

QUESTION

How can I implement accurate delirium screening and prevention practices?

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As a clinical nurse specialist (CNS), I am tasked with improving patient outcomes through collaborative research, evidence-based practice, and process improvement efforts that affect the quality and safety of patient care. However, I have learned over time that it is not enough to simply incorporate the latest evidence into organizational policies and procedures; it has to be followed in practice.

For example, I assisted with implementing delirium screening and prevention practices into my organization's healthcare system. However, nurses at the bedside were not consistently communicating delirium management practices during interprofessional rounds. In addition, when the bedside nurse relayed screening results, those results were usually negative for delirium. This occurred despite literature identifying that as many as 80% of patients in the intensive care unit and as many as 50% of patients in medical/surgical units are affected by delirium (American Association of Critical-Care Nurses [AACN], 2016; Hall, Maegher, & MacLulich, 2012). Because of this practice gap, I decided to focus the CNS-led rounds on nursing-specific knowledge and skills related to delirium.

When inquiring about delirium screening, the nurses often shared that their patients screened negative for delirium because they did not have acute mental status changes. I noticed a common trend: nurses were not capturing the acute changes from the patient's baseline status despite (a) fluctuations in the patient's level of consciousness documented during routine neurologic assessments and (b) the patient's current mental status assessments differing from the patient's prehospital mental status. Nurses at the bedside were incorrectly rationalizing fluctuations as normal.

For example, nurses followed orders to titrate medications to a goal level of se-

dation or medicate for pain. With those medications, changes in levels of consciousness were assessed as normal and related to titration of continuous IV drips; nurses knew the patient would have increased sedation after receiving pain medications. In addition, nurses also were incorrectly comparing their current assessment of the patient's mental status to the previous assessment, whether it was the previous shift, day, or week. Therefore, education about proper delirium assessment needed to be reinforced.

The education strategy started with first explaining that some routine interventions, such as medically indicated immobility, mechanical ventilation, and sedative use, despite being part of the plan of care, can increase the patient's risk for developing delirium (AACN, 2016). Conversely, some other routine interventions, such as sensory enhancements with glasses or hearing aids, promoting the sleep/wake cycle, and maintaining the least restrictive environment, can help prevent delirium development (AACN, 2016).

Next, it was reinforced that baseline assessments should be the patient's prehospital mental status (Vanderbilt University Medical Center, 2014). This understanding was critical for nurses to objectively complete a delirium assessment as intended.

The nurses now recognize their gaps in knowledge and understand their direct influence on delirium management. This was the critical clinical moment for the nurses, and it directly affected patients and changed care in our healthcare organization.

RESOURCES

- **American Association of Critical-Care Nurses**
Information on delirium practice changes impacting the care of patients
<http://bit.ly/2t5cj2h>
- **ICU Delirium and Cognitive Impairment Study Group**
Delirium information for healthcare providers, patients, and families
www.icudelirium.org/index.html
- **Society of Critical Care Medicine**
Information about care bundles to manage pain, agitation, and delirium
<http://bit.ly/2aNrUKR>

REFERENCES

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KEYWORDS

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