# Misericordia Hospital ICU

Alberta Health Services

Critical Care Strategic Clinical Network™

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## BACKGROUND

- 6 Bed ICU & 4 Bed HI - Medical Surgical unit (housed in same area)
- 5 Intensivist, 1 NP, 1 dedicated Pharmacist, 1 dedicated Dietitian, 1 dedicated Physiotherapist, dedicated Respiratory Therapists with a Respiratory Clinical Lead, 1.5 Unit Managers, 1 Clinical Nurse Educator, 2 Healthcare workers, 2 Service attendants, 4 unit clerks and 45 regular RNs plus casuals RNs
- Each Intensivist takes one week on call in the unit, supported by Clinical Associates covering the in-house night shift.
- Joined the National Delirium Collaborative in 2012 and have been focused on delirium prevention and management since that time

## AIM

- Decrease % of time ICU patients are in significant pain
- Increase % of patients with documented pain assessment Q4h
- Improve % of time that mobility plan is discussed daily
- Mobilize eligible patients 3 times/day
- Improve % patients with SBT performed and documented daily
- Decrease % of patient days where patients experience delirium in ICU

These goals support A/B/D/E of the delirium bundle: **CC-SCN Provincial Delirium Framework**

## MEASUREABLE GOALS

- % of time that patients have a CPOT $\geq$ 3 or NRS $\geq$ 4
- % of patients that have a pain score documented Q4H
- % of eligible patients that are mobilized 3 times/day
- % of time that mobility is discussed daily
- % of time that target RASS is discussed and documented daily
- % of patients that have a RASS score documented Q4H
- % of time that SBTs are performed and documented daily

## CHANGE IDEAS

- "Tea time" and "Tuck time" rounds as suggested by another ICU team
- did not work for our unit as we didn't have enough time between am rounds and "tea time" to determine if any of our strategies had made a difference
- Delirium board developed to communicate with staff, patients, and families the successes of our delirium team and how we compared to other ICUs across the province
- Deliberate focus on patient care rounds in discussing sleep, pain, target RASS, mobilization plan and a change in our nursing report sheet to accommodate this information
- Utilization of "delirium champions" on the unit from nursing and respiratory therapy to promote best delirium prevention practices, educate the staff at the bedside, provide reminders to staff, and act as mentors for other staff
- Daily am meeting including nursing, respiratory therapy and physiotherapy to develop/implement a mobilization strategy for each patient for the day
- SBT reporting on patient care rounds by respiratory therapy
- Recommendations to SCN regarding improvements in RASS charting and independent mobilization
- Development of a delirium board which highlights improvements made; provides information/education; and displays current stats

## RESULTS

| eCritical Metric | Baseline | Aug '17 | Sept '17 | Oct '17 |
|---|---|---|---|---|
| % Significant Pain | 18.5% | 28.53% | 23.71% | 16.3% |
| Q4h pain assessment | 61.6% | 76.38% | 77.64% | |
| Q4h RASS assessment | 62.1% | 77.78% | 84.43% | |
| Ever Delirium<br>Q1 (Apr, May, June '17)<br>Q2 (July, Aug, Sept '17) | | Q1: 25.42% | | Q2: 30.3% |
| Ever Delirium Eligible | 35% | Q1: 46.39% | | Q2: 31.4% |
| Target RASS documented at least once per stay | | 76.32% | 73.08% | 91.67% |
| % of Time Mobility Plan is Discussed Daily | 60% | 100% | 100% | 100% |
| % of Patients Eligible for Out of Bed Mobility who were Mobilized TID | 40% | 82% | 90% | 72% |
| % of Patients Assessed for SBTs and Documented Daily | 1% | | | 92% |

Were our Goals Achieved?

- We have made incredible positive change in the areas of pain assessment and management; Q4H RASS assessment; documentation of target RASS goals; and daily discussion of mobility plan.
- Our delirium rates are relatively unchanged, but fluctuate from month to month
- We have developed and implemented a SBT process and have made consistent improvements in implementation and documentation of same.

## LESSONS LEARNED

- The key element which contributed to the success of our change was the presence of "delirium champions" who cultivated an environment which was focused on improved patient care and outcomes and maintaining change.
- It would have been helpful to provide the "delirium champions" with support and education surrounding teaching strategies and coaching to facilltate their success.
- Even though some strategies work in other units, it is important to recognize that due to the uniqueness of each unit, these strategies may not be generalizable (ie. tea time rounds)
- It is difficult to implement change when Metavision is not consistent with changes in clinical practice. It would be helpful to have Metavision changes occur in real-time to facilitate consistency in practice and ease of charting.
- Our staff have experienced "delirium fatigue" as we have been focusing on this for several years now. We may need to "take a break" to allow our staff time to become re-engaged.

## NEXT STEPS

- Implement a new mobility strategy with the "Readiness for Mobility" roll out
- Participate in the development of delirium web resources for patients and families
- Improve our patient and family engagement strategies in the ICU
- Develop consistent processes by which non-pharmacologic therapies can be utilized in ICU patients (ie. music, massage, meditation)