

Nursing Practices to Detect Acute Delirium, Safeguard Patients Experiencing Acute Delirium, and Help Reduce or Eliminate Acute Delirium

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Abstract

Acute delirium is very common among hospital patients, particularly older patients. Nurses have a major role in the care of these patients, yet there are no evidence-based nursing care guidelines to help nurses detect patients who are experiencing acute delirium, safeguard them, and assist their recovery. This study sought to identify and prioritize nursing practices for detecting these patients, safeguarding them, and assisting their recovery from acute delirium. A two-stage voluntary paper Delphi survey was used for this purpose. This study targeted all nurses who worked on adult medical/surgical units at two full-service acute care hospitals in Western Canada

who had cared for a patient diagnosed with acute delirium in the past 12 months. The first survey revealed many nursing practices exist to detect, safeguard, and assist recovery. The second revealed one preferred practice and four others for each of the following: Detecting acute delirium, safeguarding patients, and helping patients recover. Research is now needed to establish if these constitute “best practice” nursing care for enhanced patient outcomes.

Keywords: Acute delirium, Confusion, Delphi technique, Hospital care, Nursing practice, Survey

Acute delirium is common among hospital patients, although it is often unrecognized or misdiagnosed (Morandi et al., 2009). Acute delirium is therefore typically under reported (Kales, Kamholz, Visnic & Blow, 2003, Minden et al., 2005). Regardless, acute delirium is clearly understood as a serious health condition. It is associated with prolonged hospital stays, long-standing (if not permanent) cognitive impairment, high risk of nursing home admission, and death (Gonzalez et al., 2009; MacLulich, Beaglehole, Hall & Meagher, 2009). Many studies have sought to identify the incidence or prevalence of acute delirium, its many causes, and its medical management. Few studies have focused on the nursing perspective, yet nurses are the most likely healthcare professional to detect patients who are experiencing acute delirium. Nurses are also responsible for planning and managing the day-to-day care of these patients with a need to be kept safe and a need for nursing care that will help them recover.

No studies were found through a systematic review of acute delirium research that reveal how nurses identify patients who are experiencing acute delirium, what they do to safeguard these patients, and what they do to help them recover. This research gap lends credence to the assertion of Rapp, Mentis, and Titler (2001) that over half of all nursing care that is considered “appropriate” practice is not evidence based. The need for nurse researchers to focus on acute delirium was pointed out many years ago. In 1996, Meagher, O'Hanlon, O'Mahony, and Casey emphasized the importance of early nursing identification of patients who are confused, as well as the need for best-practice nursing care for patients who are suffering from acute delirium. This lack of nursing research is problematic, as the growing body of largely pharmaceutically-oriented therapies to address acute delirium is not immediately helpful to practicing nurses.

1. Background

Acute delirium is usually defined as sudden onset, impaired cognitive functioning – often involving reduced attention, memory, planning ability, organizational skills, and orientation to time and place (Meagher, 2001). Most research studies report that while around 10-15% of all hospital patients experience acute delirium, it is much more common among older than younger patients (Arnold, 2005). One recent study found 35.4% of elderly persons developed some form of acute delirium when hospitalized (Gonzalez et al., 2009). Other studies indicate as many as 65% of senior citizens, particularly those who have surgery or who require intensive care treatment, will experience it (Kalisvaart & Vreeswijk, 2008). This diversity in findings on the frequency of acute delirium may arise from it having different forms (Yang et al., 2009). Although restlessness or hyperactivity is the most common type of acute delirium, hypoactive delirium is also common (Spiller & Keen, 2006). Hypoactive delirium is often misdiagnosed as a near-death state, coma, or transient unconsciousness (Spiller & Keen, 2006). Dementia, senility, mood disorders, and functional psychoses are often diagnosed instead of acute delirium (Meagher, 2001).

Many different precipitating factors for acute delirium have been identified to date (Minden et al., 2005). This includes a history of depression or alcohol use, hypoxia, prior cognitive impairment, dementia, stress, advanced age, untreated pain, polypharmacy, sleep deprivation, major trauma, electrolyte or acid-base imbalances, and near death states. Pre-admission screening is recommended to identify at-risk people and thus help prevent acute delirium or enable its early treatment (Minden et al., 2005). Regardless, most literature has focused on the medical care of patients after they exhibit acute delirium. Medical care generally consists of pharmaceutical management, often with some drugs stopped and others started (Meagher, 2001; Meagher et al., 1996). A growing body of literature is focused on improved diagnosing of acute delirium after it is has become apparent (Kales et al., 2003).

The nursing literature that exists to help practicing nurses identify and care for patients with acute delirium is largely based on existing medical/pharmaceutical research, and knowledge gained anecdotally by nurses over time (Andersson, Hallberg, & Edberg, 2003; Arnold, 2005). According to Foreman, Wakefield, Culp, and Milisen (2001), the nursing care of patients with acute delirium is concentrated in five areas: (a) managing their environment, (b) enhancing the physiological stability of patients, (c) supporting their sensory functioning, (d) reducing the physical activity of restless patients to promote rest, and (e) administering and monitoring medications. Andersson et al. (2003) conducted one of the few studies by nurses about the nursing care of

patients with acute delirium. Their qualitative research study revealed that caring for patients with acute delirium is very challenging for nurses.

2. Methods

In 2008, research ethics and hospital administrative approvals were obtained for a Delphi study of nursing practice. This study involved select nurses working at two representative full-service acute care hospitals in Western Canada. The Delphi technique is a well known method for systematically collecting and aggregating informed judgments, views, or information on a specific question, issue, need, or topic (Ruperto et al., 2008). The Delphi technique has been used by many professional groups. It is considered particularly successful for determining clinical research priorities and best clinical practices (Keeney, Hasson & McKenna, 2006). The Delphi technique typically involves an anonymous paper survey that is distributed to experts (Baker, Lovell & Harris, 2006). It is important that these experts are not in direct contact with each other. The responses to the first distributed Delphi survey are normally consolidated, with the researchers then creating a second and at times a third survey to refine, validate, and/or rank order the findings gained through the first survey.

For this study, two sequential questionnaires were distributed to full-time, part-time, and casual Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) working on the adult inpatient units. The University of Alberta's Health Research Ethics Board that approved this study prohibited the identification of nurses who responded to the first survey. The second survey was therefore re-distributed to all nurses again, instead of only the respondents to the first survey. Approximately 2 000 nurses were the target research group, although the survey specifically asked for respondents who had provided care within the last 12 months to one or more adult hospital patients suffering from acute delirium. A clear statement to this effect was placed on both questionnaires. This study sought to identify current nursing practices recalled by nurses who had recently cared for patients with acute delirium. With acute delirium often never diagnosed, it was anticipated that only around 10-20% of nurses (20-40 individuals) would determine that they could participate in this study.

The first survey asked nurses to respond to three basic open-ended nursing practice questions (see Table 1). Additional questions sought information on their educational background, place of work, and years of experience. The second survey asked nurses to rank, in order of importance, the responses that had been gained through the first survey. Content analysis was used by the principal investigator and research assistant to group similar first-round responses. This measure reduced the number of items needing to be ranked in the second survey. The first survey tool was developed by a larger team of nursing researchers and nursing practice leaders. This team reviewed and approved the grouped responses for the second survey. These instrument development methods are common to the Delphi technique (Baker et al., 2006). The Delphi technique avoids the need to extensively develop the validity and reliability of data collection tools, as well as the necessity to pilot test tools before collecting data through them.

The findings from the second survey were analyzed through two methods. The results of these two methods were then compared to determine if there was consensus or diversity in the findings. Two methods were used instead of one to increase the reliability of the findings. More specifically, all rankings were first tabulated to determine the percentage of respondents who ranking an item as first, second, or third priority practice. This was done to determine if any specific items were commonly identified as the highest ranked practices by nurses. In the second method, all of the actual ranks given to each item were summed. The lowest total score was used to identify the highest priority nursing practice. Progressively higher scores identified the second most important nursing practice, the third most important, and so on. As indicated, the results of these two data analysis methods were then compared. The same top ranked item in each of the three areas of inquiry was revealed by the two methods. Both methods also revealed the same three additional items in each of the three areas of inquiry as additional priority practices.

3. Results

A total of 31 nurses successfully completed the first survey and 24 the second. Eight second-round surveys were discarded as the nurse responders did not rank order the items but instead indicated that all listed items were equally important. As such, only a small proportion of 2 000 potential responders contributed to this study, although this low response rate was anticipated. Participation was no doubt reduced by the request that only those nurses who had cared in the last 12 months for an adult hospital inpatient experiencing acute delirium were to respond. Participation was also likely reduced as many nurses work 12-hour rotating shifts, nursing workloads were heavy as bed occupancy was close to 100%, and each survey was only available on the units for 4-6 weeks. Regardless, one major limitation of this study is the small number of respondents – a factor that could demonstrate this study to be a pilot only. Replicating this study with additional groups or a larger group would

be beneficial.

3.1 Responses to the First Survey

Of the 31 nurses who completed and returned the first survey, 26 (84%) identified themselves as RNs, 4 (13%) as LPNs, and 1 (3%) did not report their profession. Of these, 17 (55%) practiced on surgical units, 12 (39%) on medical units, and 2 (6%) worked on both types of units. A wide range of responses to each of the three nursing practice questions were obtained. Some responses were common among respondents, however. The two most common responses to the question of how nurses detect patients with acute delirium were that the patients were either: (a) confused or (b) disoriented. For safeguarding patients, the three most common responses were: (a) use physical restraints, (b) use a Broda chair (a type of chair that restrains the patient), and (c) ask the family to stay with the patient. The two most common responses to help patients recover from acute delirium were: (a) to stop or change medications and (b) reorient the patient.

The responses to each of the three nursing practice questions were then grouped as indicated above using content analysis (Stemler, 2001). Content analysis involves a search for common meanings among the text. Content analysis revealed 9 distinct ways that nurses detect adult hospital patients who are experiencing acute delirium, 14 distinct nursing practices to keep these patients safe and free from harm, and 15 distinct nursing actions to help shorten or end the episode of acute delirium. The second survey listed these practices and asked nurses to rank them in order of importance.

3.2 Responses to the Second Survey

A clear consensus emerged as to the most important method for detecting patients who have acute delirium: "Nurse notices that the patient's cognitive (mental) status has deteriorated overnight or from the last day that the nurse saw this patient." As indicated in Table 2, this item was ranked first in importance by 9 of the 24 (37%) respondents. It was also ranked second in importance by another 7 (29%) respondents. This item also had the lowest total score (64), as compared to the next lowest collective score for another item (96). This dual analysis method revealed four additional items were important nursing practices, and the four remaining items were much lower priority or not important nursing practices. Table 2 lists the highest priority item and the four additional important nursing practices.

A clear consensus also emerged as to the most important nursing practice for safeguarding patients who are experiencing acute delirium. "Setting up an early warning system to alert nurses to activities that could result in harm to the patient" was chosen as the top priority practice by 7 of 24 (29%) respondents. It was also chosen as the second priority practice by another 4 (17%) respondents. Collectively, this item had a total rank score of 92, the lowest score obtained for the 14 items. Four additional nursing practices also scored highly, in terms of being ranked as first or second priority practice and by having a lower collective score as compared to the 9 remaining items. Table 2 lists these four nursing practices, as well as the most important or top priority practice.

One item was also clearly identified as the most important practice that nurses use to help adult hospital patients recover from acute delirium: "Ensuring that the acute delirium is assessed and addressed by other members of the healthcare team." Four additional nursing practices also scored highly, in terms of being ranked as the first or second priority practice and/or by having a lower collective score than the four remaining items. The top ranked and four additional highest ranked items are similarly listed in Table 2.

4. Discussion

Despite the limitation of focusing on nurses who worked at 2 hospitals in Western Canada, and the limitation of low numbers of returned surveys, this research investigation was helpful for revealing nursing care practices that are considered important by nurses for identifying adult hospital patients who are experiencing acute delirium, safeguarding them, and helping to stop or shorten the episode of acute delirium. Many of these practices have not been identified before, a finding in keeping with the concern that nursing care practices have often not been researched previously and as such are largely unknown or unrecognized (Rapp et al., 2001). The nurses who returned the surveys self-identified as being familiar with the nursing care of patients with acute delirium. As such, these participants are in keeping with the normal procedure of asking experts to participate in Delphi studies.

The responses to the first Delphi survey revealed that a large number of nursing practices exist for the detection and subsequent care of patients with acute delirium. This diversity suggests that nursing practices could vary considerably across individual nurses and also across patients or perhaps hospitals. Nursing care must be patient specific to be effective, and it must also be appropriate to the time and place of care. As such, the many responses to the first survey suggest nurses are necessarily adaptable or flexible in their care. These responses

also illustrate the need for research to identify all possible nursing practices. These practices need to be studied to determine what is best-practice nursing care. This type of care is the most likely to result in optimal patient outcomes.

The dual-analyzed responses to the second Delphi survey revealed considerable consensus around a few select nursing practices, with one priority practice and four additional important practices emerging in each area of inquiry. This consensus suggests nurses collectively value some nursing practices over others. These practices may also reflect behaviours that are in keeping with expected nursing professional roles and responsibilities. It is also possible that these nurses have learned through experience that some nursing practices are more successful than others.

The nurse respondents clearly indicated that their noticing a change in a patient's cognitive or mental state was the most important method for detecting patients with acute delirium. This finding is encouraging, as it suggests a simple and rapid approach to detection. This approach is advantageous as it does not rely on expensive blood tests or the use of sophisticated screening or assessment tools. However, this before-after approach is problematic as patients may be already suffering from acute delirium when admitted (Day, Higgins & Koch, 2009). Furthermore, patients do not always have continuity in nursing staff. This study revealed that this approach requires a nurse to notice that a patient has changed by becoming agitated or restless, confused, and/or disoriented. These signs of acute delirium, although common, suggest that the nurses involved in this study are not aware of hypoactive delirium. Continuing education of nurses and education of student nurses about hypoactive delirium may be needed, as other nurses may also not recognize hypoactive delirium.

Among the many listed nursing practices for safeguarding patients who suffer from acute delirium, one practice emerged as of prime importance. The highest priority nursing practice, "setting up an early warning system to alert nurses to activities that could result in harm to the patient," is a risk-management measure that has not been recognized previously in the nursing literature. This practice encapsulates a wide range of activities, such as: (a) close monitoring of the patient by nursing staff, (b) asking family, friends, others to sit with the patient, (c) leaving the patient's intercom on so the nurses could hear and react quickly to patient movement, or (d) having the bed alarm activated so they could hear the alarm and immediately react if the patient attempts to get out of bed. One of the least preferred practices (although it was identified commonly in the first survey as a care practice of many nurses) was to restrict patient movement by applying hand or body restraints, administering sedating drugs, or by putting the patient into a (restraining) Broda chair. Although it may be quicker and easier to restrain patients by physical or pharmaceutical means, nurses indicated instead through the second survey that their main preference for safeguarding patients is by anticipating their need for safety measures and acting accordingly.

Four other nursing practices were important for keeping patients safe. One of these, "alerting others to the patient's acute delirium," reveals a communication practice of nurses that may be very helpful for preventing patient injuries and other mishaps. "Adjusting the bed" and "adapting the patient's room or immediate area" were two additional practical risk-management activities of nurses that may also be very helpful for safeguarding patients. The remaining identified nursing practice for keeping patients safe, "making sure that basic needs are met," is remarkable in that these nurses articulated an undervalued nursing role. Many qualified nurses are being replaced by care aides, with this done to reduce staffing budgets and because basic care is thought to be a simple task requiring minimal knowledge and skills. Basic care activities by nurses, such as ensuring beds are dry and comfortable, or by addressing nutrition and hydration needs, are not just undertaken to ensure patient comfort. These activities reveal a holistic approach by nurses to safeguarding patients. Patients who are experiencing acute delirium are at high risk of pressure sores, malnutrition, dehydration, and other complications. This basic care nursing practice and the other four practices demonstrate that nurses have knowledge and skills that they appreciate as being valuable to patients.

The two highest priority nursing practices that were identified as helping to end or shorten the episode of acute delirium reflect are also interesting, as they both reflect the highly interdisciplinary nature of nursing. The two practices of "ensuring that the acute delirium is assessed and addressed by other members of the healthcare team" and "assisting team efforts to determine the cause of the acute delirium" reveal nursing awareness of and respect for the contributions of other healthcare professionals who also care for patients with acute delirium. These two priority practices also reveal an advocacy role. Nurses must ensure that patient care needs are addressed by other health team members.

Three other nursing practices to help reduce or eliminate acute delirium were also revealed as important. The practice of "administering and monitoring the effects of ordered medications or treatments" is understandable, as

medications and treatments are often started or adjusted over the course of an episode of acute delirium. "Providing emotional support and reassurance to the patient" appears to be a deliberate activity that nurses use to calm patients and thus assist recovery. "Developing and carrying out a nursing care plan for the patient" was also identified as important or necessary; as the entire team of nurses working on the unit need to know about and use an individualized plan to help each patient recover.

As such, this Delphi study revealed a number of nursing practices that were recognized by experienced nurses as important when caring for patients with acute delirium. It is interesting that the most common first-round responses were not among the highest ranked items in the second survey. More specifically, the most common responses to the first survey for helping patients recover "stopping narcotics, changing or administering medication" and "re-orienting," were not among the final high priority nursing practices. These differences illustrate the value of the Delphi technique for identifying practices and then asking experts to rank order these in terms of importance. The change in findings from the first to second survey also illustrate the importance of reflecting on practice. Nurses and others need to have the time and opportunity to conceptualize what is best practice among a range of options. Although the researchers cannot presume that the priority practices identified in this study are "best" practices, the identified practices may assist nurses now who are planning care for patients experiencing acute delirium. The findings of this study may also help those who are planning future acute delirium research.

5. Conclusion

This two-stage Delphi study was designed as a first step in developing a best-practice nursing care guideline to help nurses detect patients who are experiencing acute delirium, safeguard them, and assist their recovery. This study revealed nurses think the most important method for detecting acute delirium is through their noticing a change in patient cognition. This study also revealed nurses consider it most important to safeguard these patients by instituting preventative measures through setting up an early warning system. Finally, this study revealed nurses believe it is most important to help patients recover from their acute delirium by invoking the assessment and treatment skills of the entire healthcare team. Although the respondents providing information for this study were few in number, the nursing practices identified in this study provide direction for care planning and further study.

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Table 1. First Round Survey Questions

Questions	
1.	Please tell us if you are an RN or LPN or have another profession: (a) RN, (b), LPN, (c) other.
2.	Please tell us what area you work in: (a) medical unit, (b) surgical unit, (c) both.
3.	Have you cared for an adult hospital inpatient with acute delirium (i.e. sudden confusion) in the last year? (a) yes, (b) no.
4.	Please report how you can tell if an adult hospital patient has acute delirium.*
5.	What nursing care have you given to keep these patients safe and free from harm?*
6.	What nursing care did you give to stop or help shorten the period of acute delirium?*

* Indicates the key research questions.

Table 2. Second Round Survey, Top Ranked Responses

	Overall Rating Based on Rankings	Ranked First by N (#) of Nurses	Ranked Second by N (#) of Nurses	Total of Rank Scores
1. Nurses have told us they DETECT adult hospital patients who have ACUTE DELIRIUM by the following 9 ways. Please rank the following as to their importance for DETECTING acute delirium:				
Nurse notices that the patient's cognitive (mental) status has deteriorated overnight or from the last day the nurse saw this patient.	Highest Rank	9	7	64
Family reports that the patient's cognitive (mental) status has deteriorated overnight or from the last day the family saw this patient.	Top Five	5	8	96
Patient is confused. For instance: they cannot follow instructions, do not know who they are or who others are, and/or do not understand what is being told them or asked of them.	Top Five	3	1	106
Patient is disoriented. For instance: they are unaware of what they are doing, where they are, how they got there, or what time of day it is.	Top Five	2	3	107
Patient is agitated or restless. For instance: they pull at tubes, do not lie still in bed, and/or do not want to stay in one place for long.	Top Five	4	0	108
2. Nurses SAFEGUARD adult hospital patients who have ACUTE DELIRIUM by doing the following:				
Setting up an early warning system to alert nurses to activities that could result in harm to the patient. For instance: puts bed alarm on, has security guard watch patient, has family sit with and watch patient, moves patient to open area next to nurses' desk, moves patient to room closest to nurses' desk, and/or visits frequently or monitors patient often to see that they are safe.	Highest Rank	7	4	92
Making sure that basic needs are met. For instance: keeps bed or diaper dry, patient is placed in comfortable positions, and/or ensures patient is not thirsty or hungry.	Top Five	3	2	116
Adjusting the bed to reduce falls from bed or patient getting out of bed without nurse being aware of this. For instance: puts side rails up and/or puts bed into lowest position.	Top Five	1	4	125
Adapting the patient's room or immediate area to better meet their safety needs. For instance: keeps room well lit, removes objects that could cause harm from patient's reach, and/or removes objects from patient's view (i.e. puts bed clothes over tubes or moves certain objects to closet).	Top Five	1	1	131
Alerting others to the patient's acute delirium. For instance: informs doctor or charge nurse about patient's health status, and/or tells family about patient's condition.	Top Five	6	2	133
3. Nurses help adult hospital patients RECOVER from acute delirium by doing the following:				
Ensuring that the acute delirium is assessed and addressed by other members of the healthcare team. For instance: asks physician or nurse practitioner to see patient, suggests that wound care or pain management team assesses patient, or involves dietitian in nutritional care planning.	Highest Rank	12	4	59
Assisting team efforts to determine the cause of the acute delirium. For instance: gathers specimens and/or gathers health history from patient's family.	Top Five	4	7	90
Administering and monitoring the effects of medications or treatments that are ordered by physicians or others to correct the acute delirium. For instance: gives ordered vitamin or nutritional supplements, gives and assesses the effect of new drugs, and/or carries out and monitors other ordered plans for patient.	Top Five	1	4	127
Developing and carrying out a nursing care plan for the patient. For instance: sets up a common plan for all nurses who care for patient.	Top Five	4	1	129
Reassuring and providing emotional support to patient. For instance: tells patient they will be OK, tells them that this medication or treatment should make them feel better, gives patient choices, asks patient what the nurses can do to help them, tells them that they are in hospital and that they were ill when they came in so it is normal for them not to know how they got here, and/or tells them they have had major surgery and it is normal to feel ill now.	Top Five	2	2	158