

Implementation of RASS and CAM-ICU Assessments A Process Improvement Project

A recent survey of the medical community's beliefs and practices regarding delirium revealed that although the majority of respondents (92%) reported delirium to be a serious problem in the ICU, less than 10% routinely screened for delirium using a validated clinical tool. Can and will intensive care unit (ICU) personnel take on such tasks routinely and with a high degree of reliability?

The purpose of this study was to determine the feasibility of implementing agitation/sedation and delirium monitoring via a process improvement project and to evaluate challenges of modifying ICU nurses' practice styles. We prospectively investigated the large-scale implementation of the SCCM guidelines for monitoring sedation and delirium in two different hospital systems. During this investigation, we tracked compliance closely and measured agreement with expert reference standard raters.

Reference: Pun BT, Gordon SM, Peterson JF, Shintani A, Jackson JC, Foss J et al. Large-scale implementation of delirium and sedation monitoring in the intensive care unit: A report from two medical centers. Crit Care Med 2005; 33:1199-1205.

Figure 1 Compliance Data – This line graph shows medical intensive care unit (MICU) compliance with agitation/sedation scale (Richmond Agitation Sedation Scale or RASS) and delirium monitoring (Confusion Assessment Method for the Intensive Care Unit or CAM-ICU). The nurses included all 40 MICU nurses at the university-based hospital (Vanderbilt University Medical Center or VUMC) over 12 months and all 24 MICU nurses at the community-based Veteran's Affairs (York-VA) over 6 months.

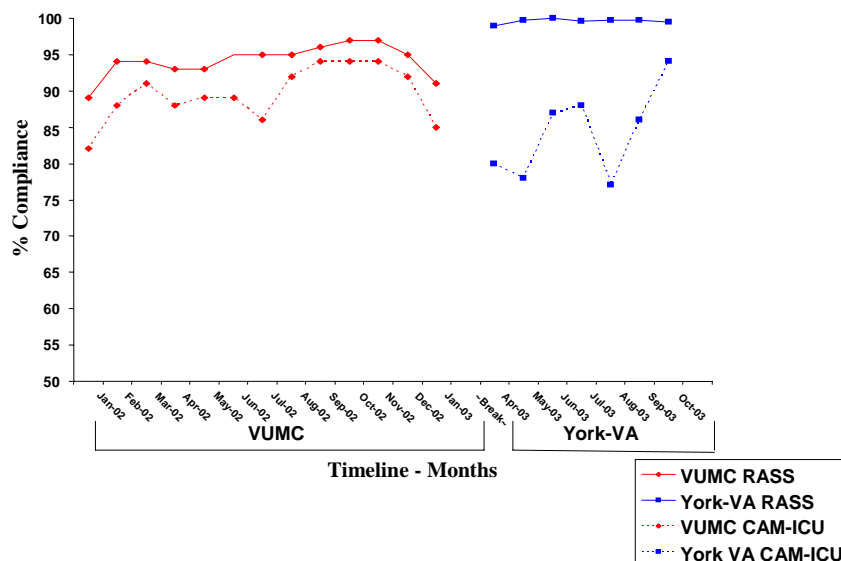


Figure 2 Agreement Data – This line graph shows agreement between bedside medical intensive care unit (MICU) nurses and expert reference standard raters using an agitation/sedation scale (Richmond Agitation Sedation Scale or RASS) and delirium tool (Confusion Assessment Method for the Intensive Care Unit or CAM-ICU). The nurses included all 40 MICU nurses at the university-based hospital (Vanderbilt University Medical Center or VUMC) over 12 months and all 24 MICU nurses at the community-based Veteran’s Affairs (York-VA) over 6 months. The baseline values noted on the X-axis were obtained during a pre-implementation phase to allow comparison with data obtained on subsequent months following educational in-services and hands-on feedback geared to improve the quality of the bedside nurses’ performance.

