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Editorial: Nurses' role in improving interdisciplinary delirium care in inpatient settings: steps for action

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Nurses' role in improving interdisciplinary delirium care in inpatient settings: steps for action

Providing care for someone with delirium is something all acute care nurses have in common, with at least one in five hospitalised patients experiencing delirium on any given shift (Ryan et al., 2013). Delirium occurs even more frequently in areas such as critical care, where up to 70% of older patients are reported to experience this syndrome (Barr et al., 2013; McNicoll et al., 2003).

The experience of delirium is distressing for patients, families and health care teams and is linked to a range of serious adverse outcomes. Hospitalised patients who experience delirium are not only likely to fall more often, they also have longer stays, are more likely to be discharged to a nursing home, develop a long term cognitive impairment and/or die (National Clinical Guideline Centre for Acute and Chronic Conditions, 2010). Memories of delirium experiences continue to cause a person considerable distress and fear long after it has passed (Teodorczuk, Harrison, Lavery, & Cave, 2011). Family members who witness a delirium episode report high rates of distress, and wished that health professionals had provided them with more information and demonstrated greater respect towards their relative during the delirium episode (O' Malley, Leonard, Meagher, & O' Keeffe, 2008). Of all health professionals, nurses experience the greatest distress and strain when caring for delirious patients (Leventhal et al., 2013). Delirium also impacts on the health care system, with admissions for elderly delirious patients costing two and a half times more for than those without delirium (Leslie, Marcantonio, Zhang, Leo-Summers, & Inouye, 2008).

Fortunately, delirium can sometimes be prevented and is often reversible (National Clinical Guideline Centre for Acute and Chronic Conditions, 2010). Even if delirium is not reversed and/or results in longer-term cognitive and functional problems, recognition and understanding by all team members remains equally important, to ensure ongoing supportive care of patients and their family (Pandharipande et al., 2013). However, as nurses we often don't recognise when our patients are experiencing delirium, as this complex syndrome manifests in various, fluctuating and often subtle ways, which are even harder to recognise if we lack delirium knowledge

or work in environments where there are few systematic processes to support its detection (Hosie, Lobb, Agar, Davidson, & Phillips, 2014; Steis & Fick, 2008).

Given delirium's prevalence, it seems incongruous for it to be so poorly recognised by hospital nurses. In part, our sub-optimal recognition and assessment of this syndrome may be because delirium assignment has traditionally been viewed as a purely medical responsibility; or more specifically, a psychiatric one (American Psychiatric Association, 2013). While establishing diagnoses is indeed a medical responsibility, nurses also have a professional responsibility to understand and recognise common acute changes to patients' condition, undertake comprehensive patient assessment and clearly communicate their findings to the interdisciplinary team. (Nursing and Midwifery Board of Australia, 2006; Registered Nurses Association of Ontario, 2004). Clinical practice guidelines now advocate that delirium diagnosis be determined by healthcare professionals who are trained in the use of the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic criteria for delirium or a validated delirium diagnostic tool, with the choice of tool dependent upon the setting (Clinical Epidemiology and Health Service Evaluation Unit - Melbourne Health, 2006; National Clinical Guideline Centre for Acute and Chronic Conditions, 2010). Acute care nurses' 24-hours presence at the bedside provides intimate contact with patients and frequent opportunities for communication with family members. Therefore, we are ideally placed to become more involved in not only delirium recognition processes, but also in assessment, diagnosis and management. Achieving improved delirium outcomes for hospitalised patients and families will thereby require nurses to participate in this translation of existing delirium knowledge into clinical practice.

For nurses to be actively engaged in delirium care, we contend it is necessary for nurses to know and apply both appropriate tools *and* the diagnostic criteria for delirium. The APA-DSM delirium diagnostic criteria transcend settings and tools, provide us with the foundational and internationally accepted description of this complex syndrome and offer a precise structure for nurses to shape and report patient assessment findings, in a language that is most likely to be accepted and understood by our medical colleagues. The recently released APA DSM-5 diagnostic criteria for delirium could potentially better serve as the basis for nurses to understand and report observed changes in patients, through reference to the following:

- A. Disturbed attention and awareness;
- B. Occurring acutely, representing a change from baseline, tending to fluctuate in severity over the course of the day;
- C. Additional disturbance in cognition (manifesting as memory, language, orientation, visuospatial and/or perceptual disturbance);
- D. A and C are not explained by a dementia nor within a severely reduced level of consciousness such as coma;
- E. Occurring as a physiological consequence of a medical condition or substance intoxication or withdrawal (American Psychiatric Association, 2013).

While the intent of the DSM-5 is be: “*A practical, functional, and flexible guide... that can aid in the accurate diagnosis and treatment of mental disorders...for a wide range of health and mental health professionals*” (American Psychiatric Association, 2014), it is highly likely that many nurses will not have be aware of this criteria, primarily because this manual is an expensive resource, is not primarily targeted at a nursing audience and its translation into the literature and clinical practice guidelines is likely to still be years away. However, without ready access to this primary knowledge resource, it is difficult for nurse to develop a truly shared understanding and language of delirium and the expertise to ensure timely delirium recognition, diagnosis or management.

If we are serious about improving delirium outcomes for the patients we care for we need to promote the DSM-5 delirium criteria within nursing, and work to make these internationally recognized criteria more readily available as a point-of-care resource and accessible to all members of the interdisciplinary team. We need to also strengthen our interdisciplinary team collaborations, as we cannot provide effective delirium care in isolation from our medical and allied health colleagues. Despite there being some barriers to interdisciplinary collaboration, largely related to differing discipline specific delirium knowledge, language and experiences, these barriers are not insurmountable and can be addressed through inter-professional training and education and promoting effective teamwork, grounded in open communication and respect (Health Professions Network Nursing and Midwifery Office, 2010). Within our teams, we ought determine how we will: i) integrate validated delirium-screening,

assessment and diagnostic tools into our daily systems of care; ii) immediately initiate comprehensive patient assessment, medical team review and determination of a delirium diagnosis or otherwise, following a positive delirium screen; and iii) collaboratively ensure appropriate, evidence-based interventions are promptly implemented. We also need to ensure that there is a focus on non-pharmacological strategies, in view of the limited evidence for efficacy of drug interventions and potential for adverse effects (National Clinical Guideline Centre for Acute and Chronic Conditions, 2010). Other key considerations for interdisciplinary teams to determine are: which delirium screening tool/s are most valid and appropriate for the patient populations we predominately care for; which discipline should take responsibility for various elements of comprehensive patient assessment; in what circumstances should a delirium diagnosis be confirmed by a psychiatrist, with workable strategies to achieve this in a timely and efficient manner; and how we will streamline each discipline-specific delirium process into systems that better meet the needs of the inpatients we care for.

Each of us needs to actively contribute to driving these delirium practice and system changes by ensuring that more nurses: i) access and understand the DSM-5 diagnostic criteria for delirium and use these to frame daily patient observations and team communications; and ii) develop truly collaborative interdisciplinary practice, according to the best available evidence. By starting with these fundamental steps, we will each contribute towards ensuring more informed and coordinated care of patients at risk of, experiencing and/or recovering from delirium during a hospital admission, improved delirium outcomes for patients, meeting the related needs of family and reduction of health care costs.

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