Alberta Health Services
Critical Care Strategic Clinical Network™

Critical Care Strategic Clinical Network
Provincial ICU Delirium Framework

PAD Care Bundles: ABCDEF	**Provincial Recommendations for Standards of Care:** (Selected from evidence based best practice guidelines for enhancing standards of care)	**Clinical Practice Expectations** (Provincial recommendations translated into clinical practice activities that need to be implemented)	**Provincial Performance Targets:** (Expectations for how often the implemented practice needs to be completed)
A: Assess, Prevent & Manage Pain	Pain assessed and documentation using validated tool (CPOT and NRS) Self Reporting of pain is the gold standard	Assess and document q4h and prn Critical Care Pain Observation Tool (CPOT) is to be used for patients not able to verbalize; and Numeric Rating Scale (NRS) to be used for patients able to verbalize.	100% of patients assessed for pain and documented q4h
	Unit specific pain management guideline to align with SCCM PAD recommendation	Each unit/zone must establish a pain management guideline and/or protocol	By Sept 2017 a unit specific pain management guideline is developed
	Pain management guideline should emphasize: a) treat pain before sedation b) the importance of having a pre-procedural pain management therapy c) consider using non-pharmacological pain management strategies as an adjunctive therapy	Pain management is in accordance with developed unit based pain management protocol and/or guidelines	100% compliance with unit specific pain management and/or protocol
		Pain and pain management should be reviewed daily within multidisciplinary team	100% of the time pain and pain management will be discussed and communicated daily

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B: Both Spontaneous Awakening Trials (SAT) and Spontaneous Breathing Trials (SBT)	Depth and quality of sedation should be routinely assessed and documented on all ICU patients daily using validated tool Richmond agitation-sedation scale (RASS)	Assess and document agitation (RASS) and sedation q4hr & PRN	100% patients will have RASS assessed and documented Q4hr
		Unless contraindicated aim for Goal RASS of -2 to +2	100% time ICU patients will meet target RASS -2 to +2 unless contraindicated
	Set daily targeted level of sedation for each patient at least once per day	Discuss and document targeted level of sedation at least once per day	100% of eligible patients will have target level of sedation ordered and documented daily
	Target the lightest possible sedation and/or use daily SAT Goal of light sedation is to adequately sedate patients, and still be able to adequately assess pain	Assess, discuss, and perform SATs daily on eligible patients	100% of patients eligible for SAT will have SAT completed within 12 hours of eligibility
	Unit specific sedation & agitation management guideline to align with SCCM and PAD recommendations	Each unit must establish and utilize a pain and sedation management guideline and/or protocol	By Sept 2017 a unit specific and sedation management guideline and/or protocol is developed
	Sedation management guideline should emphasize: a) analgesia before sedation b) titrate to targeted level of sedation c) Minimal use of benzodiazepines	Sedation management is in accordance with established unit based sedation management guideline and/or protocol	100% compliance with unit specific sedation management guideline and/or protocol (audit)
	Establish a unit specific SBT pathway and/or protocol	Unit specific SBT guideline and/or protocol is developed	By Sept 2017 a unit specific SBT guideline and/or protocol is developed
	SBT eligibility discussed daily on all ventilated patients and document whether eligibility criteria met or not	SBT is assessed and performed in accordance with established unit based SBT guideline and/or protocol	100% compliance with unit specific SBT guideline and/or protocol (audit)

Last Revised (2017Sep20)

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B: Both Spontaneous Awakening Trials (SAT) and Spontaneous Breathing Trials (SBT)	SBT ordered and completed on all ventilated patients daily After successful SBT, potential for extubation is discussed	SBT eligibility assessed and documented daily on all ventilated patients	100% of ventilated patients will have SBT eligibility assessed and documented daily.
		Q-daily SBT performed on eligible patients and documented daily	100% of patients eligible for SBT had SBT performed daily and documented
		Target extubation within 2 hours after successful SBT unless contraindicated	100% of patients who pass SBT are extubated within 2 hours unless contraindicated

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C: Choice of Analgesia & Sedation	Determine target RASS daily	Assess and document agitation (RASS) and sedation Q4hr and PRN	100% of patients will have RASS assessed and documented q4h
	Have a standardized guideline for treatment of pain and sedation. The guideline should emphasize:	Pain assessed and documented q4h and PRN	100% patients assessed for pain and documented q4h
	a) Assessment and treatment pain first	Pain and pain management should be reviewed daily with interdisciplinary team	100% of time pain and pain management will be discussed and communicated daily
	b) Use of pre-emptive pain management strategies c) Consider PRN management of analgesic and/or sedation prior to using infusions	Each unit must establish and utilize a pain and sedation management guideline and/or protocol	By Sept 2017 each unit must establish and utilize a standardized guideline for the treatment of pain and sedation
	d) Target the lightest possible sedation e) Benzodiazepines should be avoided unless specifically indicated (example: ETOH or benzodiazepine withdrawal)		100% compliance with unit specific pain and sedation management guideline and/or protocol (audit)
	Recommend Bundle A Clinical Practice Expectations are accomplished before or congruently with Bundle C where appropriate (Items replicated from Bundle A identified here in peach colour)		100% of eligible patients (i.e. on continuous infusion) will have target level of sedation assessed and documented

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D: Delirium: Assess, Prevent & Manage	Delirium is assessed and documented using a validated tool (ICDSC)	Assess delirium using intensive care delirium screening checklist (ICDSC) Q 12 hrs & PRN	100% of patients have assessed and documented ICDSC q12h
	Routinely discuss ICDSC score & risk factors with multidisciplinary team Collaboratively implement appropriate delirium prevention and/or management strategies Have a standardized delirium prevention and management guideline that aligns with SCCM PAD recommendations, and should emphasize: a) early mobility b) sleep promotion c) sedation and analgesia d) early discussion of and proactive approach to all patients at risk of delirium	Daily discussion of ICDSC score, risk factors, and prevention and delirium management strategies within multidisciplinary team Each unit must establish and utilize a delirium prevention and management guideline	100% of time delirium score will be discussed and communicated daily By Sept 2017 each unit must establish and utilize a delirium prevention and management guideline

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E: Early Mobility & Exercise	A mobility protocol or guideline should be established, recognized and endorsed by all members of the inter-professional team	By Sept 2017 A unit specific mobility protocol or guideline should be established, recognized and endorsed by all members of the inter-professional team	100% compliance with unit specific mobility protocol or guideline
	Consistent approach/assessment of patient's ability to mobilize	Each unit should establish their own specific relative and absolute contraindications	
	Patients should receive appropriate mobility (mobility events should be appropriate for patient's ability and acuity)	Patient's current level of mobility, attempts at progression and barriers to mobilization should be discussed each day at rounds	100% of patients will have established daily mobility plan/goal
	Early mobilization should start on first day of admission unless there are absolute contradictions to doing so **<u>Daily Assessment</u>** - patient's ability to mobilize is assessed and reassessed continuously throughout the ICU stay to maximize progression	Default activity for patients should be AAT unless otherwise ordered	100% of patients will have mobility assessment completed and documented q12h
	Patients should receive multiple mobility events everyday (Day definition 24 hour period) Recognize All Barriers to Mobility Early and Address	Target 3 mobility events/24hrs; two mobility events ideally should occur during the daytime and one in late evening	100% of eligible patients will receive 3 mobility events each day

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References:

Barr J., Fraser G., Puntillo K., Wesley E., et al. Clinical practice guidelines for the management of pain, agitation, and delirium in adult patients in the intensive care unit. Journal of Critical Care Medicine. 2013; 41(1):264-306.

www.icudelirium.org

American Association of Critical Care Nursing

Society of Critical Care Medicine

Colour Coding

Yellow Box: Mandatory Metric as decided Nov 9/2016
Gray Box: Recommend not selecting as a unit specific performance indicator at this time for building scorecard.