**APPENDIX 1.** Delirium Observation Screening Scale (DOS)1

1. Doses off during conversation or activities. (Yes=1/No=0)
2. Is easily distracted by stimuli from the environment. (Yes=1/No=0)
3. Maintains attention to conversation or action. (Yes=0/No=1)
4. Does not finish question or answer. (Yes=1/No=0)
5. Gives answers that do not fit the question. (Yes=1/No=0)
6. Reacts slowly to instructions. (Yes=1/No=0)
7. Thinks they are somewhere else. (Yes=1/No=0)
8. Knows which part of the day it is. (Yes=0/No=1)
9. Remembers recent events. (Yes=0/No=1)
10. Is picking, disorderly, restless. (Yes=1/No=0)
11. Pulls IV tubing, feeding tubes, catheters, etc. (Yes=1/No=0)
12. Is easily or suddenly emotional. (Yes=1/No=0)
13. Sees/hears things which are not there. (Yes=1/No=0)

**APPENDIX 2.** DOS Nursing Survey

* This survey is designed to elicit your attitudes toward and comfort using the Delirium Observation Screening Scale (DOS). Thank you for taking the time to fill it out.
* Please report your number of years of experience/practice.
* What is your typical unit assignment? (choice of units plus free response)
* Performing the DOS is easy. (Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree)
* How confident do you feel administering the DOS? (Very unsure, somewhat unsure, somewhat confident, very confident)
* The DOS provides me with valuable information for the treatment of my patients. (Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree)
* Patient care is enhanced by using the DOS.(Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree)
* How much time does it take you to complete the DOS? (Less than 1 minute, 1-3 minutes, 3-5 minutes, more than 5 minutes)
* The DOS is worth the time required to perform the assessment. (Strongly disagree, disagree, neither agree nor disagree, agree, strongly agree)
* What percentage of the time do you perform the DOS? (0-25% of the time, 25-50% of the time, 50-75% of the time, 75-100% of the time)
* In your opinion, how often should the DOS be performed? (It is currently done twice per day at 2AM and 2PM). (Once per day, twice per day, once per shift, more than once per shift, other [free response])
* What are some of the barriers to performing the DOS assessment? (Time it takes to perform assessment, difficulty using assessment, low applicability of results to patient care, other [free response])
* If the DOS was not required, would you still use it? Why or why not? (yes [free response], no [free response])
* Any additional comments about the DOS [free response]

**APPENDIX 3.** Nursing Survey Free Responses

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| **If the DOS was not required, would you still use it? Why or Why not? (**N=49) | |
| Responses and Themes | Examples |
|  |  |
| Yes (n=15) | *“It is a great tool for stopping and thinking about changes in my patient's mental status”*  *“It helps me prioritize where pt. needs/my interventions will be”*  *“It makes one realize to what extent your patient is at risk for or has delirium”*  *“I think it helps encourage nurses to consider factors they may be too busy or distracted to consider otherwise”* |
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|  |  |
| Provisionally (n=8) | *“Only if delirium suspected”*  *“I would use it if conversation with pt is not tracking”*  *“If I was starting to notice my patient was getting confused and I was unclear on the reason”* |
|  |  |
| No (n=26) | *“Even with a score indicating a patient has delirium nothing happens to help treat the condition so it is a waste of my time”*  *“It doesn't seem to change the way that I care for my patient”*  *“Just another thing to chart that takes up time”*  *“I tend to look at the neuro assessment on whether they are confused”*  *“Based on my personal nursing skills/judgment, you can tell if someone has delirium”*  *“It is mainly for the physicians. I can interpret the mentation of my patients without it.”* |
|  |  |
| **Any additional comments about the DOS?** | |
| Supportive (n=5) | *“I think having a scale that assesses the delirium risk/status of a patient is very important, as sometimes delirium goes unnoticed. I love that our hospital is making efforts to better patient care, especially for the geriatric populations. I would like more information on HOW the scale can be better implemented and used to provide better care for my patients.”* |
| Non-supportive (n=13) | *“It can be helpful to compare small changes in mental status, but it does not always represent an accurate assessment of the patient due to the lack of further details”*  *“Be careful with have so many assessments- sometimes it can be unrealistic the amount of charting nursing has to do. My concern is that they really don’t get done or just seen as ‘another thing that nurses have to do’ instead of seeing it as a useful tool.”* |