Alberta Health Services

Critical Care Strategic Clinical Network™

Royal Alexandra Hospital

Delirium team members and poster contributors:

BACKGROUND

- 25 bed Medical/Surgical/Trauma Unit
- The RAH is also home to the Zone Regional Thoracics Program and High Risk Obstetrics Program
- Clinically staffed by 178 RNs, 4 UMs, 4 CNEs, 6 NPs, 4 NAs

AIM

Focus on element B of the Delirium Bundle

Both SAT and SBT

We hoped to improve the screening of our ventilated patients eligible for SBT's. Our goal is to always keep our patients RASS 0 to -1 unless otherwise ordered

MEASUREABLE GOALS

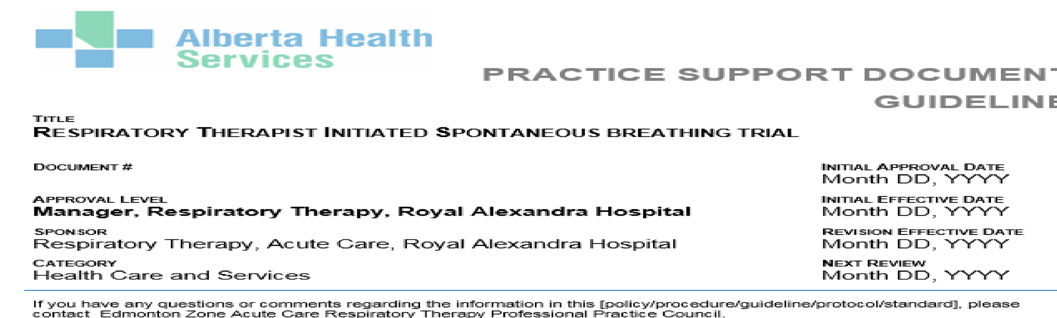
We audited our RT staff prior to the creation and implementation of the SBT practice guideline to identify if we actually had a problem on our unit.

We soon discovered that our staff were not proactively assessing and completing SBT's. The RT staff were waiting until rounds to assess and perform for SBT once an order was received from our Physicians.

We audited using the same tool pre and post roll out of the RAH RT initiated practice guideline.

CHANGE IDEAS

- Part of the focus was to get the buy in from the senior staff. The RT educator and manager did an excellent job of transferring accountability to the RT staff through their initial education. We focused on the why delirium is important, and the long term consequences before we taught them about the new practice guideline.
- The RT leads encouraged the senior staff to mentor the junior staff. The educator and manager modeled for them and educated in the moment which made a big impact.
- We focused on completing the SBT early in the shift so that extubation, if appropriate, could be completed before or during rounds allowing observation of the patient for the majority of the day.
- Our RT team has been having a daily (in the morning after report) discussions around which patients that we think will be placed on an SBT, extubated or weaned toward that goal.



Alberta Health Services

PRACTICE SUPPORT DOCUMENT
GUIDELINE

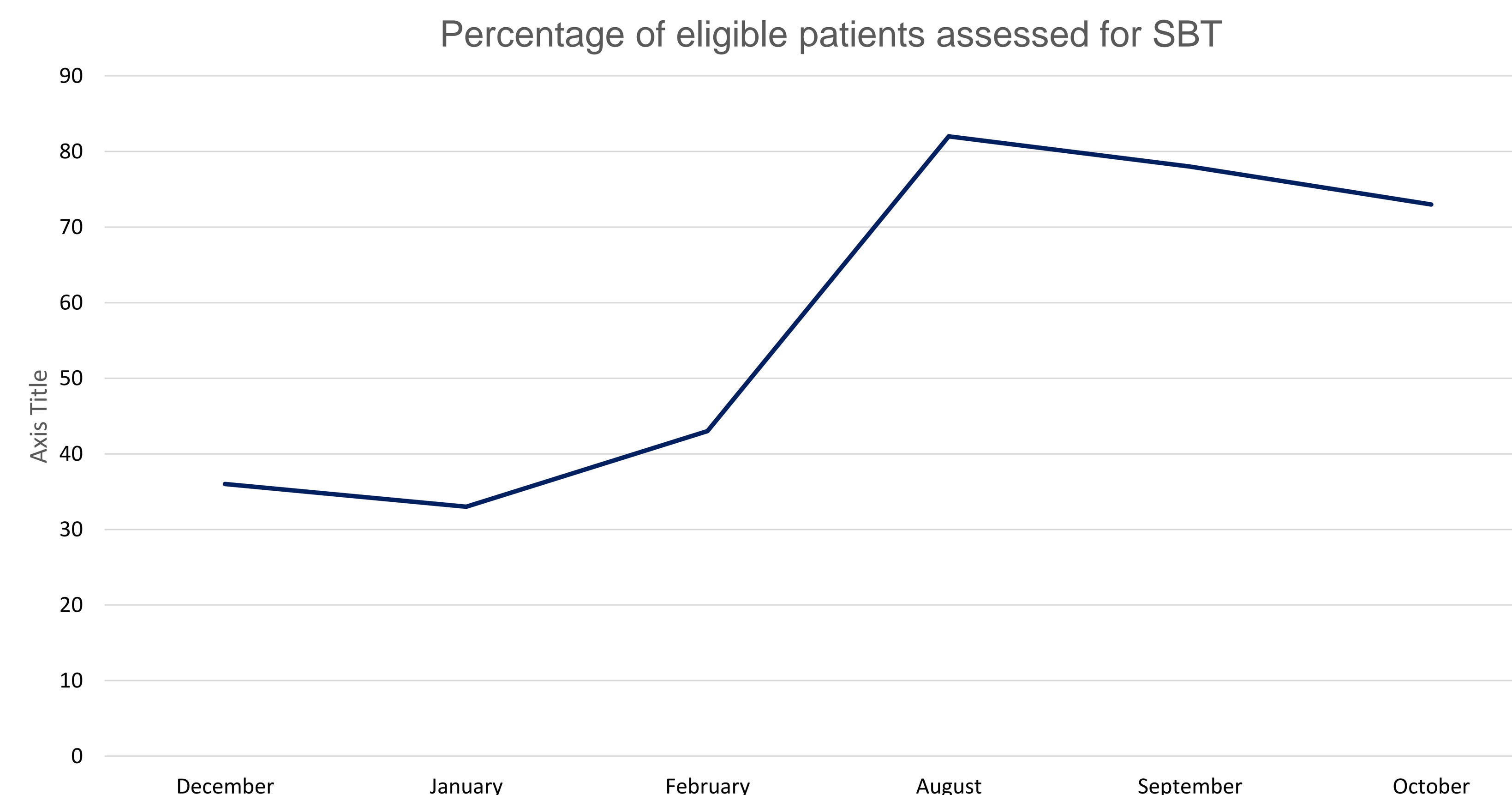
TITLE
RESPIRATORY THERAPIST INITIATED SPONTANEOUS BREATHING TRIAL

DOCUMENT #	INITIAL APPROVAL DATE Month DD, YYYY
APPROVAL LEVEL **Manager, Respiratory Therapy, Royal Alexandra Hospital**	INITIAL EFFECTIVE DATE Month DD, YYYY
SPONSOR Respiratory Therapy, Acute Care, Royal Alexandra Hospital	REVISION EFFECTIVE DATE Month DD, YYYY
CATEGORY Health Care and Services	NEXT REVIEW Month DD, YYYY

If you have any questions or comments regarding the information in this [policy/procedure/guideline/protocol/standard], please contact Edmonton Zone Acute Care Respiratory Therapy Professional Practice Council.

RESULTS

We increased our SBT screening and implementation by 40 percent in the first month that we rolled out the SBT guideline.

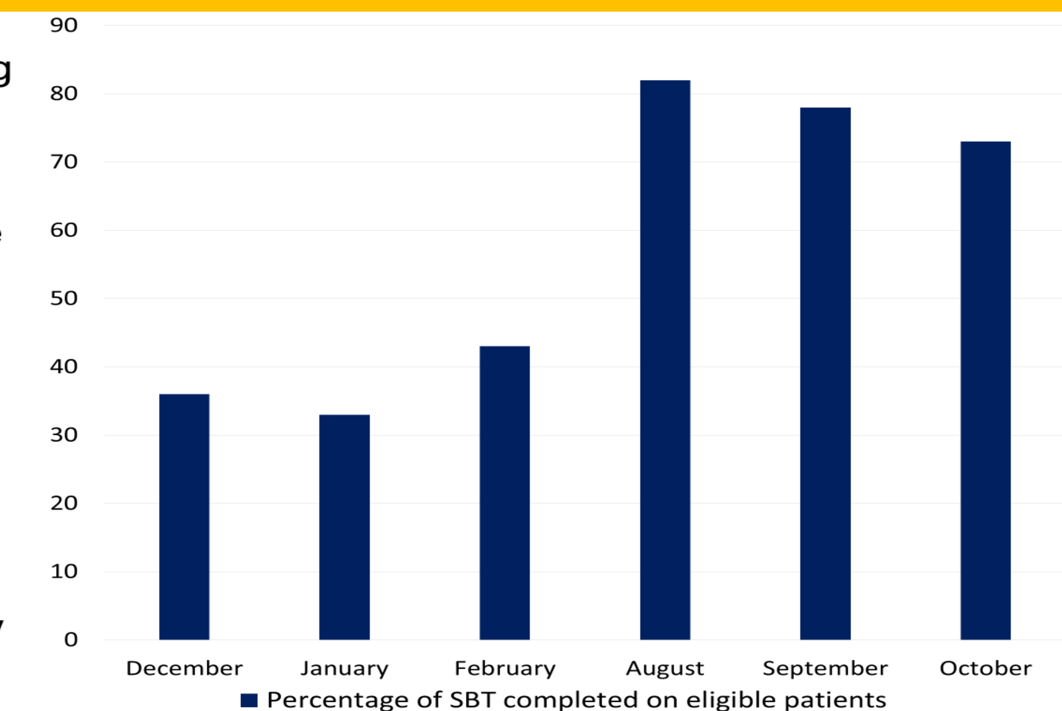


RT Initiated Spontaneous Breathing Trials

The Royal Alexandra Hospital Delirium working group created an RT initiated SBT practice guideline.

Education sessions were completed in June and July The new practice guideline was rolled out and started on August 1/2017.

Our graph depicts the number of SBT's performed on eligible patients before and after we implemented the new practice guideline.



LESSONS LEARNED

Including the front line staff was instrumental in the major improvement of SBT assessment for eligibility.

It was important to have the RT's understood why and how early SAT and SBT is important in preventing delirium.

A policy that empowers staff to use their professional judgement allows for more efficient completion of tasks. The completion of the SBT is, by this policy, initiated entirely by the RT themselves rather than waiting to be directed to do this by a physician. This has resulted in earlier, and more consistent completion of SBTs.

Good communication between RNs at the bedside, RTs performing SBTs and physicians is vital for success.

NEXT STEPS

- Our RT Critical care Supervisor meets daily with Physio (after their mobility rounds) so they can coordinate mobility and weaning objectives for the day.
- We have incorporated many elements of the bundle into our yearly certification of specialized clinical competencies. The lecture focuses on "the agitated patient" identification and prevention strategies. We have incorporated a case study and discuss non-pharmacological strategies, choice of analgesia/sedation, treating pain first, mobilization of the body and the brain, and structured reorientation.
- Falls Prevention