Inspiring colleagues to learn about delirium

How a team of nurses raised awareness of delirium and introduced a screening tool on their intensive care unit

By Siby Sikhamoni

According to the National Institute for Health and Care Excellence (NICE), hospitalised patients with delirium can die within a year of diagnosis. Delirium can occur in about 83% of patients in intensive care. It is an independent predictor of mortality, hospital readmissions and reduced quality of life.

The condition also places a significant financial burden on healthcare services, costing an estimated $4-16 billion (£3-12 billion) annually in the US, and is recognised as major public health problem.

Caring for patients with delirium who display combative and disruptive behaviour can affect staff morale, increase levels of stress and reduce job satisfaction. Standards of care can fall and nurses may fail to comprehend a patient’s behaviour due to their lack of awareness.

Delirium also increases length of hospital stay and risk for early dementia. And it has a significant effect on a patient’s family, who may experience distress at seeing their loved one with delirium.

However, early recognition and intervention usually helps prevention or shortens the delirium’s duration.

And cost-benefit analysis in various studies has shown that implementing preventive strategies can save money. Even though low-cost interventions can prevent and manage delirium, and improve patients’ lives, a two-week audit in my cardiothoracic intensive care unit showed that 26% of the patients had delirium, of which 66% cases were unrecognised.
It also highlighted that no screening tool for detection of delirium was being used. I wanted to improve patient experience and ensure we were providing safe and quality health care. To do this, I improved the nursing team’s awareness and ability to diagnose delirium by introducing the NICE-recommended confusion assessment method for ICU (CAM-ICU) assessment tool.

The project was easy to sell to my matron because the prevalence of delirium had already been highlighted by the audit. I formed a team – the Delirium Care Group (DCG) – to take the project forward. This group included eight enthusiastic ICU nurses, an intensivist, matron, pharmacist and physiotherapist.

I adopted a bottom-up approach, making small incremental steps using a PDSA (plan, do, study, act) cycle. SMART (specific, measurable, achievable, realistic, time-bound) goals were written, to be achieved in 3-6 months.

The DCG created a pre-educational audit questionnaire that was completed by all nurses. A non-probability method of convenience sampling was used.
Data were collected electronically and exported to Excel for analysis. The results showed a lack of knowledge on delirium and the screening tool. Based on the results, I organised a study day to train DCG members to become trainers. The group then began educating the rest of the unit’s nurses, which involved bedside one-to-one sessions, teaching via demonstration, observation and active listening events, and monthly sessions on mandatory study days.

Any change comes with challenges. The greatest was achieving nurses’ acceptance of the new screening tool as part of their daily patient assessment and documentation. This was slowly achieved by using bedside coaching and team days to continuously increase nurses’ awareness of the tool and its benefits.

After 2 or 3 months, an initial lack of compliance demotivated my team but producing ideas on how to address this motivated them to continue with the project.

Through brainstorming and collaboration, more ideas were identified to increase awareness.

Barriers to performing CAM-ICU were identified. For example, the tool was seen as too complex to use, and nurses lacked confidence in using it. They reported that medical staff were not paying attention to CAM-ICU results, and patients lacked stimulating equipment such as televisions and radios.

To address the latter point, the unit’s nurses took part in a charity fun run and raised about £1,000 to buy clocks, televisions and radios.

Reminder stickers that promote use of the tool were placed on daily ITU charts, and pocket cards with the CAM-ICU pathway were easily accessible to all staff. Posters on delirium care were mounted in staff areas.

Assessing progress
We continually assessed compliance through staff feedback and audit. Monthly compliance on CAM-ICU performance was assessed and the results emailed to all.

A post-educational audit showed nurses’ awareness of delirium, which was assessed by true and false questions, had improved significantly. Screening with the tool has become the norm.

A unit guideline for delirium management has been devised and made accessible to all staff, and a pathway to manage delirium has been established.

We are also now teaching doctors to assess, prevent and manage the condition.

There has been interest in delirium awareness week from outside the trust, and the results of the post-educational audit and recommendations were presented at the Euroanaesthesia Conference 2016 in London in the form of a poster.

We also presented our work at the British Association of Critical Care Nurses Conference in September.

Continuous learning
We saw such an improvement in compliance after our awareness week that we plan to repeat it on an adhoc basis.

Our project’s results have laid the foundation for further research and innovation – more needs to be done to prove if early assessment and prevention of delirium helps to reduce the incidence of delirium in intensive care.

We are continuing with the PDSD cycle to strive for 100% compliance in assessment and early management of delirium. This will contribute to providing safe and quality care for our patients.

Siby Sikhamoni is a senior staff nurse at St George’s University Hospitals NHS Foundation Trust. Her team was a finalist in the Leadership category of the RCN Nurse Awards 2016, sponsored by NHS England and our sister title Nursing Management. To enter the RCN Nurse Awards 2017 go to rcni.com/nurse-awards