Bedside Checklist for ABCDE Protocol Cheat Sheet

by [deleted] via cheatography.com/2754/cs/7512/

Introduction

Why? 60-80% of mechanically ventilated patients & 20-60% of lower severity ICU patients develop delirium.

Awakening and Breathing Coordination (ABC)

Step	Action	Yes No	Reason Why
Awakening and Breathing Coordination (ABC)	SAT screen passed? If not, why?	[_] [_]	_____
	SAT done? If not, why not?	[_] [_]	_____
	SBT screen passed? If not, why?	[_] [_]	_____
	SBT done? If not, why not?	[_] [_]	_____
	SAT & SBT Coordinated/Paired?	[_] [_]	_____
Delirium Nonpharmacologic Interventions	Pain assessment/management	[_] [_]	_____
	Orientation	[_] [_]	_____
	Sensory (eyes/ears)	[_] [_]	_____
	Sleep (nonpharm)	[_] [_]	_____
Early Exercise and Mobility	Active ROM	[_] [_]	_____
	Sitting up on side of bed	[_] [_]	_____
	Standing	[_] [_]	_____
	Walking	[_] [_]	_____

For D: Check any intervention that was performed during your shift (including night shift).
For E: Check any level of activity the patient performed during your shift (including night shift).

By **[deleted]**
cheatography.com/deleted-2754/

Published 20th March, 2016.
Last updated 12th May, 2016.

TOP 10 Teaching Tips for Delirium Monitoring

1. Assessment is FAST: 90% of RASS/CAM-ICU assessments take <1 minute. The other 10% take only a few minutes. Speed and ease of use make this feasible on a large scale multiple times daily (often done q8 h).

2. RASS & CAM-ICU: Implementing RASS without CAM-ICU (sedation scale without delirium tool) leaves only half of consciousness assessed (arousal, not content), is clinically unsatisfying, and hurts compliance.

3. Tailor Exam: You don't have to do every CAM-ICU feature if you get your answers via a brief exam sooner

4. Starting with Features 1 and 3: Feature 1 is comparing folks to their "baseline MS" and Feature 3 is about their "LOC right now ." Since many ICUs repeat sedation scale assessment q2-4 h, these data are readily available. A quick mantra:** "Is patient at his/her baseline or fluctuating +RASS now + Inattention test."

5. Inattention (Feature 2): This is THE cardinal feature and must be present to diagnose delirium. F2 is quick and simple. 95% of evaluations are done using only "hand squeezes" on correct letters or numbers. We need the picture method of screening for inattention in <5%, who are often very interesting patients.

6. Hand Squeezing: In the absence of other specific neurological diagnoses, a patient who squeezes on all letters, squeezes on NO letters, or misses >2 letters/numbers/pictures is inattentive and F2 positive. With a RASS other than "0," he/she is delirious from many possible causes (e.g.:** sepsis, sedatives, CHF).

7. UTA: The term 'Unable to Assess' is only recorded when patients are in stupor/coma (RASS -4/-5).

8. Rare F4: It is only necessary to proceed to Disorganized Thinking (F4 in new training manual) when a patient is F2 positive (inattentive) and Awake and Alert (RASS 0) at the time of CAM-ICU evaluation.

9. Subsyndromal Delirium: Patients may have some features without the full syndrome of delirium (e.g., F2 only or F1&4 only). This is a (subsyndromal) intermediate state of badness between normal and delirium. Reassess with CAM-ICU frequently to determine the clinical course of his/her emerging brain dysfunction.

10. Key to Success: MDs and RNs must be on the same page. The TEAM must understand the definition of delirium, its prognostic implications, modifiable causes, and treatment options. Enthusiasm is destroyed when physicians donot respond to nurses who report that a patient is CAM-ICU positive. Overcome this implementation barrier by engaging and educating all members of the ICU team and having experts.

By **[deleted]**
cheatography.com/deleted-2754/

Published 20th March, 2016.
Last updated 12th May, 2016.