leak
- Gag response

It is an expectation for the RN to document extubation rounds in MetaVision.

RTs are to check in with physiotherapy post-exubation for mobilization plans. This is a direct discussion from RT to PT.

Foothills ICU

Goal: increase # of patents receiving out of bed mobility

Strategy: easy to access information on mobilization for all staff

What are they working on now?

Mobility Care Plan: laminated "at a glance" care plans at each patient bedside

The Foothills team discovered it wasn't always easy to remember what was done to mobilize ICU patients, so they created dry-erase care plans for each patient room with mobility info in an accessible format.

Feedback on the bedside card tool has been positive so far!

ICU Mobility Care Plan

Patient: Date:

CURRENT MOBILITY STATUS: *May be completed by PT/OT or RN*

Patient can dangle with ______

Patient can stand with ______

Patient can transfer with ______

Patient can mobilize with ______

Seating System e.g. tilt in space w/c (OT assessed) ______

Mobility achieved today ______

Mobility plan for tomorrow ______

Therapy assistant referral (done by PT/OT): Yes No

Family involved in patient exercise program (assessed by PT): Yes No

Physio's will leave their personal pager numbers on the whiteboards in patient rooms. ICU Physio group pager is 13181

Stollery PICU & PCICU

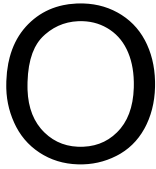
Learning from others

Goal: Inter-hospital Collaboration

Strategy: Site Visit pre-LS#3

Lead: Justin (PT) and Lara (OT)

Photo courtesy of L. Sreibers

n November 28th, Justin Kiew, Occupational Therapist and Lara Sreibers, Physical Therapist (Stollery Children's Hospital) spent a day with the rehabilitation team at the Alberta Children's Hospital. These two sites provide care for all critically ill children in province of Alberta.

The teams have had recent momentum in management of delirium and early mobilization supported by the Critical Care Strategic Clinical Network. Of note, the teams have created an Early Mobility Algorithm, Extubation Readiness Plan and E-Critical Mobility Documentation – implemented across both sites.

With the goal of inter-hospital collaboration in mind, the day spent together offered the two PICU rehabilitation teams the opportunity to discuss best patient care and review successes and barriers pertinent to both sites with regards to delirium management and early mobility.

Staff gained an appreciation for the similarities and differences between sites first hand, from equipment availability for mobility to patient room design. Practical, hands on shadowing between sites will facilitate improved understanding of both Intensive Care Units' needs when working together towards common goals and standard of practice.

The Stollery and ACH rehabilitation teams look forward to continuing to work closely together in providing and establishing best practice care for critically ill children.

Image credit:
www.westernchildrensheartnetwork.ca

Royal Alexandra Hospital ICU

Goal: targeted unit education on pain, agitation, and delirium yearly

Strategy: "Caring for the Agitated Patient" module for annual recertification

Lead: RAH Unit Educator Team

Ensuring all 250+ RNs working at the RAH ICU are up to speed on the latest best practice for pain, agitation, and delirium care can be hard to do, so the educator team came up with a scenario-based module that is part of the yearly recertification day for ICU RNs.

This 28 slide package incorporates scenarios and clinical practice questions around the topics of acute agitation, pain management, pharmacology, and sedation practices. Frontline staff leave armed with **key concepts** to promote targeting lightest sedation, good pain management, and incorporating non-pharmacologic strategies into everyday care.

If you are interested in learning more, please contact heather.colaco@ahs.ca

Want to learn more? **lori.coutts@ahs.ca for more info**

Ask an Occupational Therapist

Dear Allison,

My unit has an OT, but I'm not really sure what her role is in ICU. Can you help me?

An OT's role in the ICU varies a lot and can depend on how alert and engaged the patient is.

If a patient's RASS score is -5 to -2, OTs can make recommendations for positioning, pressure management and assess for splints.

To help manage or prevent delirium, OTs can provide family education and strategies of how they can help including: bringing in photos or familiar items, talking to the patient about current events or family and friends, playing familiar music, re-orienting the patient throughout the day, and providing physical touch such as rubbing their hands.

Nursing can encourage families to try these strategies as well.

If a patient is more alert (RASS -1 to +1) OTs can do much the same as for a drowsier patient but also assess mobility and cognition, upper extremity function, ADLs and fit for a wheelchair.

Patients should participate in as much of their self-care as possible as well as cognitively stimulating tasks such as puzzles and games to help manage and prevent delirium.

If a patient is being discharged home from the ICU, OTs can assess their function to make recommendations for supports and equipment for discharge. If in doubt, talk to your unit OT about how they can assist with your patient's care. *Submitted by Foothills OT Allison Friesen*

January 25th Skype Session 1400-1445h

The Role of the OT in ICU

(Hosted by Mallory Watson OT)

Please see your educator for more information

Agitation - what can I do?

CAUSES OF AGITATED BEHAVIOUR

Recognition of cause for agitation may prevent further escalation of the unwanted behaviour and reduce or eliminate the need for restraint.

Possible Causes for Agitated Behaviour	Preventative and Alternative Strategies for Patient Management
Gastrointestinal issues -constipation, urge to defecate, incontinence -nausea	Check for and treat constipation. Provide toileting assistance regularly. Administer antiemetic if ordered for nausea.
Untreated or under treated pain or discomfort	Assess and monitor pain using validated assessment tools (e.g., Critical-Care Pain Observation Tool (CPOT), numeric pain scale). Administer analgesia regularly when indicated. Provided regular repositioning and mobilization. OT/PT consults.
Sensory impairment or loss	Have eye glasses, hearing aids, and dentures in place during the day.
Emotional distress, depression, anxiety.	Introduce yourself. Use calm, reassuring tone of voice. Take time to listen. Allow patient more control or choices. Provide call bell.
Unfamiliar surroundings	Place familiar objects in room (e.g. clock, calendar, family pictures). Encourage family visits and involvement. Reorientation to environment as required. Provide consistent caregivers.
Malfunction of device.	Assess for compromise to medical equipment (e.g. obstruction of urinary catheter, interstitial peripheral intravenous catheter).
Delirium	Frequent reorientation and education regarding purpose of medical equipment (e.g. urinary catheter, intravenous tubing, etc). Place tubing/catheters out of patient view whenever possible. Discontinue lines and catheters at earliest opportunity. Administer medication as ordered to treat delirium. Mobilize whenever possible.
Abnormal blood work - hypoglycemia, hypoxemia, malnutrition, dehydration, infection.	Monitor and correct abnormal lab values. Monitor for clinical signs of infection.
Sleep deprivation	Balance rest and activity. Provide environment conducive to sleep to establish sleep/wake cycle.

(from AHS Restraint as a Last Resort Policy: Critical Care (#HCS-176)

Check out the **new** AHS Delirium Website!

https://www.albertahealthservices.ca/scns/Page13419.aspx

- Click on “Learning Session” tabs to see videos from our collaborative days
- Download the new “Readiness for Safe Mobilization Tool” and new mobility audit tool!
- Access presentations shared with the unit teams, including patient stories and guest speakers

Upcoming Events:

Canadian Association of Critical Care Nurses (CACCN) National Dynamics Conference will be in Calgary on September 24-26th, 2018.

If you, or any of your team members are interested in presenting at this conference, the call for abstracts is now open. This is a great opportunity to share the work your units have been doing.

Click the link below for more info:

https://www.caccn.ca/en/events/dynamics_2018__calgary_ab/call_for_abstracts_submission/index.html

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