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Abstract 1

Title: Under-thinking and Over-investigating: Chest Radiographs in Cardiac Pain are a Costly Bad Habit

Authors & Institution: Dr Andrew Chadwick. Co-authors: Dr A Pugh, Dr E Nuttall Musson, Dr C Campbell. Buckinghamshire Healthcare NHS Trust

Name of contact: Andrew Chadwick

Abstract:

NICE recommends performing a CXR in patients presenting as ACS to screen for other causes of chest pain (CP), although there is no evidence base for this. This study examines current practice of performing CXRs and the utility of the CXR as a screening test in this context.

Methods: retrospective cohort analysis of patients presenting with CP to CSRU in March 2015. Notes were examined to identify variables including pain character, diagnosis and CXR report (if performed). The CXR was assessed as a screening test and the sensitivity, specificity and likelihood ratios were calculated. A cost analysis was performed based on the cost of £28.61 per CXR.

Results: 196 patients were examined. 122 had cardiac sounding CP, 94% of which had a CXR. Only 4/122 patients had an abnormal CXR affecting diagnosis/management. Analysis of CXR reports compared to diagnoses revealed a high “false negative” rate giving the CXR as a screening tool a sensitivity of 0.06 and a negative likelihood ratio of 1.1. The cost to the Trust for CXRs in patients with cardiac sounding CP was £3290.15.

Conclusion: 94% of patients presenting with cardiac sounding CP have a CXR but it is seldom of any value. The CXR is a poor screening test with a very low sensitivity and performing a CXR has very little effect on the post test probability of “ruling-out” other causes of CP. Current practice is costly financially and in terms of patient and staff time. Consideration about who requires a CXR is needed.

Total Word Count (Abstract Body Only): 249
Abstract 2

**Title:** A Pilot study investigating the benefits of performing sleep diagnostics out in primary care

**Authors & Institution:** Trish Matharu, University Hospital Coventry and Warwickshire

**Name of contact:** Trish Matharu

**Abstract:**

OSA holds a UK prevalence of 5%. Over time, awareness of sleep disordered breathing has increased. As a result, the number of diagnostics being performed within secondary care has increased significantly. This has placed a massive strain on the facilities available within secondary settings, simultaneously causing a number of breaches on the 18-week care plan.

The aim of the study was to determine a service development to see whether performance of diagnostics for sleep disordered breathing performed in primary care improved the pathway faced by patients today, true for a local population. There was an 80% detection rate of OSA within the GP cohort, with the majority of positive studies being of the severe category (60%). The study also looked at the correlation between risk factors of OSA and positive AHI. There was no significant difference figuratively between time from study to time for analysis with is being 15.00 +/- 7.99 for the new pathway and 15.20 +/- 5.35 says for the old pathway. However, the time taken from GP diagnosis was significantly shorter in the new pathway than the current. Factors that may have influenced this include only one member of staff facilitating the new pathway against four staff members working to the current pathway.

As a pilot study this research as shown potential scope for a change, however the research would need to be extended for this to be confirmed as it has been limited by a significantly reduced sample size.

**Total Word Count (Abstract Body Only):** 243
Title: Pre-THRIVE (transnasal humidified rapid-insufflation ventilatory exchange) checks: improving patient safety and team working in ENT surgery

Authors & Institution: Valdinger S, Sharma S, McGlashan J, Evans D, Rollason C. Queen’s Medical Centre, Nottingham.

Name of contact: Dr. Stefan Valdinger

Abstract:

THRIVE allows for the provision of gas exchange during prolonged apnoeic periods. It is a documented technique [1] for providing oxygenation while securing a difficult airway, and allowing both oxygenation and CO2 clearance during surgical procedures on the larynx.

Our institution uses THRIVE to provide apnoeic ventilation for ENT surgery requiring optimal surgical access during microlaryngoscopy. A review of our first 40 cases found two episode of significant desaturation (SpO2<90%). They occurred at the transition point at the beginning and end of the surgery when airway patency is lost as the airway is passed from anaesthetist to surgeon and visa versa. Our THRIVE case series (pending publication) also suggests that this transient loss of the airway plays a role in reducing the effectiveness of CO2 clearance. It is critical that team members are aware that the apnoeic window is not unlimited. Finally, all theatre staff need to be aware of the plan for intra-operative desaturation.

Our experience suggests that safe and successful use of this technique depends upon effective team working and communication amongst theatre team members. Checklists have been shown to improve team communication and improve patient safety [2] and so we developed a simple pre-THRIVE checklist to avoid unnecessary delays in securing the airway and maximise efficient use of the apnoeic window. Following positive feedback from theatre team members this has been implemented as standard practice in our ENT theatres. We believe this simple change has improved both patient safety and theatre efficiency for ENT cases involving THRIVE.

References:


Total Word Count (Abstract Body Only): 250 (excluding references.)
Abstract 4

Title: The acute effect of continuous positive airway pressure titration on blood pressure in awake and obese subjects with obstructive sleep apnoea

Authors & Institution: Culadeeban Ratneswaran, Martino F Pengo, Sichang Xiao, Yuanming Luo, Gian Paolo Rossi, Michael I Polkey, John Moxham, Joerg Steier

Name of contact: Culadeeban Ratneswaran

Abstract:

Background. CPAP improves upper airway obstruction in OSA patients. Although it is thought that CPAP improves long-term BP control, the impact of acute and short-term CPAP on the cardiovascular system in obese patients has not been described in detail.

Method. Obese patients (BMI>30kg/m2) with OSA were studied awake, supine, during incremental CPAP titration (4-20cmH2O, +2cmH2O/3mins). BP was measured continuously with a beat-to-beat BP monitor (Ohmeda 2300, Finapres Medical Systems, Amsterdam/NL). BP variability (BPV) was calculated as the standard deviation of BP at each CPAP level, the 95% confidence interval was reported for the changes in BP and BPV.

Results. 15 patients (12male, 48(10)years, BMI 38.9(5.8)kg/m2) were studied; the baseline BP was 131.0 (10.2)/ 85.1(9.1) mmHg. BP and BPV increased linearly with CPAP titration (systolic BP r=0.960, p<0.001; diastolic BP r=0.961, p<0.001; systolic BPV r=0.662, p=0.026; diastolic BPV r=0.886, p<0.001). The systolic BP increased by +17% (+23.15 (7.9, 38.4) mmHg; p=0.011) and the diastolic BP by +23% (+18.27 (2.33, 34.21) mmHg; p=0.009) (figure 1), when titrating CPAP to 20cmH2O. Systolic BPV increased by +96% (+5.10 (0.67, 9.53) mmHg; p<0.001) and was maximal at 14cmH2O, and diastolic BPV by +97% (+3.02 (0.26, 5.78) mmHg; p<0.001) at 16cmH2Os.

Conclusion. Incremental CPAP leads to BP and BPV increase in obese OSA patients while awake. OSA and obesity are known independent correlates with increased sympathetic drive. BPV, a marker of sympathetic activity, confers increased cardiovascular risk in this group during titration. Precise titration is therefore needed to reduce nocturnal awakenings while maintaining BP control.

Figure 1

Total Word Count (Abstract Body Only): 250
Abstract

In November 2016 the Cystic Fibrosis Trust launched the UK Cystic Fibrosis (CF) Insight Survey. This aimed to learn more about the lives and experiences of people with cystic fibrosis across the UK, as well as their families and friends’ perspectives on a range of subjects.

The survey was designed with the involvement of people with CF, family members, partners and friends.

In 4 weeks we received just under 1000 responses, representing nearly 10% of the UK cystic fibrosis population.

People were asked to answer questions about the time it takes to follow a treatment regime, the quality of CF care, how they personally manage their own care and general wellbeing, how comfortable they are talking about their own or a family member’s condition in different circumstances, and what life with CF is like. In all cases this was information that can not be gathered at present through clinical interactions. The survey was anonymous, and provided ample space for people to express themselves.

Key findings indicate that people with CF and their families would like greater access to participation in clinical trials, don’t exercise as much as they are recommended to, and are using an extremely wide range of technology and apps to assist with CF care.

I would like to present a poster with key findings and a brief overview of how involvement of people with cystic fibrosis made a difference to the survey’s planning and future development.

Total Word Count (Abstract Body Only): 239
Title: The introduction and potential development in practice of an inline blood gas analyser within adult and paediatric critical care

Authors & Institution: Claire Jennings, Ian Sutheran, Stephanie Hawthorne and Natalie Fowler (all based at Central Manchester Foundation Trust)

Name of contact: Natalie Fowler

Abstract:

The use of blood gas analysis is an integral part of care planning for critically ill patients, to monitor essential gases and electrolyte levels. Traditional methods of testing involve the removal of a blood sample which is processed through a bench-top analyser. However, this frequent sampling can have a physiological impact on patients particularly for paediatric and neonatal patients due to smaller total blood volumes.

The aim of this pilot study was to implement an alternative intervention, the Proxima inline blood gas analyser. The main objectives of the pilot included: measuring blood loss using the inline analyser in comparison to normal sampling methods, determining if nursing time could be saved at the bedside in comparison to normal sampling methods and comparing analysed results to evaluate the accuracy of this product. 2 inpatients (for >72 hours) who had an arterial line in situ, were selected. A blood sample was taken and analysed by the inline gas analyser. A repeat blood sample was then analysed using a bench-top analyser. This method was repeated as required in response to the patient’s clinical condition. Initial results demonstrate that all inline analyser results trended closely, with a correlation coefficient of 0.7-0.9, to the bench-top analyser results. Additionally, the inline analyser took 50% less time to obtain a result and with no time required away from the bedside. Expansion of this pilot study will enhance collaboration for product development, potentially a promising technology, with increasing benefits for varying patient groups within critical care.

Total Word Count (Abstract Body Only): 247
Title: Does The Introduction of Electronic Surveillance reduce the incidence of ward based Cardiac Arrest?

Authors & Institution: Karen Turner Advanced Nurse Practitioner Papworth Hospital NHS Foundation Trust

Name of contact: Karen Turner

Abstract:

Cardiac arrest rates in adults post cardiac surgery at the largest single centre for cardiac surgery in the UK was 0.82% for the pre VitalPAC™ era. The ALERT service was implemented trust wide in 2009 in response to the National Confidential Enquiry into Patient Outcome and Death, An acute problem? London: NCEPOD; 2005 and the subsequent publication of NICE CG50 (2007) guidelines.

This led to the implementation of a track and trigger modified early warning score (MEWS) (appendix 1) system with a graded escalation response for all inpatients. The use of paper observation charts was superseded by the introduction of VitalPAC™ nurse in 2013 and then VitalPAC™ doctor in Feb 2015 which sends alerts via an iPod™ hand held device to the ALERT Advanced Nurse Practitioner on duty.

The modification of MEWS to CTEWS (cardiothoracic early warning score) which is so far invalidated (appendix 2) has increased the sensitivity of known physiological parameters shown to be indicative of impending deterioration and ultimately cardiac arrest as identified by NCEPOD (2012) report ‘Time to intervene’. The main objective of the study was to investigate whether the introduction of VitalPAC™ using CTEWS has reduced the cardiac arrest rate in this group of patients over a 5-year period with data collected before its introduction, during and after implementation. The current cardiac arrest rate in this patient group for the post VitalPAC™ respectively has fallen to 0.29%. The frequency of events has diminished from 1 arrest every month to 1 arrest every 2.5 months.

This is a single centre quantitative observational cohort study using retrospectively analysed contemporaneously collected data from resuscitation forms, patient notes, observation charts and VitalPAC™ analysis. The data analysis has been broken down into three distinct eras which includes a breakdown of unheralded, heralded and uncertain arrest classification, specific surgical procedure incidence and frequency of events.
Abstract: we audited 53 patients using AIRVO HFNC within the ward setting. Duration of therapy was between 1 and 18 days. The AIRVO was used for a total of 121 days. 41/53 patients were appropriate for escalation of care of whom only 23 required escalation – 18 receiving NIV on ICU. 23/53 patients were managed successfully on the ward. 7/53 patients were palliated. The patients who were successfully managed on the ward used AIRVO for 103 days. These patients were all appropriate for escalation of care and therefore would have to have been admitted to ITU if AIRVO wasn’t available. We saved 103 HDU bed days as a result of using AIRVO HFNC in our first year. We estimated a cost saving of around £82,400.

The outcome for those admitted to ITU is as follows 23/53 were admitted to ITU, 18 received NIV, 9 patients died on ITU, 10 patients survived to Critical Care DC and 4 patients survived to home DC.

The Airvo allowed us more time to assess patients re suitability for escalation of care and EOL decision making. The AIRVO was tolerated in all but 3 of the patients. Reduced Strain on Critical Care Units.

Total Word Count (Abstract Body Only): 200
Title: A comparative evaluation of 999 call-to-needle time of patients presenting with red flag sepsis, treated with antibiotics by paramedics and ED staff.

Authors & Institution: Jonathan Chippendale BSc MCPara 1, Adele Lloyd RGN 2, Tanya Payne BSc (Hons) RGN3, Gregory Adam Whitley MSc MCPara4


Name of contact: Jon Chippendale

Abstract:

Background

National Institute for Health and Care Excellence guidelines on the recognition, diagnosis and early management of sepsis suggest that in all cases of high risk (or red flag) sepsis a broad spectrum antibiotic is given without delay and within one hour. For patients identified pre-hospital, GP’s and ambulance services are advised to have mechanisms in place that will allow them to give antibiotics but only where the transfer time is over one hour.

Whilst one hour is the recommended time in which to receive antibiotics, the 999 call dispatch process is often overlooked and there are no studies to date that examine the 999 call-to-needle time for sepsis patients.

Method

Data collected from a feasibility evaluation was used to determine the call-to-needle time of a broad spectrum antibiotic given by a paramedic pre-hospital. Patients arriving in the emergency department by ambulance with ‘red flag’ sepsis during the same 6 month period were identified with the call-to-needle time collected retrospectively. A Mann-Whitney U test was performed to determine if there was any significant difference.

Results

Of the patients that were treated (N=140) the median call-to-needle time of patients treated by paramedics was 45:30 minutes (n=60), compared to a median call-to-needle time by ED staff of 113:30 minutes (n=80) (P<0.001).

Conclusion

Considering the call and dispatch challenges that all ambulance services experience, patients with red flag sepsis can be treated with an antibiotic within an hour of the 999 call and on average one hour earlier than patients who are treated by ED staff.

Total Word Count (Abstract Body Only): 249
Title: A pilot study to assess the feasibility of paramedics delivering antibiotic treatment to ‘red flag’ sepsis patients

Authors & Institution: Jonathan Chippendale BSc MCPARA 1, Adele Lloyd RGN 2, Tanya Payne BSc (Hons) RGN3, Sally Dunmore MCPARA4, Dr Bethan Stoddart5


Name of contact: Jon Chippendale

Abstract:

Background

Sepsis is associated with a 36% mortality rate rising up to 50% for septic shock. Currently when an East Midlands Ambulance Service (EMAS) clinician recognises ‘red flag’ sepsis, only the oxygen and fluid elements of the ‘Sepsis 6’ care bundle are delivered, omitting the antibiotic therapy. Each hour antibiotics are delayed there is an increased risk of septic shock which is associated with a 7.6% greater risk of death. Ambulance clinicians are therefore appropriately placed to assess and commence treatment at the earliest point of recognition.

Methods

A prospective six month feasibility pilot evaluation was introduced in May 2016. Paramedics were trained and given access to a broad spectrum antibiotic along with a patient group directive (PGD) to administer the antibiotic to ‘red flag’ sepsis patients.

Results

20 paramedics volunteered and successfully completed the training. Of the patients that were identified as ‘red flag’ sepsis (N=113) 93% (n=107) were confirmed as infected by hospital record. 98 blood samples were harvested of which only 7.14% (n=7) were reported contaminated compared to an overall 8.48% of those taken in ED during the same time period. 80% (n=90) of patients assessed by paramedics met the criteria and were treated with meropenem.

Conclusion

EMAS paramedics were accurate and reliable in their recognition of identifying ‘red flag’ sepsis and able to administer meropenem safely in accordance with the PGD. EMAS paramedic blood sample contamination rate was lower than those taken in the ED.

Total Word Count (Abstract Body Only): 235
Abstract 11

**Title:**
A 3-year review of the use of High Flow Nasal Oxygen Therapy (AIRVO) on the wards under Critical Care Outreach care supervision

**Authors & Institution:** I Gonzalez, L Garcia, The James Cook University Hospital, Middlesbrough

**Name of contact:** Dr Isabel Gonzalez

**Abstract:**
The use of high flow nasal oxygen therapy (HFNO) in the critical care areas is well established in our organisation. We intended to expand the use of HFNO to the adult wards in a safe manner facilitated by the critical care outreach (CCO) team.

Since 2014 until present time, HFNO therapy has been used in 1049 patients on the wards. A review of these cases has shown that the main indication to commence HFNO was type 1 respiratory failure secondary to a variety of conditions, such as, community acquired pneumonia, hospital acquired infection, postoperative respiratory failure, sepsis and trauma being the most common cases. In 57% (595) of the cases the patients improved on the wards, 30% (312) needed escalation to critical care and 13% (142) died.

The CCO team reviewed all the patients for HFNO therapy, set up the equipment and make sure the wards have basic training in its use and contacted the CCO team to troubleshoot. One of the main concerns on the use of HFNO therapy is the risk of masking deterioration of the patient and delaying escalation to appropriate setting. The CCO team has proved to be essential in the adequate management of these patients and on the safe and successful establishment of HFNO therapy on the wards. A specific prescription for the use of HFNO therapy on the wards has helped with the communication between the teams looking after these patients.

**Total Word Count (Abstract Body Only):** 237
**Title:** Investigation of clearance of carbon dioxide during apnoea in anaesthesia using computer simulation

**Authors & Institution:**

Marianna Laviola¹, Stefan Valdinger¹, Anup Das², Marc Chikhani¹, Declan G. Bates², Jonathan G. Hardman¹

¹ School of Medicine, University of Nottingham, United Kingdom
² School of Engineering, University of Warwick, United Kingdom

**Name of contact:** Marianna Laviola

**Abstract:**

Apnoea is common soon at induction and emergence from anesthesia¹. Gas-mixing in the anatomical deadspace (AD) with stimulation of respiratory ventilation through cardiac oscillations is an important physiological mechanism at the onset of apnoea. An improved understanding of these physiological mechanisms would allow the development of more effective ventilation support.

This study is aimed at investigating carbon dioxide (CO₂) clearance during apnoea, in a simulated subject under anesthesia, using our computational model of the pulmonary and cardiovascular systems²,³.

We developed three new modules: cardiac oscillations, representing the pressure of the heart acting on the alveoli; anatomical deadspace gas mixing, representing the degree of gas-mixing between the series laminae in the AD; tracheal insufflation, representing the gas-flow penetrating the glottis. A virtual subject was simulated with reduced functional residual capacity (1.6 L) and reduced oxygen consumption (200 ml·min⁻¹). We evaluated the effect of variation of cardiac oscillations, varying degrees of mixing in the AD and a various rates of tracheal insufflation (with ambient oxygen), during 14 min of apnoea.

Arterial partial pressure of CO₂ (PaCO₂) was progressively smaller as the strength of cardiac oscillations was increased and it strongly decreased when the mixing between adjacent AD laminae was complete.

For a cardiac oscillation value generating a tidal volume of 25 ml⁴,⁵, we found prolonged apneic oxygenation and ventilation (rate of rise of PaCO₂ = 0.35 kPa·min⁻¹, end-tidal CO₂=0.32 kPa·min⁻¹).

In conclusion, cardiac oscillations are a key factor that contribute to gas mixing deadspace and alveolar gas, providing oxygenation and CO₂ clearance.

**Total Word Count (Abstract Body Only):** 250
Title: Winning-at-Weaning: Empowering ICU nurses to autonomously support the respiratory weaning process through implementation of a guideline

Authors & Institution: Leanne Franklin (RGN), Stoke Mandeville ICU, Buckinghamshire NHS Trust

Name of contact: Leanne Franklin

Abstract:

Background

Prolonged weaning from mechanical ventilation is a recognised problem challenging many Intensive Care Units and is associated with complications, such as ventilator-acquired pneumonia (VAP), increased mortality and overall healthcare costs.

Success rates and outcomes vary but early weaning adopting a nurse-driven and or protocolised approach can accelerate the process subsequently reducing total ventilator days.

Vast inconsistencies in approach prompted the creation of our multi-disciplinary respiratory weaning group.

Objective

The groups’ aim was to empower the bedside nurse to autonomously support the weaning process, by designing a guideline aiding a successful and consistent approach, thus improving patient outcomes and overall experience.

Methods

Primarily data was gathered through an extensive literature search, underpinning the guideline. Three simplistic flow diagrams were designed, categorised by tube type and duration plus supplementary individualised holistic goal documents ensuring patient specific care. Data was collected pre-and post-implementation from the nurses and consultants by questionnaire. A bedside audit reviewed compliance post implementation.

Results

Prior to implementation of the guideline only 50% of patients had a written weaning plan. Following implementation, 71% of nurses felt the guideline empowered them. 81% were confident in progressing or stopping based on the readiness to wean criteria. 97% of nurses found the holistic goals beneficial and 93% of patients had weekly holistic goals set.

Conclusion

Many variables create difficulties in directly attributing implementation of the guideline with a reduction in total ventilator days. However, its use has empowered the nurses and resulted in fewer inconsistencies. Total Word Count (Abstract Body Only): 243