EZ – Sturgeon Community Hospital ICU

Critical Care Strategic Clinical Network™

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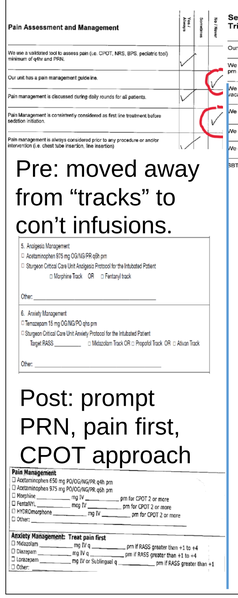
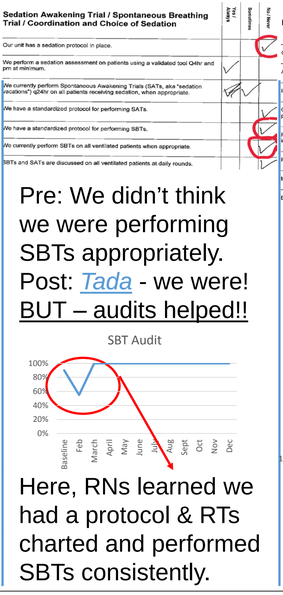
THE PAST

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



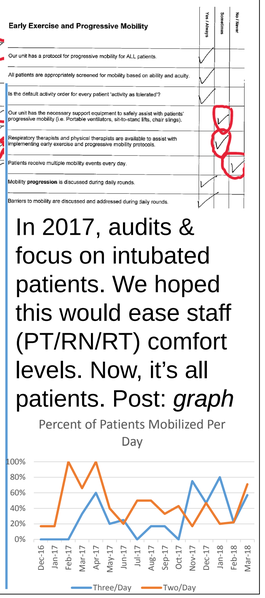
Pre: moved away from "tracks" to con't infusions.

Post: prompt PRN, pain first, CPOT approach



Pre: We didn't think we were performing SBTs appropriately. Post: *Tada* - we were! BUT – audits helped!!

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

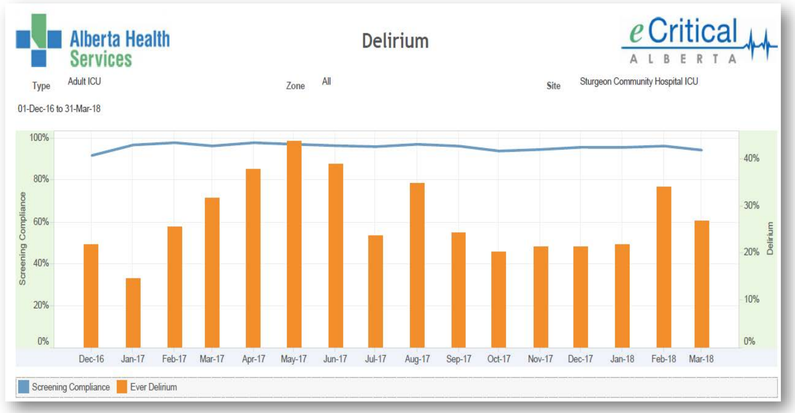


In 2017, audits & focus on intubated patients. We hoped this would ease staff (PT/RN/RT) comfort levels. Now, it's all patients. Post: *graph*

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 sill 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.