Collaborating to Implement the A-F Bundle

5/18/2016

Shellie Rizza, NP
Stephanie S. Johnson, RN, BSN

Objectives

- Define organizational culture
- Present history
- Define structure
- Explain resources
- Examine progression and future action plan

ST. JOSEPH'S
Health
A Higher Level of Care

Organizational Structure

- St. Joseph's has embraced concept of Shared Governance which has helped support changing culture to shift to more multi-disciplinary collaboration.

Historical progression of St. Joseph's Hospital ICU

- ICU initially managed by attending physician in concert with anesthesia providing ventilator management.
  - Clinical affiliates were utilized to bridge the gap in coverage.
  - This set up a lack of consistency of providers and lack of ownership of unit outcomes.

- Over time the clinical affiliate involvement grew along with the Anesthesia team.
- An intensivist service was created in and formal ICU management ensued.

ST. JOSEPH'S
Health
A Higher Level of Care

ICU Rounding

- Formal rounding started shortly after the addition of intensivists.

ICU Rounding (2)

Rounds has evolved into this expanded model of interdisciplinary collaboration based on best practice evidence.

Support Structure

- Critical Care Committee
  - Multidisciplinary committee meeting in which department representatives report out on quality initiatives in this forum.
  - Meets bi-monthly

Support Structure (2)

- Through continuing multi-disciplinary education and conferences, both the medical and nursing teams bring up to date evidence based practice research to the Critical Care Committee
- New knowledge and unit practice council initiatives help facilitate change to keep us in line with the best practice guidelines.

Resources

- Quality Improvement Department partnered with the NYS PFP.
  - Hospital Quality Liaison coordinated with PFP Project Manager to do a gap analysis of current practices against PFP recommendations.
  - Utilization of PFP resources for education, data & implementation strategies.

Gap Analysis

- After completing the gap analysis it was apparent that we had all of the pieces to the bundle puzzle; we just had to coordinate to put them together.

Gap Analysis (2)

- Utilizing the Critical Care Committee Meeting forum, the results of the gap analysis were presented within the structure of the A-F bundle.
- Through education, awareness, flowsheet generation and reporting; we found that we could easily progress to incorporating the A-F bundle compliance in our daily routine.

Continuing Progression

- It takes time!
  - Just 5 years ago we sedated and restrained all of our intubated patients with propofol, did sedation vacation once a day, kept them in bed turning them every two hours and restricted visitors.

Continuing Progression (2)

- Now, our pts are at a target RASS 0-We use propofol only on significantly respiratory compromised pts, use mits for safety-only if necessary, get intubated pts out of bed, and have open visiting hours.

A-F Bundle

- A-Assess, Prevent and Manage Pain
  - CPOT documentation
  - Re-work order set.

FENTANYL CONTINUOUS INFUSION 2500MCG/50ML (50MCG/ML)

For patients with CPOT $\geq$ 2 or pain scale $\geq$ to 4/10:

- **FENTANYL** 50mcg IV bolus then 25mcg/hr, titrate to a max of 250mcg /hr for pain and sedation.

(GUIDELINES RECOMMEND MAX 2 mcg/Kg/hr)

For titration bolus doses or anticipated activity intolerance,
FENTANYL 25mcg IV q30 min prn pain maximum 6 doses in 24 hour period

SEDATION: TO TARGET RASS -2 TO +1

MIDAZOLAM (Versed) 1mg IV q 30 min prn sedation/agitation

A-F Bundle (2)

- B-Both SAT's and SBT's

DAILY INTERRUPTION OF SEDATION: Unless Intensivist identifies that a patient is not a candidate for sedation interruption, continuous infusion Fentanyl, Propofol or benzodiazepines will be stopped daily at ~0730 (coordinate with RN and RT). Ensure adequate analgesia before turning off sedation agent. For Propofol doses > 20 mcg/kg/min, RN may taper dose by 50% q30 min with a goal for sedation to be off by 0730-0800. If patient response is acceptable, use intermittent sedation as needed (confirm with MD). If response is unacceptable, bolus if needed and resume continuous infusion at 50% of previous rate.

A-F Bundle (3)

- C- Choice of sedation

SEDATION: TO TARGET RASS -2 TO +1

MIDAZOLAM (Versed) 1mg IV q 30 min prn sedation/agitation

For Cardiac Surgery patients only:

☐ Propofol (Diprivan) infusion 0 – 25 mcg/kg/min

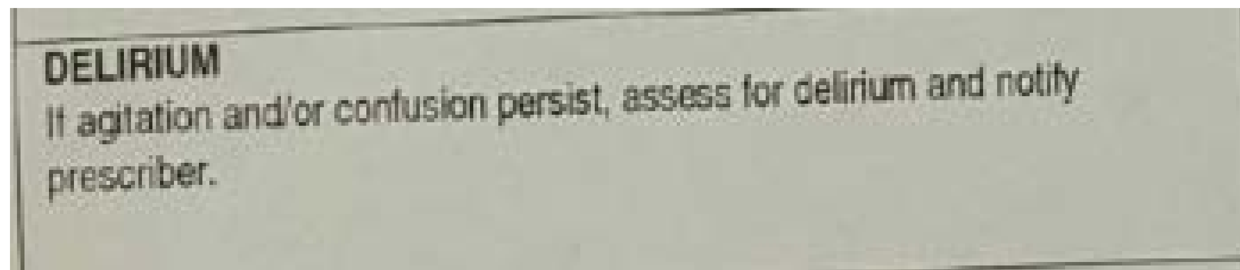
May give IV bolus of 0.5 mg/kg over 1 minute to maintain target sedation score, if needed may be repeated x 1 in 10 minutes prn.

Wean Propofol to off 4 hours after admission to SICU.

ST. JOSEPH'S
Health
A Higher Level of Care

A-F Bundle (4)

- D- Delirium: Assess, Prevent and Manage


DELIRIUM
If agitation and/or confusion persist, assess for delirium and notify prescriber.

- Educating on CAM-ICU and RASS scoring
- Developing protocol for ordering and documentation in epic

A-F Bundle (6)

- E-Early Mobility and Exercise
  - Significant improvement in involving PT early in the ICU
  - Can progress to admission order sets including PT on ALL ICU pts (exceptions listed in order: Significant O2 requirements, open abdomen)
  - Start walking stable intubated pts.

A-F Bundle (7)

- F-Family Engagement and Empowerment
  - Open visiting policy
  - Family is included on rounds
  - Family updates are given regularly at the bedside face to face with provider.
  - Families are encouraged to participate in reorienting and engaging of delirious pts.

ST. JOSEPH'S Health
A Higher Level of Care

Future Plans

- Flowsheet with bundle elements is being generated in Epic
- New sedation protocol and order set is being finalized
- Education has started (CAM-ICU, RAAS)
- Nurse reporting script on bundle elements during rounds is being developed