

# EZ – Sturgeon Community Hospital ICU

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## THE PAST

The 3 biggest gaps in our unit's pre & post Delirium Collaborative are:  
 (1) Pain Assessment & Management (2) SBT (3) Early Mobility

Category	Current Practice	Target Practice
<b>Pain Assessment and Management</b>	<ul style="list-style-type: none"> <li>Our unit has a validated tool to assess pain (i.e. CPOT, NRS, BPS, pediatric tool) (revised: 01/16/18)</li> <li>Our unit has a pain management protocol</li> <li>Pain management is discussed during daily rounds for all patients</li> <li>Pain management is consistently considered as first-line treatment before sedation initiation</li> <li>Pain management is always considered prior to any procedure or activity intervention (i.e. chest tube insertion, line insertion)</li> </ul>	<ul style="list-style-type: none"> <li>Our unit has a sedation protocol in place</li> <li>We perform a sedation assessment on patients using a validated tool (q4hr and prn as minimum)</li> <li>We currently perform Spontaneous Awakening Trials (SATs), aka "sedation vacations" (q4hr on all patients receiving sedation, when appropriate)</li> <li>We have a standardized protocol for performing SATs</li> <li>We have a standardized protocol for performing SBTs</li> <li>We currently perform SBTs on all ventilated patients when appropriate</li> <li>SBTs and SATs are discussed on all ventilated patients at daily rounds</li> </ul>
<b>Early Exercise and Progressive Mobility</b>	<ul style="list-style-type: none"> <li>Our unit has a protocol for progressive mobility for ALL patients</li> <li>All patients are appropriately screened for mobility based on ability and acuity</li> <li>Is the default activity order for every patient "activity as tolerated"?</li> <li>Our unit has the necessary support equipment to safely assist with patients' progressive mobility (i.e. portable ventilator, wheelchair, chair, stretcher)</li> <li>Respiratory therapists and physical therapists are available to assist with implementing early exercise and progressive mobility protocols</li> <li>Patients receive multiple mobility events every day</li> <li>Mobility progression is discussed during daily rounds</li> <li>Barriers to mobility are discussed and addressed during daily rounds</li> </ul>	<ul style="list-style-type: none"> <li>Our unit has a protocol for progressive mobility for ALL patients</li> <li>All patients are appropriately screened for mobility based on ability and acuity</li> <li>Is the default activity order for every patient "activity as tolerated"?</li> <li>Our unit has the necessary support equipment to safely assist with patients' progressive mobility (i.e. portable ventilator, wheelchair, chair, stretcher)</li> <li>Respiratory therapists and physical therapists are available to assist with implementing early exercise and progressive mobility protocols</li> <li>Patients receive multiple mobility events every day</li> <li>Mobility progression is discussed during daily rounds</li> <li>Barriers to mobility are discussed and addressed during daily rounds</li> </ul>

**Pre:** moved away from "tracks" to con't infusions.  
 Pre: We didn't think we were performing SBTs appropriately.  
 Post: *Tada* - we were! BUT – audits helped!!

**Post:** prompt PRN, pain first, CPOT approach

**SBT Audit**

**In 2017, audits & focus on intubated patients. We hoped this would ease staff (PT/RN/RT) comfort levels. Now, it's all patients. Post: graph**

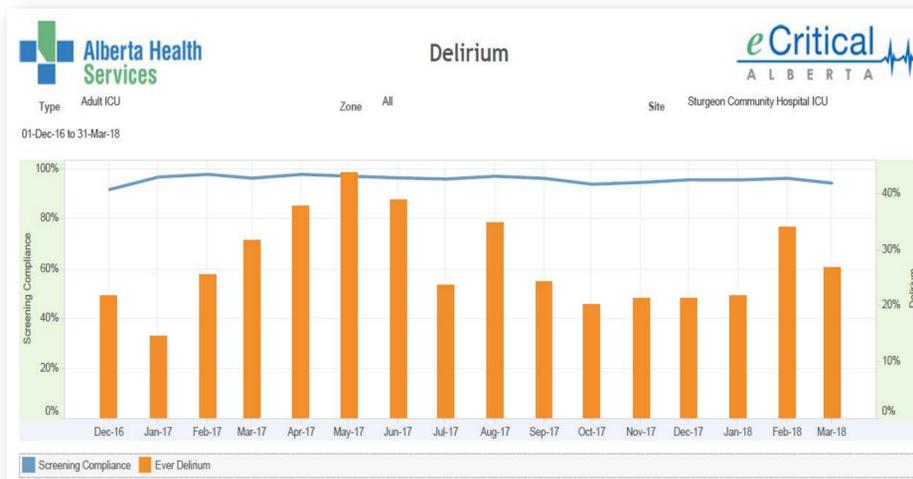
Here, RNs learned we had a protocol & RTs charted and performed SBTs consistently.

## OUR UNIT DELIRIUM TEAM



## THE PRESENT

→ We were scared the collaborative may dismay staff and current momentum with our delirium awareness and monitoring. Specifically, since our unit participated in a CPSI delirium program in 2012-2014 that put us in the beginning stages of learning about early mobility and changing ISCDC compliance. We're proud that it didn't.



Specific changes for each component of the "ABCDEF Bundle" that our unit has under taken are:

- A:** Prompt/Request CPOT score(s) in rounds.
- B:** Repeated SBTs in the afternoon and extubations earlier in a day shift.
- C:** Addition of SAT trial into our Mechanical Ventilation Order Set for RNs to reduce sedation unless patients have the listed exclusion criteria.
- D:** Reducing the use of mechanical restraints. We started auditing the restraints with the new Restraint Policy and MetaVision changes.
- E:** Cue-ing a change in culture for the third mobility event on nights by having the patient in the chair already for shift change.
- F:** The work around family first contact reminds us to bring the family in promptly and allows us to learn about the patient early in their admission.

→ A key to changing some culture around delirium best practice was when we emailed the PAD guideline to all front-line RNs. Sharing research and/or rationales has been the biggest help for buy-in.

- **Our three biggest challenges are:**
1. variable expectations of haldol prescription and use
  2. progressive mobility (i.e. chair position vs. attempt to "dangle").
  3. day/night routine and sleep hygiene

## THE FUTURE

→ We plan to embed this in our new unit quality council:

- Currently, considering alternative ways to meet as staff i.e. phone meetings (staff on days off may call in).
- Teach frontline staff about and how to use Tableau.
- Re-create our quality board to a more "living format" that tracks current work and entices all staff to update.

→ Anticipate delirium prevention remaining a priority for "readiness to discharge".

- We understand and have experienced bounce-back/re-admissions because of delirium. Our unit is limited with patient transfers to our medical and surgical wards that do not have high-intensity off-service beds.

### We commit to de-adopting:

The routine audit of Spontaneous Breathing Trials. If there are concerns going forward, we can complete a random audit to verify continuing practice. Also, we will stop monitoring ISCDC compliance because our measures reveal results and the data is reliably reproducible via Tableau.

### We commit to adopting:

A standardized approach for sleep promotion and proactive occupational therapy. Our unit has no dedicated FTE for Occupational Therapy. We are currently working with our site OT Lead to learn more about sleep hygiene and plan to pick one patient for a "pilot". This involves trialing occupational therapy treatment sessions and monitoring the patients' outcome. We hope that this pilot and a few subsequent trials will support/fund for regular OT rounds through our unit.