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Feature Article

Narrative-based educational nursing intervention for managing hospitalized older adults at risk for delirium: Field testing and qualitative evaluation

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ABSTRACT

Though delirium is a common complication among hospitalized older adults and the nursing care required in these situations is complex, the subject has received little attention in the literature on continuing nursing education. A study was undertaken to field test and qualitatively evaluate a narrative-based educational intervention for nurses in hospital units with a high incidence of delirium. Triangulated data collection allowed carrying out a qualitative evaluation of the intervention process and outcomes. Process evaluation showed that the intervention was facilitated by the participants' attitudes and diversity of experience, as well as by the use of real care situations, which allowed integrating theory and practice. Outcome evaluation brought to light numerous elements of empirical, ethical and esthetic knowledge expressed by the participants. Study results evidence the applicability of such interventions as part of continuing nursing education and their contribution to knowledge development.

Background

Hospitalized older adults are at risk for delirium. This syndrome is characterized by a sudden, fluctuating and temporary alteration of the person's attention, consciousness, and discourse, combined with difficulty answering direct questions, registering what is going on, and thinking clearly, rapidly, and coherently. Sleep, memory, psychomotor activity and perceptions may be disturbed as well.[1,2] Delirium affects the person's cognitive and functional abilities, length of hospital stay, and prognosis.[3–6] Moreover, persons with delirium experience a sense of incomprehension and other disturbing feelings, such as anxiety, distress, isolation, fear, and frustration.[7] When signs of delirium appear, it is essential that nurses recognize the situation and proceed rapidly to a global assessment of the patient in order to identify and eliminate physiological, pharmacological and environmental risk factors. It is incumbent on nurses, also, to diminish the impact of this syndrome on the patient's comfort, safety and physiological equilibrium.[8–11] Acknowledging what the person is experiencing, offering explanations of the situation, showing understanding, providing support, seeking the reassuring presence of family, and allowing the person to explain what they are experiencing are all interventions that can help the person get through an episode of delirium.[7]

In facing such a complex care situation, nurses must call upon different patterns of knowing: empirical, ethical, esthetic, personal, and emancipatory.[12] When nurses employ these different patterns, they engage in a process of problem solving and logical reasoning based on existing scientific knowledge, appreciate the profound significance that patients and their families attribute to their experience, find creative ways to transform this experience, and use their identity in a therapeutic manner so that their relations with patients become significant. These patterns serve, also, to question what the right and responsible thing to do is in a specific situation, to clarify the cultural beliefs and values required to render the situation fair and equitable, and take action in order to transform it.[13]

To our knowledge, no study involving nurses who attend to patient groups at risk for delirium has sought to develop these patterns of knowing. The studies found in the literature involving such nurses concern training in the use of a screening instrument for delirium[14–16] or the management of delirium with a standardized protocols.[11]

Reading articles on the different patterns of knowing described by Chinn and Kramer,[17–25] discussing stories or specific clinical

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situations, and sharing experiences have been the methods most commonly used to develop these patterns. In this regard, Chinn and Kramer[12] stated that nurses could enhance their different patterns of knowing and improve their practice by consciously and deliberately asking themselves critical questions regarding specific clinical situations. Narrative pedagogy, a phenomenological approach derived from nursing research, supports this vision of education as well. This innovative approach encourages participants to come together to learn by listening, interpreting, and questioning their experiences and by exploring other possibilities for the future.[26–28] Numerous studies, literature reviews and theoretical papers have explored or discussed narrative pedagogy.[13,28–39] These articles have underscored narrative pedagogy's capacity to develop holistic and interpretative thinking skills, create a partnership in learning, meet the needs of learners more effectively, address moral, ethical and social considerations critical to care and open learners up to multiple possibilities of care.

In this context, we set out to field test and qualitatively evaluate an educational intervention based on narrative pedagogy for nurses who take care of hospitalized older adults at risk for delirium. The aim of the evaluation was to identify intervention implementation facilitators and constraints, as well as the empirical, ethical, esthetic, personal and emancipatory knowledge expressed by participants during the educational intervention.

Framework

The framework selected for the study consisted of Diekelmann's narrative pedagogy[26] and Chinn and Kramer's patterns of knowing.[12] Narrative pedagogy grew out of two decades of hermeneutic phenomenological research aimed at gaining an in-depth understanding of the learning and teaching experiences of more than 200 nursing teachers, students and clinicians.[26] In interventions based on narrative pedagogy, teachers and students meet, stop, listen, share lived experiences, render the meaning of these experiences explicit, interpret and question these experiences, and are open to explore different possibilities for the future. Narrative pedagogy served to design the structure and process of the intervention under study (e.g., number of training days and interval between them, strategy for transmitting scientific information on delirium, instructions to participants, management of presentations and discussions) with a view to creating an enabling environment for learning.

The patterns of knowing[12] derive from the works of Carper[40] and the writings of various nursing theoreticians.[12,23,41–46] According to Chinn and Kramer,[12] these interdependent patterns of knowing are necessary to understanding a clinical situation. These authors have proposed a set of critical questions (see Table 1) for investigating clinical practice. The five patterns of knowing served also to structure the different guides and forms used for data collection and analysis.

Methods

To gain an in-depth understanding of the intervention's process and outcomes, we opted for a case study research design.[47,48] The educational intervention field tested with the nurses was the case under study.

The study was carried out on a short-stay hospital's cardiac and orthopedic surgery units – departments that tend to have a high delirium incidence.[49–52] The project was approved by the hospital's institutional review board (IRB). Nurses working on those units were recruited via a purposive sampling strategy with a view to selecting a sample of participants from different work shifts and with varying levels of education and experience. To be included in the study, nurses had to hold a regular full- or part-time position; write, understand and speak French; have experience attending to an older adult at risk for delirium; and be available for the entire duration of the intervention. Participants were recruited by the first author (LB) with the help of unit managers. Of the 23 nurses who agreed to meet the first author to receive information about the project, eight declined to take part owing to renovation work on the unit, organizational changes, and concurrent training activities. Participants signed an IRB-approved consent form.

The final sample consisted of 15 participants 23–64 years of age. More than two-thirds had less than six years' work experience and nearly half had a Bachelor's degree. The majority (78%) held full-time positions. Slightly fewer than 30% of the participants worked on the orthopedic care unit. Six participants worked the day shift, five the evening shift, and four the night shift. Three participants were male. No participant dropped out of the study.

Intervention

The intervention consisted of four days of training at three-week intervals and was offered to three separate groups of five participants. On the first day, the participants were handed a documentation package with guides for each of the activities planned over the course of the intervention (i.e., individual reflective exercises, group workshops), all the forms required to take part in these activities, and information sheets on delirium. These sheets contained brief summaries of the theoretical and empirical knowledge of the causes of delirium, people's lived experiences of the condition, recommended assessments and interventions, and how to manage related ethical problems. Bibliographical references for further reading were given on each of these sheets.

Three activities were planned on each day of the educational intervention. These are summarized in Table 2. At the start of the day, each participant completed an individual reflective exercise in which they had to describe a lived care situation involving a person with or at risk for delirium. The exercise was completed with the help of a guide comprising instructions and questions based on Chinn and Kramer's[12] patterns of knowing in nursing.

Then, the participants regrouped for a workshop during which they shared the content of their reflective exercises. During each presentation, the participants were asked to listen attentively, maintain a respectful and non-judgmental verbal and non-verbal attitude, participate actively in discussions, and allow persons wishing to express themselves the time to think, which could mean enduring silent pauses.[26] The workshop facilitator used Chinn and Kramer's[12] critical questions (Table 1) to prompt the discussion.

Table 1
Critical questions for understanding clinical situations.

Patterns of knowing	Critical questions
Empirical	What is this?
	How does it work?
Ethical	Is this right?
	Is this responsible?
Esthetic	What does this mean?
	How is this significant?
Personal	Do I know what I do?
	Do I do what I know?
Emancipatory	What are the barriers to freedom?
	What is hidden?
	What is invisible?
	Who benefits?
	What is wrong with this picture?

Adapted from Chinn and Kramer.[12(p14)]