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Delirium News

A newsletter from the Critical Care Strategic Clinical Network
Winter 2018

Learning Session #5

Better Together: Celebrating and Sustaining Excellence

When: Feb. 11, 2019

Location: Executive Royal Hotel, Calgary

Featuring:

- 21 provincial ICU teams are coming together to share their progress
- Guest speaker Dr. Damon Scales (Sunnybrook Hospital, Toronto): Lessons learned from quality improvement work in critical care,
- Implementation expert Kelly Mrklas (SCN): Breaking down barriers & maintaining momentum in quality improvement work

Unit Success Stories

Mazankowski Cardiovascular Intensive Care Unit (CVICU): Using patient stories in a meaningful way

Laura Cunliffe, Social Worker for the MAZ CVICU, shares how providing staff with patient updates helps recognize their important work:

"We see patients when they return for a follow-up cardiac appointment. At their first follow-up visit, we show them an example of other patient stories and ask if they are interested in sharing their experience. Many are excited to share a few pictures of 'life after CVICU.' The patient stories are reviewed with the patient before being emailed to staff and then posted in a dedicated space – our Patient Update board. Our staff appreciate the updates."

Learn how patient stories can improve intensive care on The Conversation website

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University of Alberta Hospital General Systems Intensive Care Unit (GSICU): New Spontaneous Breathing (SBT) Trial Guideline implemented

The GSICU new SBT guideline has been implemented and is having an impact. Preliminary data from the past few months is demonstrating success in SBT screening, communication between espiratory Therapists (RT) & physicians, and time to extubation.

Data: Decreased time from MD notified of successful SBT to extubation order: 62 minutes down to 23 minutes. The team is now looking at improving time from successful SBT to extubation: (Sept was 109 minutes – lowest since Baseline April 2018).

New 2018 Society of Critical Care Medicine (SCCM) Guidelines

The 2013 SCCM guidelines provided recommendations for the prevention and management of pain, agitation and delirium in the adult critical care population. The updated 2018 guidelines have an increased focus on sleep promotion, rehabilitation and mobility.

Did you know? There are no randomized controlled trials that show improved sleep will reduce delirium in ICU. However, improving sleep is an important comfort measure, and implementing sleep promotion strategies can improve the patient experience & quality of life.

To view the full 2018 SCCM guidelines, visit the Society of Critical Care Medicine

Cognitive Cart at Misericordia Hospital (MIS ICU)

The new Cognitive Cart has mobilized at the MIS ICU. Every day staff offer activities to patients & families. A quick tip sheet was created for staff to help explain contents and use of items.

Photo courtesy of K. Scherr

More success stories across the province

- **Red Deer ICU:** They hosted their first-ever former ICU patient & family meet and greet event in December.
- **Northern Lights:** Given recent ongoing changes in staff and leadership, they are re-launching their pain, agitation, and delirium work.
- **South Health Campus:** They recently implemented an ICU day/night routine to enhance mobility and sleep promotion. Now they are re-defining what this means to frontline staff & patient care.
- **Chinook Regional Hospital:** They are adding a new nurse clincian role to the team. The nurse clinician will be the 'constant' during patient discussions and planning of care.

Did you know?

Sleep does not equal absence of pain or pain relief

- Assess & document pain every 4 hours.
- If the patient is asleep, do not wake them.
- Document on the pain assessment form and select 'unable to assess – patient sleeping' in the 'patient status' dropdown menu.
- Always use Critical Care Pain Observation Tool (CPOT) or numeric score to assess pain
- Only use the comment box for any additional pain assessment details

Provincial Clinical Practice Expectation

Q4h Pain assessment (provincial average) 76.7%

When should we assess and document pain?

- Minimum expectation: every four hours and prn
- Before any procedure (turning, suctioning, mobilizing)
- After any intervention for pain (re-assessment after medication administered or non-pharmacological therapy)

Cat naps aren't cool: How to improve your patients sleep

Do:

- Take a look and listen around your unit – what environmental factors contribute to sleep disruption? What can be modified to make it less noisy/bright/uncomfortable?
- Think about physical reasons patients can't sleep: Pain? Too cold? Can't breathe? Hunger? Nausea or need to void? Uncomfortable?
- Consider what disruptions are care-related. Does your patient really need to be woken up for bloodwork or assessment at 4 am? Examine your unit's routine monitoring to see if it can be made more sleep-friendly.
- Recognize that patients may have worry, stress, fear, and anxiety, too. Providing comfort and reassurance in an unfamiliar setting can be helpful. Find out if they have a sleep routine at home and what 'normal' sleep is for them.

Don't:

- Accept that environmental noise is 'normal' in ICU. Many things that cause noise in ICU can be modified to be less-disruptive.
- Assume your patient can communicate all of their needs. Asking questions helps. Consider an evening mobility event with routine patient care.
- Wake patients unnecessarily. Cluster care to minimize interruptions. Goal: uninterrupted sleep during nighttime hours.
- Resort to 'sleep-promoting' medication. It can be considered, but non-pharmacological strategies may offer the best chance of patients getting a good night's sleep.

Highlights from the Pain Webinar

In November we hosted a webinar with Barry Kushner, Clinical Pharmacy Lead, to address pain management in ICU. Here are the top questions you asked:

1. What should we consider for procedural pain management?

The 2018 SCCM guidelines recommend pre-emptive analgesia and/or non-pharmacological interventions be administered to alleviate pain in adult ICU patients before chest tube removal and other painful procedures. Consider:

- Opioids at the lowest effective dose
- Timing opioid administration to peak effect prior to procedure **see table for common opioid used in ICU*
- Adjusting doses for advanced age (patients 65 years and older)

PRN pain treatment is recommended over continuous infusions, unless pain cannot be well-controlled with prn dosing. Speak to the unit physician, NP, or pharmacist if the pain management strategy is not effective or you have concerns about treatment plan & effectiveness.

2. Are there alternative treatments available other than opioids?

Consider using non-opioids (i.e. acetaminophen, gabapentin) and non-pharmacological therapies if appropriate and available. Always approach a "treat pain first" strategy before resorting to sedative medications.

3. How should we approach treating acute pain in the chronic patient population?

Chronic pain is often treated differently than acute pain. Patients in the ICU for critical illness need careful examination of their home medication profile, consideration of equivalent medication in ICU, and discussion with a pharmacist to optimize acute pain treatment.

	Morphine	Fentanyl	Dilaudid
Common dose	2.5—15 mg	25—100 mg	0.5—2 mg
Onset	5—10 min	1—2 min	10—15 min
Duration	1—4 hrs	30—60 min	2—3 hrs
*Key points	* histamine release can cause allergic reaction, itching, inflammatory response	* short acting; less histamine response * 80-100x more potent than morphine e.g. 100mcg Fentanyl = 10mg Morphine * synthetic	* long acting; less histamine response * 5-8x more potent than morphine (per mg) e.g. 2mg Dilaudid = 10mg Morphine * synthetic

Source: L. Coutts, CNE RAH ICU

Provide feedback or suggestions for future newsletter content, email criticalcare.scn@ahs.ca

ICU Family Education of Delirium (iFAM-ED) study: Clinical Research Network

Can providing family caregivers with education about delirium help them identify, prevent, and manage delirium in ICU? This new study will employ a module to educate family caregivers on delirium symptoms, how to identify delirium and how to prevent and manage delirium using non-pharmacological strategies. The iFAM-ED education module was co-designed with the Foothills Medical Centre (FMC) multidisciplinary ICU delirium working group committee and patient researchers. The feasibility and usability of this education module will be evaluated in a pilot study in the FMC ICU beginning in January 2019.

Learn more about Dr. Kirsten Fiest & Dr. Karla Krewulak's critical care delirium research or other research areas from the University of Calgary's Critical Care Research Network.

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