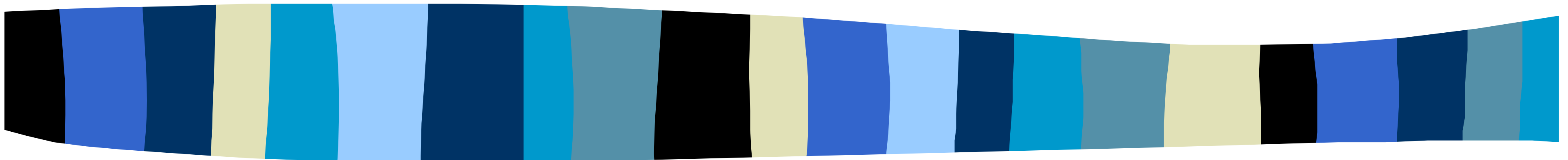
A Two-Phase Delphi Survey of Nursing Care of Adult Hospital Patients Experiencing Acute Delirium



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Introduction

- Nurses commonly care for patients who are experiencing acute delirium.
- Acute delirium is not a new concern. Much has been said and written about it.
- A literature search revealed 10-15% of all hospital patients experience acute delirium, with the rate of acute delirium much higher for older patients (40-50% in select populations) than younger ones.

Background to Research Study

- Many studies have sought to: (a) identify contributing factors, (b) improve its diagnosis, and (c) improve medical and pharmacological management of AD.
- Only one nursing study was found, it revealed that the care of AD patients is very challenging for nurses (Andersson et al., 2003).
- Yet - Nurses commonly detect patients with AD, and they plan and provide ongoing care to protect these patients and help them recover.

Aim of Research Investigation

- This study sought to learn from nurses how they:
  (a) detect adult hospital patients who are experiencing acute delirium,
  (b) how they safeguard them, and
  (c) how they assist their recovery.
- This study was undertaken to contribute to best-practice nursing care by providing evidence about current nursing practices.

- A 2-stage Delphi study was planned, as the Delphi technique is helpful for gathering expert opinions, knowledge, or viewpoints on a defined topic, and then refining those findings through rank-ordering or other consensus building methods.
- The participants are at a distance from each other, to prevent their influencing each other. Mail (postal) surveys are common.
- Each survey builds on the past one.

Method - Implementation

- After research ethics and administrative approvals, this study was conducted in 2 full-service hospitals in Western Canada in 2008.
- Participation was limited to nurses working on medical/surgical units, and to those who believed that they had cared for an AD patient in the past 12 months.
- Surveys, at 6-week intervals and with much advance notice, were left on the wards for easy access and anonymous completion.

In addition to a few basic introductory questions, participants were asked to respond to three questions:

1. Please report how you can tell if an adult hospital patient has acute delirium.
2. What nursing care have you given to keep these patients safe and free from harm?
3. What nursing care did you give to stop or help shorten the period of acute delirium?

- Many different responses to the 3 questions were provided, although a few were more common:

1. Detecting AD patients by noticing that they were (a) confused or (b) disoriented:
2. Safeguarding AD patients by (a) using physical restraints, (b) using a Broda chair, and (c) having family stay with patient
3. Reducing AD by (a) stopping or changing medications and (b) reorienting the patient.

- The first-round responses to the three questions were grouped, using content analysis, to reduce the number of items for rank ordering in terms of importance in the second survey.

  1. Detecting patients with AD

     had 9 items to rank.

  2. Safeguarding patients

     had 14 items to rank.

  3. Reducing AD

     had 15 items to rank.

- Two methods were used to identify the most important, second, third, etc. ranked items:

1. All rankings by participants were reviewed to see if some items were more commonly ranked as #1, #2, and #3 priority choices.
2. All rank scores for each item were totaled, with the lowest score identifying the top ranked item, the next lowest score the 2nd ranked item, etc.

* These two methods yielded the same findings.

1st Round – Detection Findings

- A clear consensus emerged on the top ranked item: Nurse notices that the patient's cognitive (mental) status has deteriorated overnight or from the last day that the nurse saw this patient.
- 4 of the other 8 items were also ranked highly:

1. Family reports that the patient's mental status has deteriorated overnight or from the last time that the family saw this patient.
2. Patient is confused. For instance: they cannot follow instructions, do not know who they are or who others are, or do not understand what is being told them or asked of them.
3. Patient is disoriented. For instance: they are unaware of what they are doing, where they are, or how they got there.
4. Patient is agitated or restless. For instance: they pull at tubes, do not lay still in bed, or do not want to stay in one place for long.

2nd Round – Safeguarding Findings

- A clear consensus emerged on the top ranked item: Setting up an early warning system to alert nurses to activities that could result in harm to the patient.
- 4 of the other 8 items were also ranked highly:

1. Making sure that basic needs are met. For instance: keeping bed or diaper dry, patient is placed in comfortable positions, or ensures patient is not thirsty or hungry.
2. Adjusting the bed to reduce falls from bed or patient getting out of bed without nurse being aware of this.
3. Adapting the patient's room or immediate area to better meet their safety needs.
4. Alerting others to the patient's acute delirium.

2nd Round – Recovery Findings

- A clear consensus emerged on the top ranked item: <u>Ensuring that the acute delirium is assessed and addressed by other members of the healthcare team</u>.
- 4 of the other 9 items were also ranked highly:

  1. Assisting team efforts to determine the cause of the acute delirium.

  2. Administering and monitoring the effects of medications or treatments that are ordered by physicians or others to correct the acute delirium.

  3. Developing and carrying out a nursing care plan for the patient.

  4. Reassuring and providing emotional support to patient.

- Clear consensus emerged as to the top ranked nursing practice in each area, with 4 additional practices in each area also important. The top ranked items are particularly revealing of nursing practice:
- Noticing a change in the patient is a simple way to detect AD, but it relies on nurse/patient continuity.
- Setting up an early warning system to safeguard patients shows that chemical and physical restraints are not considered priority practices.
- Ensuring that other healthcare professionals assess and address the patient demonstrates an appreciation of the team and a patient advocacy role.

- This study identified a wide range of nursing practices and also for determining what nurses consider are the most important among these practices for identifying adult hospital patients who are experiencing acute delirium, safeguarding them, and helping to stop or shorten the episode of acute delirium.
- Research is now needed to determine if these are “best practices” in that they have the most efficacy for adult patients experiencing acute delirium.

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