Alberta Health Services

Critical Care Strategic Clinical Network™

University of Alberta Neurosciences ICU

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BACKGROUND

We are a small ICU, specializing in the management of critically ill patients with an acute Neurosurgical or Neurological diagnosis.

- 10 Critical Care beds + 1 (organ donor bed)
- 4 High Intensity beds
- 4 Hyper-Acute Stroke OBS beds

Our team is comprised of RNs, RTs, neuro-intensivists, neurosurgeons, neurologists, pharmacist, PT, OT, registered dietitians, SLP, HCAs.

AIM

"We have bigger fish to fry!"

Prior to this provincial SCN Delirium initiative, there was little to no emphasis around delirium in the Neuro ICU. There was an established working culture that with an acute acquired brain injury, delirium assessment, prevention and management would be inconsequential.

Moving forward…

1. A secondary diagnosis of delirium on top of an existing neurological insult would be missed unless actively monitored for in the neuro critical care population.
2. Assessment, prevention and management of delirium can be monitored using validated assessment tools.
3. Delirium assessment, prevention and management is a priority in the neuro critical care population in terms of decreasing morbidity and mortality and increasing quality of life after critical illness.

MEASUREABLE GOALS

Delirium Scorecard

1. Integrating agitation assessment tool (RASS) into clinical practice to guide analgesic and sedation regimes.
2. Consistently documenting pain assessment.
3. Documenting spontaneous awake trial (SAT).

****NEW**** Using SAT to inform clinical decisions on pain management and in minimizing sedation.

CHANGE IDEAS

Our program used the Prosci ADKAR® Model for change to help guide us with planning and implementation.

Awareness of the need for change

- Learning Collaboratives promotes engagement of front-line staff and leadership
- Unit education sessions (45min-1hr)

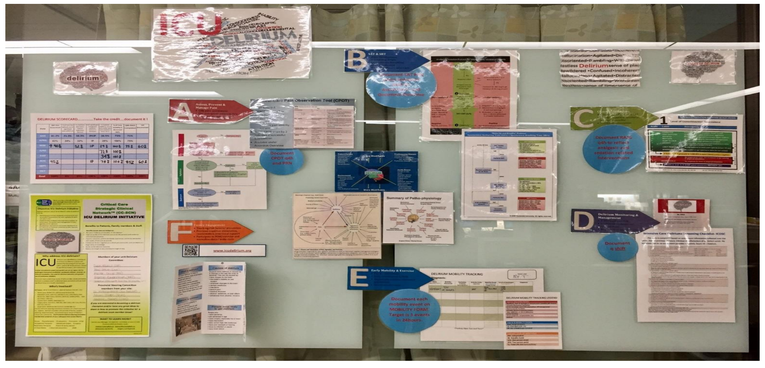
Desire to support the change

- Using patient stories and case studies to highlight delirium in our patient population and make it relevant to the staff.

Knowledge of how to change

- Learning Collaboratives – learning from other sites where delirium management has been integrated into practice (i.e. RAH and FMC).

Delirium Education Board – A, B, C, D, E, F.



Royal Alexandra Hospital Visit

RESULTS

Ability to demonstrate new skills and behavior

RASS: % of Compliance with q4H Documented RASS assessment

Baseline **(February)** – 69.52% → 85.80% **(August)** **---** 64% **(Oct)**

SAT: Baseline **(February)** – no documentation (0%) → **(October)** all eligible patients have a SAT documented in eCritical (100%)

Development of unit-specific delirium assessment, prevention and management guidelines (DRAFT)

Real Win = Frontline staff reporting delirium and taking meaningful action in delirium management and prevention

LESSONS LEARNED

Reinforcement to make the change stick

- Polling staff to determine the cause in variances in documentation.

Understanding how data is reported and its application to actual clinical practice.

Making priorities relevant to your patient population

Example – Mobility events = making bed to chair count

NEXT STEPS

- Using a common language amongst all practitioners when reporting delirium (i.e. SAT, SBT & RASS)
- Finalizing and implementing unit-specific Delirium guidelines
- Holding each other accountable by:
  1. Reporting and posting data regularly
  2. Providing meaningful feedback to all care providers
  3. Reinforcing delirium guidelines