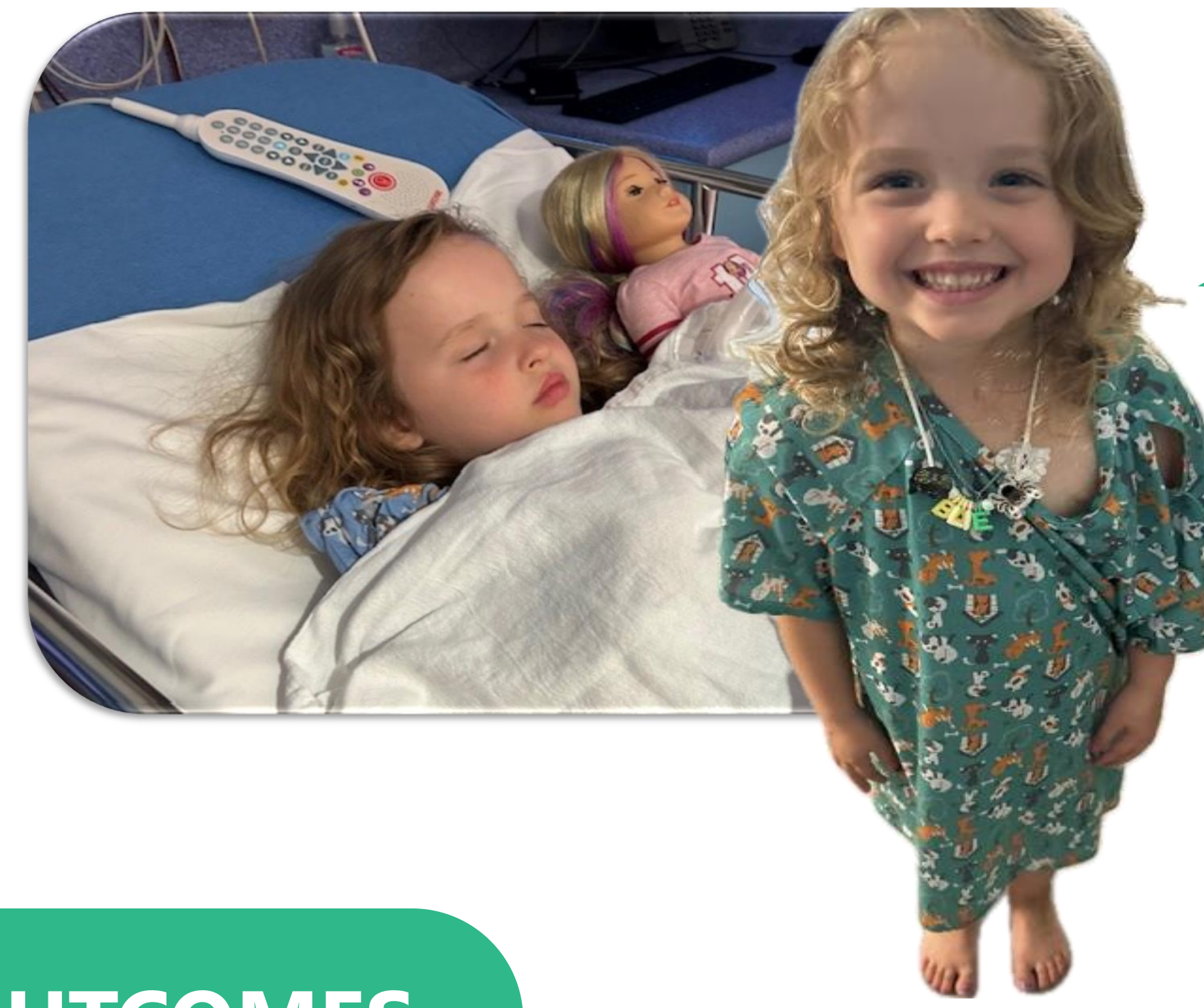


BACKGROUND

Emergence delirium (ED) is a **temporary state of confusion and agitation** that can occur when patients wake up from anesthesia.

Emergence delirium typically appears within the first few minutes after surgery and may include behaviors such as **crying, thrashing, disorientation, or inconsolability**.

Nurses in a rotational transition-to-practice program noted a **lack of objective assessment** practices that led to **inconsistent identification and management** of patients displaying symptoms of ED.



Hi! I'm Blaire.

I'm Kaylee's daughter and I inspired this project.

PICO QUESTION

For perioperative nurses (P), would use of an objective pediatric emergence delirium scale (I), compared with current practice (C), improve accurate identification of patients with emergence delirium and communication among staff (O)?

IMPLEMENTATION STRATEGIES

The IOWA Model Revised was utilized to:

1. engage nurse managers and unit educator,
2. distribute a pre-intervention survey,
3. provide education regarding use of the Pediatric Anesthesia Emergence Delirium (PAED) scale,
4. initiate use of the PAED scale into daily workflows utilizing paper forms,
5. distribute a post-intervention survey, and
6. present findings to unit and organizational leaders.

OUTCOMES

Most nurses (80%) reported use of an objective assessment tool would **improve identification of patients who are experiencing emergence delirium**.

All nurses (100%) reported that use of the PAED scale **improved collaborative communication among staff members** when caring for patients recovering from anesthesia.

Barriers included:

- workflow challenges,
- confusion regarding when to utilize the PAED scale, and
- a short pilot period.

CONCLUSION

Use of an objective assessment tool, such as the PAED scale, can improve accurate identification of patients experiencing emergence delirium.

Integration of the assessment tool into the electronic health record, versus use of paper forms, may resolve workflow challenges.

Education emphasizing use of the assessment tool for every patient, versus only those the nurse suspects of having emergence delirium, may resolve confusion regarding when to utilize the scale.

References

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