Detection of Delirium by Nurses in Acute Care

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Introduction/Background
- Delirium is a type of acute brain failure commonly found in acute care that can prolong hospital stay, increase mortality and mortality, and lead to poor physical/cognitive function with increased risk for institutionalization (Makridakis, 2017).

Purpose
- To improve our understanding of how experienced nurses use clinical reasoning to detect diagnosis, and respond to delirium symptoms

Methodology
- A qualitative study using focus groups with RN oversight.
- Setting: Nurses were recruited at three different hospital: an academic teaching hospital, a quasimilitary regional referral center, and a community hospital in the Midwest.
- Sample: Nurses (N=150) with 2+ years of clinical experience and currently working on a medical, surgical, or intensive care unit.
- Procedure: Semi-structured 60-minute focus groups sessions (N=10) were conducted.
- The sessions were audio-recorded with permission. Recordings were transcribed verbatim, reviewed for accuracy, and uploaded into NVivo12 software.
- Data were inductively analyzed using book derived from dimensional analysis (Caron & Bowl, 2000), a qualitative method used to understand how concepts are “socially constructed”.
- Key concepts were identified, coded by 2 independent reviewers, and analyzed by the team.

Key Concepts
- Clinical reasoning: “to combine cognitive processes that uses formal and informal thinking strategies to gather and analyze patient information, evaluate the significance of this information, and weight alternative solutions” (Simonnek, 2003, p. 1118).
- Clinical decisions involve making a judgment about the current health status and a decision about a course of action. (Cowling & Thompson, 2003)
- Social: “pertaining to societies or groups, interactions and relationships

Limitations
- Convenience sample
- Greater representation from medical units and quasimilitary setting may have influenced findings. Academic & ICU settings were less represented in the sample.

Conclusions
- Nurses use clinical reasoning processes to detect and manage delirium symptoms
- Nurses work within social structures that impact their clinical reasoning & subsequent actions
- Navigating both the clinical and social aspects of delirium is essential to successful management of symptoms to keep patients safe

Study Implications
- Delirium is challenging with concerns about under-recognition for many years
- Interventions to improve delirium detection and management must address both the clinical and social aspects
- A larger study examining the social factors that influence staff nurse clinical reasoning regarding delirium is needed

Social & Clinical Factors Influence the Recognition and Response to Delirium Symptoms

First Order Analysis

What? Risk Factors for Delirium and Language
- Nurses describe having knowledge to recognize and manage delirium
- Altered mental status
- Unable to focus, organize or follow commands
- A “lot going on”
- “See it in their eyes”
- Sundowning that persists (doesn’t get better by morning)
- Hypervigilant to be in more secure environments
- Hypoactive (prior medication uses rule out underlying etiologies)

Why? Causes
- Delirium may be caused by many factors and challenging to diagnose and treat
- Underlying condition(s) including dementia, stroke, delirium tremens, acne renal failure and alcohol
- Caused by hospitalization including lack or disrupt sleep, physical environment, and medications

How? Processes Used by Nurses to Recognize Delirium
- Nurses recognize symptoms and prioritize care to maintain patient safety
- Spectrum of knowledge and confidence
- Subjective (e.g. objective) assessment
- Conversation with patient
- Review provider notes
- Diagnostic test
- Communication with staff
- Underlying assumptions based on being situation before admission

All risk factors for delirium using Confusion Assessment Method (CAM) concepts:
- Mental status parameters not recognized as indicators of delirium
- Nurses are in close proximity to the patient – report “worsening” process
- Nurses work within social structures and processes to keep patient’s safe (use work-arounds especially on all shifts)
- Nonpharmaceutical interventions including promoting sleep at night, keeping busy activities during the day, offering / redressing, managing symptoms to comfort, calm, and keep safe

Second Order Analysis

Implementation: What Works to Prevent and Support Successful Efficacious Strategies

Knowledge – Nursing and Medicine
- Time
- Communication
- Scope of Practice
- Use of electronic health record

Consequences – Related Perceptions

- Understanding lack of consensus
- Fear of missing clinical changes
- Risk to personal authority
- Risk for conflict with provider
- Negative provider response (specifically) time of day
- Negative patient/family outcome for the family

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