

# Edmonton Royal Alexandra Hospital

## THE PAST

- We were already doing a pretty good job of mobilizing our patients at least twice a day. However, no significant decrease in delirium was noted.
- Identified gaps on our unit were:
  - Assessment and treatment of pain
  - Lack of non-pharmacological strategies used in our unit to prevent delirium other than mobilization
  - Lack of Pharmacological guidelines for residents/nurses
  - Lack of adequate pain and RASS documentation by nursing staff

## THE PRESENT

All unit staff have a good understanding of what delirium is, how it can be prevented and why it is important. We reviewed and educated accurate use of the ICDSC tool.

**We have implemented the following strategies :**

- 1) Noise Reduction (limiting significant noise from paging systems, staff and equipment, use of ear plugs).
- 2) Sleep Promotion (lighting changed, eye masks, use of white noise machines).
- 3) Education regarding treating pain first (long vs short acting, preemptive analgesics for patients, use of benzos for withdrawal patients, titrating sedation to a goal RASS).
- 4) Yearly education created regarding delirium and the ABCDEF bundle for all staff and included in orientation for new staff and residents to our unit.
- 5) Increase mobility to 3x/24 hours- inclusion of the use of puzzles to mobilize the brain.
- 6) Creation of an SBT protocol

## THE FUTURE

- Maintain current culture by continuing routine audits of sleep promotion and noise reduction on night shifts, chart audits re: RASS and pain assessments by nursing staff.
- Focus on maintaining awareness and diligence of delirium prevention.
- Increased collaboration in promoting early mobilization with Allied Health (PT & OT)

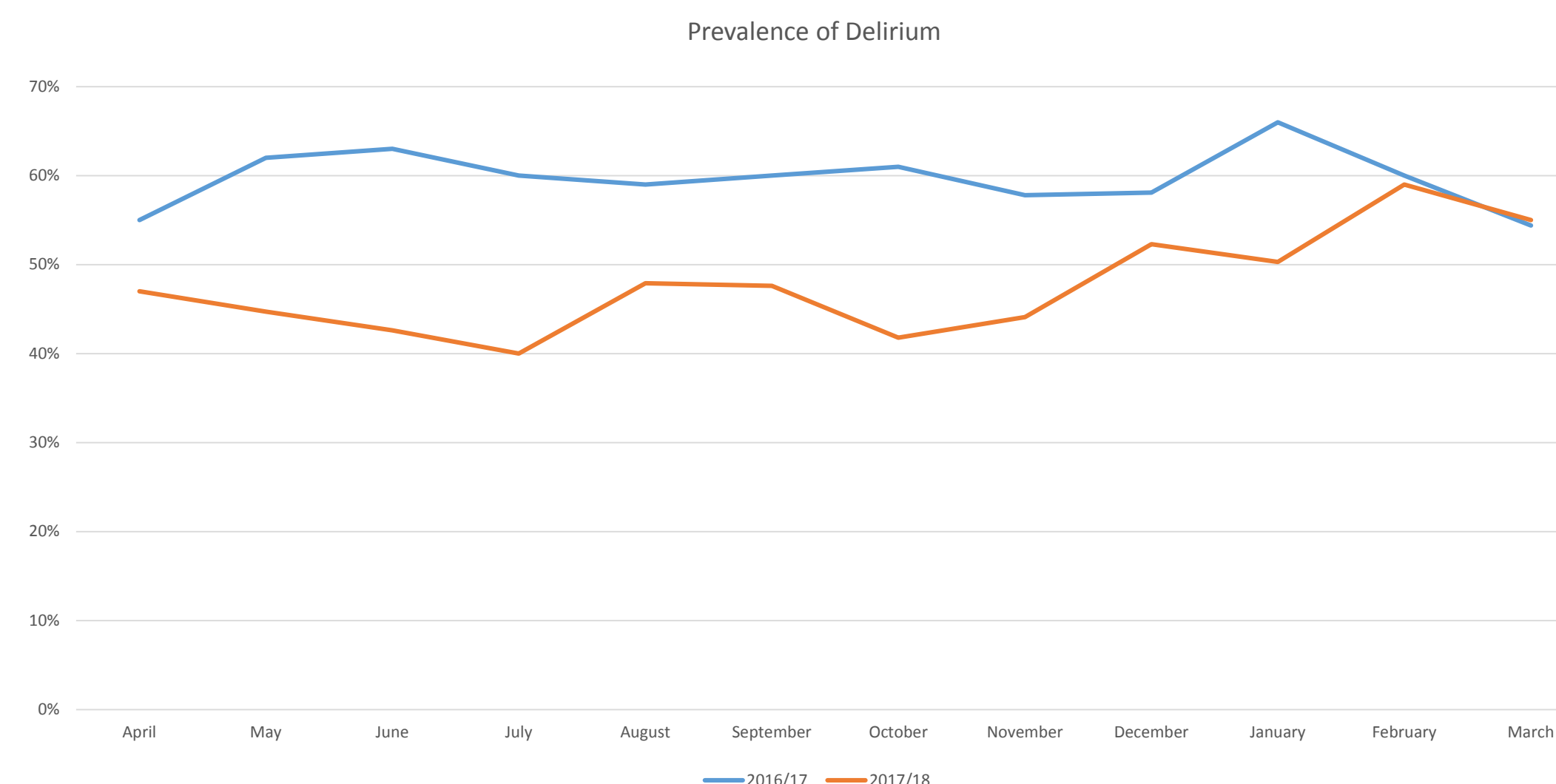
**We commit to de-adopt:** Moving away from mobilization as a “day shift” responsibility only

**We will adopt:** Continued annual education about the ABCDEF bundle for all new staff to our unit (nurses, allied health, residents)

## OUR UNIT DELIRIUM TEAM



## We have decreased our prevalence of delirium



**Caring for the Agitated Patient**

**CHALLENGES**

- Fear of self-extubation
- Inadvertent removal of lines, tubes and drains
- Overstimulation
- Poor progress
- Difficult to provide good patient care

**ANALYZING YOUR ASSESSMENT**

- Consider other causes
- Pain
- Mechanical ventilation
- Assess underlying metabolic derangements
- Seizure
- Hypoxemia

**SLEEP PROMOTION**

*Our Goal is to balance the needs and safety of the patient while promoting quality sleep and rest overnight.*

**MOBILITY**

- The goal is mobility events per day morning, afternoon, evening
- If your patient can stand and walk, we cannot ask the bed chair for a mobility event.

*The goal is to complete the previous mobility event and attempt to progress the patient further.*

**CASE STUDY**

- You are caring for Mr. G an 85 y.o male admitted to ICU for sepsis, aspiration, and a PEA arrest.
- Prior to this admission with deep vein infection following a tooth extraction, at break Hungarian (Romanian).

**STRUCTURED REORIENTATION**

- Call the patient by their first name
- Provide visual, glasses and hearing aids
- Encourage communication and orient patient
- Reportedly reorientation and encourage family to participate
- Update whiteboards (day and date)
- Encourage family to fill out the part time picture form
- Daily schedule care plan visible for long stay patients

**TREAT PAIN FIRST**

*Independent assessment of pain remains a significant challenge for many ICU residents.*

**CLINICAL PRACTICE QUESTION**

Mr. G is currently intubated, restless in bed and grimacing when he is turned.

His vital signs are stable: HR 88 bpm, BP 142/112

What should you do?

“Caring for the Agitated Patient” package