Alberta Health Services

Critical Care Strategic Clinical Network™

Mazankowski Heart Institute - CVICU

Delirium team members and poster contributors: Todd MacLure, Daniel Grimsen, Diana Ly, Jennifer Hewko, James Eeles, Jocelyn Unland, Ruth Santos, Desiree Ross, Kathy Labrentz , Cate Bulbuc

THE PAST

Gaps in practice:

- Lack of bedside provider knowledge surrounding delirium mortality/prevalence
- Need for improved compliance in Q4H pain assessment
- Identified knowledge gap in ICDSC scoring
- Need for Improved ICDSC scoring compliance.
- Identified culture of high dose/frequency use of antipsychotics

Unit Culture:

- Disconnect between medical staff/nursing staff in terms of managing delirium.
- Culture surrounding delirium included that it was an expected process of critical illness.

OUR UNIT DELIRIUM TEAM

THE PRESENT

Implementations:

- Formal presentation surrounding Delirium by Todd MacLure, NP at the annual Cardiology Update.
- Peer-peer led education sessions
  - Pain Assessment / ICDSC Scoring
  - 80% staff attendance goal with formative peer evaluation
  - Scenario Based with pre/post testing
- Environmental changes
  - Blackout blinds & Soft close doors outside patient rooms.
- Development of “Delirium Board”
  - Located at charge desk, used to disseminate data and initiatives to staff.
- Incorporation of a delirium committee component into weekly “high tea” where new and upcoming changes to the unit are discussed with staff on shift.
- New family pamphlet: tool used to educate families and patients about delirium. Available in waiting room, for bedside staff to share and included in long stay patient letters.
- Daily order set at rounds: allowing for re-assessment of patient goals and interventions.

Successes:

- Staff buy in, support for the delirium initiative, voiced investment in learning about delirium, positive feedback from presentations.
- Managerial buy in / support for the initiative.

Challenges:

- Unit Demographics: unit size provides a challenge in incorporating change of practice to 120+ RN staff on a high turnover 26 bed unit.
- Entrenchment in how delirium has been handled/treated for decades.
- The nature of being a post operative cardiac surgical ICU has led to increased prevalence of significant pain and related delirium.
- Staff retainment on committee secondary to career changes.

New Business

- Shift away from narcotic and benzodiazepine infusions.
- Increased use of Precedex.
- Adoption of formal wrist restraint policy / culture shift.
- Increased focus on changing post operative culture towards fast tracking patients resulting in earlier extubations.

THE FUTURE

Roadmap:

- Continue to re-establish our committee team due to staff turnover.
- Developing another peer led, scenario focused education session surrounding sleep practices and enhancement via non-pharmalogical interventions and hygiene.
- Developing another peer led education session surrounding the relationship between mobilization and delirium utilizing patient stories.
- Focusing on more accurate attendance recording and continued emphasis on completion of peer evaluations.

Next areas of focus from bundle:

- Delirium – Assess, prevent, manage
  - Associated scoreboard metric: Accessibility - % of patients who receive 4 or more hours of consecutive sleep overnight
- Early mobility and exercise
  - Associated scoreboard metric**:** Effectiveness % of patients eligible for "out-of-bed" mobility who were dangled, stood or ambulated 0,1,2 and 3 times in 24 hrs

We commit to de-adopt:

Unnecessary prolongation of interventions/screening/monitoring (I.E. Nightly CXR, BID blood work on ward ready patients, Q4H assessments overnight on stable patients)

We will adopt:

Environmental changes to help enhance sleep promotion measures.