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Intensive care nurses' experiences and perceptions of delirium and delirium care

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ABSTRACT

Objective: To explore nurses' experiences and perceptions of delirium, managing delirious patients, and screening for delirium, five years after introduction of the Confusion Assessment Method for Intensive Care into standard practice.
Research design and setting: Twelve nurses from a medical-surgical intensive care unit in a large teaching hospital attended two focus group sessions. The collected qualitative data was thematically analysed using Braun and Clarke's framework (2006).
Findings: The analysis identified seven themes: (1) Delirium as a Secondary Matter (2) Unpleasant Nature of Delirium (3) Scepticism About Delirium Assessment (4) Distrust in Delirium Management (5) Value of Communication(6) Non-pharmacological Therapy (7) Need for Reviewed Delirium Policy.
Conclusion: Nurses described perceiving delirium as a low priority matter and linked it to work culture within the intensive care specialty. Simultaneously, they expressed their readiness to challenge this culture and to promote the notion of providing high-quality delirium care. Nurses discussed their frustrations related to lack of confidence in assessing delirium, as well as lack of effective therapies in managing this group of patients. They declared their appreciation for non-pharmacological interventions in treatment of delirium, suggested improvements to current delirium approach and proposed introducing psychological support for nurses dealing with delirious patients.

Introduction

Delirium is a reversible manifestation of acute brain dysfunction, characterised by an abrupt onset and a fluctuating course of disturbed consciousness, attention, cognition and perception (American Psychiatric Association (APA), 2013). The syndrome affects up to 80% of intensive care patients and has been associated with increased mortality, higher intubation rates, extended intensive care and hospital admissions (Ely et al., 2001; Ely et al., 2004; Page et al., 2009), and anincreased risk of dementia and institutionalisation (Witlox et al., 2010; Brummel et al., 2014). It therefore presents a significant economic challenge for healthcare providers (Milbrandt et al., 2004) and can be seen as a public health threat.

It is recommended that clinicians routinely screen patients for delirium using a validated tool, such as theConfusion Assessment Method for the Intensive Care Unit (CAM-ICU), which gathers information from a structured observation and interview to formally measure the characteristics of delirium (Barr et al., 2013; Ely et al., 2001; National Institute for Health and Clinical Excellence (NICE), 2010). CAM-ICU is an adaptation ofthe Confusion Assessment Method, which was originally developed to be used by clinicians without formal psychiatric training with elderly hospitalized patients (Inouye et al., 1990). CAM-ICU is specifically designed for nonverbal patients.

Critical care nurses, who have continuous contact with patients, are in the best position to monitor fluctuationsin delirium symptoms, and ensure prompt recognition and introduction of appropriate treatment. The initial measures to address delirium include identification and correction of its organic causes such as hypoxia, pain or infection, as well as rationalisation of drug regimens to avoid poly-pharmacy. It is also a good prac-

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Implications for Clinical Practice

- This study provides an insight into the cultural viewing of delirium in ICU and into the perpetuation of nurses' concerns about CAM-ICU.
- Educational initiatives should be tailored to the specific needs of healthcare staff and they should be extended to patients' families to develop effective patient-centred care.
- Early introduction of non-pharmacological therapies should be promoted as one of the nursing priorities in the care of all ICU patients.
- ICU nurses need a forum to discuss their negative emotions associated with caring for delirious patients and should receive psychological support to optimise their ability to deliver effective patient care.

tice to implement early non-pharmacological interventions, such as patient reorientation, early mobilisation and sleep promotion, as these address other factors that may precipitate delirium. Failure to resolve the symptoms with these strategies should lead to introduction of drug therapies, i.e. neuroleptics and atypical antipsychotics into patient treatment (Borthwick et al., 2006; Fong et al., 2009).

However, the syndrome remains under-recognised (Cadogan et al., 2009; Forsgren and Eriksson, 2010; Mac Sweeney et al., 2010). A routine compliance audit in the author's local ICU indicated that a third of delirium assessments were not attempted (Zamoscik et al., 2014). These reduced efforts in detecting delirium were identified despite delirium screening being integrated into core ICU nurse training, mandatory critical care competencies and nursing documentation, and despite the local policy on delirium management and provision of informal bedside teaching to staff.

BACKGROUND

ICU nurses report having a good understanding of the seriousness of delirium, but simultaneously assign low priority to screening for and dealing with the syndrome (Devlin et al., 2008; Price, 2004; Scott et al., 2013). Some nurses feel uncomfortable when delirium is diagnosed, and when faced with patients' distrusting, irritable and sometimes violent behaviours (Jung et al., 2013). They experience emotional and physical exhaustion due to high levels of stress, heavy workload and occasional injuries related to caring for delirious patients (Yue et al., 2015). While nurses evaluate pharmacological treatment as delaying patients' progress, administering drugs to delirious patients is frequently practised to ensure patient safety, and sometimes to avoid dealing with the patients' psychological needs (Jung et al., 2013; Price, 2004).

Nurses surveyed about using CAM-ICU generally consider it to be useful, accurate and enriching patient neurological assessment (Eastwood et al., 2012; Pun et al., 2005; Riekerk et al., 2009; Scott et al., 2013). However, the available qualitative studies of CAM-ICU perceptions report nurses' unjustified concerns about the instrument: regarding its Richmond Agitation Sedation Score (RASS) component as subjective, believing that the test's repetitiveness can lead to false positive results, and preference to trust subjective judgement over the outcome of CAM-ICU assessment (Jung et al., 2013; Oxenboll-Collet et al., 2016). Other perceived obstacles to delirium assessment include lack of time, physician indifference, complexity of ICU patients, and concern that the test might challenge patients' dignity (Devlin et al., 2008; Oxenboll-Collet et al., 2016; Pun et al., 2005; Scott et al., 2013; Soja et al., 2008).

Nurses' experiences and perceptions of ICU delirium, managing delirious patients and screening for delirium have only been examined shortly after introducing delirium screening with CAM-ICU into practice, while no such research has been conducted in settings where CAM-ICU assessment has been part of standard practice for several years. It has been observed that for up to a year following implementation of CAM-ICU, nurse compliance can exceed 84% (Pun et al., 2005; Riekerk et al., 2009; Page et al., 2009) and that the reliability and sustainability of delirium assessments performed by bedside nurses can be maintained over a period of threeyears of data collection (Vasilevskis et al., 2011). However, the high level of nurse compliance with CAM-ICU in the implementation studies could be influenced by recent educational interventions, whereas the reported sustainability of delirium assessment in routine practice could be biased due to a Hawthorne effect.

The present study took place in a setting where CAM-ICU assessment has been part of standard practice for five years. Staff did not receive additional teaching sessions and were unaware that their performance was audited.

This study i aims were to answerthe following research questions:

RQ1 How do ICU nurses perceive delirium?

RQ2 How do ICU nurses perceive delirium assessment?

RQ3 How do ICU nurses evaluate current care provision for delirious patients?

RQ4 What are the challenges and possible barriers to assessing ICU delirium?

Methods

This study sought to gain an understanding of a phenomenon from the perspective of the individuals experiencing it, a qualitative approach was utilised (Burns and Grove, 2011; Neergaart et al., 2009). The participants' experiences and perceptions were elicited in focus group discussions which, apart from being more time-efficient and cost-effective than a series of one-to-one interviews, have the potential to generate new ideas through verbal interaction driven by group dynamics (Krueger and Casey, 2009; Rabiee, 2004). Thematic analysis (Braun and Clarke, 2006) was decided to be the most suitable for this study, as its goal was to provide a purely qualitative and rich account of all data. The flexibility, theoretical freedom, and descriptive (as opposed to interpretative) character of this method make it preferable to such alternative approaches as Phenomenological Analysis or Grounded Theory (Kyriacou et al., 2009).

Setting and sample

A purposive sample of twelve nurses was recruited from a 20-bed adult medical-surgical ICU at a large teaching hospital in the United Kingdom (UK). The inclusion criteria of being a member of permanent nursing staff for at least six months and not holding a managerial position were to ensure breadth and depth of opinions, as well as comfort during discussions. Letters inviting staff to contact the researcher if they wished to participate in the study were placed in the unit's communication book, displayed as a poster, and emailed to all nurses by the ICU manager. All participants were female, aged between twenty-five and forty-three, with experience in nursing ranging from two to thirteen years, and ICU experience

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