Alberta Health Services

Critical Care Strategic Clinical Network™

# It's "EZ - eeee" to move at the SCH ICU

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## BACKGROUND

- 5 bed ICU and 3 bed Close Observation Unit (however, excluded from audit) staffing typically is 50/50; 60/40 for 1:1 and 1:2 ("doubled").
- Delirium Collaborative roll-out was simultaneous with the start of our Tier 1 coverage with our NPs (Celine, Castro, Karen).
- We share all INTD staff with our hospital (i.e. RRT, SW, PT, OT, RD, SLP). The INTD staff rotate the coverage without a FTE/PTE dedicated wholly to our critical care program.
- Our PCM and UM oversee and organize the delirium collaborative work and a frontline RN completes monthly audits. Of note, we do not audit the same patient twice in the same admission.

## AIM

- Focus on Early Mobility & Exercise because after the first LS #1, our baseline data from December 2016 and January 2017 showed us that we were not mobilizing any patients out of bed three times a day.
- We wanted to focus on a best practice recommendation that could be audited fairly month-to-month, capturing acuity, and challenging our staff and patients.
- Best practice recommendation from the Provincial Delirium Framework: "Target 3 mobility events/24 hours; two mobility events ideally should occur during the daytime and one in the late evening"
- We wanted to hone in on this best practice recommendation knowing good pain management, sleep hygiene, and early extubation are key enablers to achieving our goal.

## MEASUREABLE GOALS

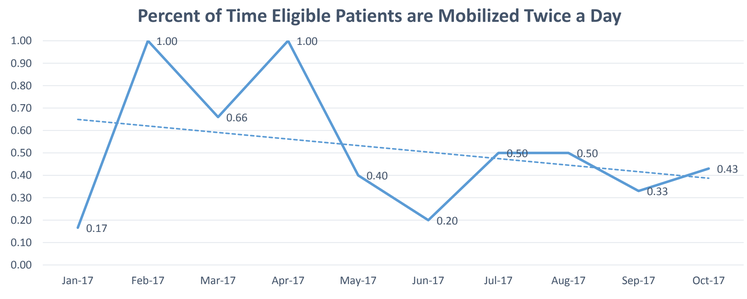
- Mobilize eligible patients out of bed 3 times day.
- What is an eligible patient? To complete fair monthly audits that had equal representation of acuity, the UM, CNE, and frontline RN compiled the criteria, sought feedback from RT and PT, and utilized the Provincial Early Mobility Minimum Expectations (Nov 2015).
- See Change Idea section for our Cool Criteria Box.

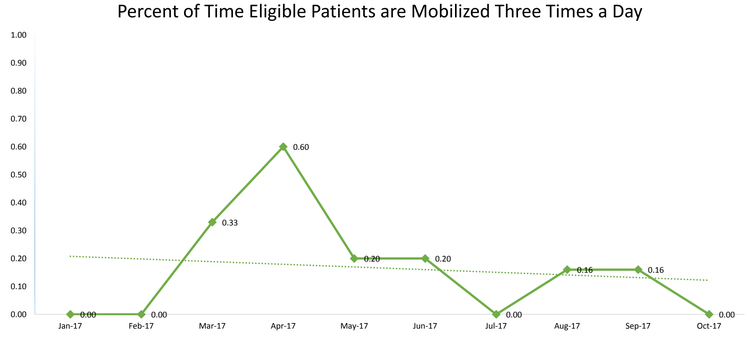
## CHANGE IDEAS

- AUDIT CRITERIA: (1) exclude first 24hrs since admission (2) First week day after 24 hr admission period (weekends not negative tally if done) (3) admission to ICU bed only (4) RASS > or = -1 (SBT); (5) Fio2 < or = 50% (exclude PEEP) (6) HR 40-150 (7) SBP 90-200 (8) 3 or less IV inotropes, vasoactive, antiarrythmic infusions (rates irrelevant) (9) Intubated or NIV on arrival to ICU or within 5 days of admission
- Work with PT revealed an change to page them and mobilize between 08-09, before our team rounds.
- Recently, bedside RN does not go to Lean Rounds freeing time for a morning mobility event. Traditional, bedside rounds with RN resumed.
- "Puffer" times changed – none scheduled 2200 - 0600, unless prn.
- Trialing new order sets (Sept 2016): (1) sedation and analgesic order options provided, also more as prn & less cont gtt "tick boxes" (2) SAT and SBT ordered with educational bullet points for all staff (3) order prompts for less monitoring if asleep or as acuity dictates

## RESULTS

- Did you meet your goal? Yes, we "moved the dot" on a zero baseline ☺




## LESSONS LEARNED

- A very helpful piece for working towards out goal is having mechanical ceiling lifts in each ICU room.
- Qualitative observations:
  - Sleep-wake patterns addressed more often on rounds.
  - Better Nursing & INTD staff awareness to keep patients awake during the day and appreciation for how mobility events encourage this.
  - Number of mobility events achieved in a shift is proportionally related to nurse-patient staffing ratios, and availability of Nursing Attendant.
  - Overall, staff would informally agree that two mobility events are very do-able between both the A and B shift.
  - Mobility events are not started on the B shift; patients may be put back to bed but an event itself is not initiated.
- Staff 's two keen interests are in differentiating (1) patients' baseline dementia, Alzheimer, or Parkinson from delirium (2) benefits of "chair position" versus mechanical lift out of bed. For the next session round, we would like provide some staff education and discussion on their verbalized interests.
- We could have semi-formally identified unit champions on the unit to identify and initiate more mobility events.
- We need to explore a way to regularly connect with all staff (nursing, INTD, etc) that accommodates each staff responsibilities within the hospital. Despite challenges without having unit staff (nursing/INTD) solely dedicated to our intensive care program and the collaborative itself, we are able to "mobilize" changes for delirium management.

## NEXT STEPS

- Work towards having the third mobility event initiated on night shifts.
- Provide staff education and support on any mobility questions and documentation. We'd like staff to be numerically documenting mobility with its specific tab in metavision, hoping staff will count and feel cued to initiate a second/third mobility event.
- Consider having "mobility moment" schedule on the unit, protected time where staff are expected to be available to help mobilize patients (keeping in mind how acute and busy the unit is).
- Tie in efforts with EZ-Patient Family Centered Care in ICU and encourage family to participate with mobility exercises and be present for the mobility events.
- On the other end of the spectrum, build in "rest periods" – as staff have vocalized concerns on stressing and tiring out sicker patients.