



Knowledge to Action Translation Framework: Screening for Delirium in Inpatient Psychiatry Populations

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Background

Evidence based practice is an important element of quality care in all domains of nursing by optimizing outcomes for patients, improving clinical practice and achieving cost-effective nursing care with accountability and transparency in decision-making (CNA, 2000). Despite a growth in nursing research, findings have consistently shown ineffective up-taking of such theory into new nursing practices: 30-40% of patients in United States and the Netherlands are not receiving care based on sound evidence (Graham et al., 2006). With a lack of research findings being taken up in practice settings, many patients are missing out on the best possible care. This problem is known as the knowledge translation gap, and has led to inefficient use of already limited health care resources. Knowledge to action process links research knowledge synthesis and implementation for best clinical practice and improved outcomes (Graham et al. 2006). Peggy Simpson, Clinical Nurse Specialist Consultation Liaison Psychiatry at St. Paul's Hospital has been using the Knowledge to Action Process as a framework for implementing the revised Nursing Care Standards Protocol for Delirium (NCS6323, 2011) in Inpatient Psychiatry Units.

Purpose

- To use the Knowledge to Action framework to implement and monitor the uptake of the Delirium Nursing Practice Standard by nurses working in inpatient psychiatry
- To evaluate changes in Conceptual use (changes in levels of knowledge, understanding or attitude) and Instrumental use (changes in behavior or practice), to determine extent of research knowledge uptake with staff nurses (potential-adopter group) and whether the interventions were adequate to bring about the desired change

Knowledge to Action Process

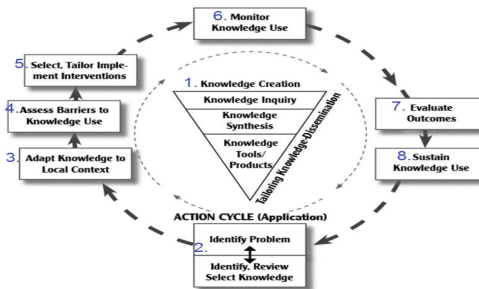


Figure 1: Knowledge to Action Process

- 1) Knowledge Cycle:** Delirium is a medical emergency; results in higher incidence of hospital mortality, length of stay, functional decline, leading to institutionalization and dementia; 70% patients are misdiagnosed; identified risk factors can predict delirium; CAM and PRISME tools can accurately identify and prevent delirium (Balas, 2009; Dasgupta & Dumbrell, 2006; Witlox, 2010).
- 2) Identify Problem:** 15% incidence rate of Delirium in psychiatry inpatients, 35% for Bipolar patients; only 48% of delirious patients actually recognized (Ritchie et al., 1996).
- 3) Adapt Knowledge to Local Context:** Nursing Care Standards Protocol for Delirium revised to include assessment and intervention strategies to improve patient outcomes (NCS6323, 2011).
- 4) Assess Barriers to Knowledge use:** Peggy Simpson surveyed staff nurse knowledge about assessing and managing Delirium. She held knowledge sharing education sessions attended by Nurse Leaders, Nurse Educators and UBC Nursing Students to determine the interventions required to facilitate changes to clinical practice.
- 5) Select, Tailor and Implement Interventions:** Staff education sessions held on applying the NCS6323-Delirium Algorithm; Nurses to fill out new Delirium Screening and Care Plan Flow sheet with risk factors, CAM screening and PRISME interventions.
- 6) Monitor Knowledge Use:** UBC Nursing students conducted chart audits to determine number of patients pre-screened for Delirium who are at risk; Connected with individual nurses to understand their knowledge; Engaged in group Participatory Action Appreciative Inquiry Sessions with Peggy and staff nurses to create a forum for discussion about Delirium in psychiatry and any barriers/suggestions to implementing the new practice standards

Table 1: Chart Audit results:

Charts Audited	12
Patients with 3+ Delirium risk factors	12 (100%)
Patients with completed Delirium Screening and Care Plan flow sheet	2 (17%)
Patients experiencing Delirium	2 (17%)

7) Evaluate Outcomes:

Staff nurses utilize Delirium Screening and Care Plan flow sheet for patients experiencing Delirium but not for pre-emptive screening. Identified barriers:

- Insufficient time to attend education sessions on Delirium
- Lack of access to Delirium Screening and Care Plan flow sheet
- Distinguishing Delirium versus Psychosis
- Patient case load and level of acuity of patients on units
- Unit culture or belief of Delirium not common on psychiatry units
- Lack of support by physicians

8) Sustain Knowledge Use:

- Further education sessions to permeate knowledge of NCS6323- Delirium algorithm among staff
- Nurse mentor on each unit to start culture of Delirium screening
- Reassess staff nurses to determine whether the lack of change is related to resistance to change or other barriers beyond their control
- Tailor interventions to these barriers, monitor ongoing knowledge use, and evaluate the impact of Delirium in Psychiatry knowledge translation to Delirium algorithm usage in clinical practice

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