Introduction

Delirium is a well-recognized and severe problem in Adult Intensive Care Units (A-ICU). It is present in as many as 80 to 90% of mechanically ventilated patients, globally (Sturm et al., 2013). Delirium has been defined as an acute change in consciousness accompanied by restlessness and either a change in cognition of perceptual disturbances (Van Rongen et al., 2008).

Clinically, there are three sub-types of delirium, the hyper-active delirium where patients present with agitation, visual hallucinations or have out of characteristic behavior; hypo-active delirium, patients present with hypo-activity or lethargy, which often go unnoticed because the patient appears not to pose difficulties in their clinical management. The first type, mixed delirium, manifests is a combination of hyperactivity and hypo-activity. In all three forms patients' symptoms will fluctuate between calm and disturbed periods over the course of the day (Brummel et al., 2013; Pandharipande & Ely, 2008). The primary risk factor for delirium is pre-existing cognitive impairment, and other risk factors include advanced age, the prevalence of acute systemic illness or medical diseases with high mortality and use of certain medications such as benzodiazepines (Ouimet et al., 2007).

Due to the high incidence of delirium in A-ICU, International best practice guidelines recommend nurses perform assessments and treatment of delirium (Royer et al., 2013).

Methods

A survey questionnaire and a cross-sectional design was utilised to achieve the objectives of the study. The study respondents were ICU nurses affiliated to six A-ICUs, using a self-administered questionnaire. The study was conducted from April to July 2016. The protocol for this study was approved by the Research Ethics Committee of the University of the Witwatersrand (M16089130).

The survey tool was developed from literature by its authors (Devlin et al., 2008), it comprises two sections.

A-ICU sedation and delirium practices and their perceptions towards delirium assessment.

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Current Practices in Assessing Sedation and Delirium

Although only nurses from ICUs with sedation protocols were surveyed, 80.9% of nurses stated their unit's sedation protocol either does not specify that delirium should be assessed or they are not sure if the protocol does specify such assessment. Subsequently, nurses routinely assessed level of sedation (either sedation protocol either does not specify that delirium should be assessed or they are not sure if the protocol does specify such assessment) more frequently than they assessed for the presence of delirium (87.6% vs. 59.0%; p<0.05). For the nurses who do not know if their ICU sedation protocol does specify such assessment. Substantially, more nurses routinely assessed level of sedation either sedation protocol either does not specify that delirium should be assessed or they are not sure if the protocol does specify such assessment (80.9%) than assess for the presence of delirium (59.0%); p<0.05).

Assessment (Royer et al., 2013) and assessment of altered level of consciousness (Van Rompaey et al., 2008).

Barriers to Assessment of Delirium in ICU patients

In this study, the most commonly reported barriers to assessment of delirium by nurses in the ICU was "lack of confidence to use delirium assessment tools" (46.6%) and "presence of agitation" (21.1%), while nurses reported higher than "improper placement of invasive device" (8.6%) and "presence of pain" (2.9%).

Results

Of 125 nurses who were invited, 105 (84.0%) responded. Most of the respondents had an advanced diploma in ICU nursing and worked in a General A-ICU. Most of the nurses were aged between 30 to 39 years and had from 1 to 5 years of work experience.

Delirium is an undiagnosed problem

Delirium is a problem that requires active intervention on...

Patients with delirium usually have symptoms that are...

A-ICU sedation and delirium practices and their perceptions towards delirium assessment.

Table 1: Current sedation and delirium assessment practices

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<th>Delirium assessment per 12 hr shift</th>
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Frequency of Use of Possible Methods of Assessing Patients with Delirium

Of the six possible methods for assessing the presence of delirium that were presented in the survey, assessment of the "ability to follow commands" was assessed most frequently (at least once per shift, 44.7%), assessment of "agitated related events" (33.0%), use of CAM-ICU (18.1%) and ICDS (6.7%) and last, the CAM-ICU and psychiatric consultations (1.9%), respectively.

Nurses perceptions of Assessment of Delirium

Nurses perceptions of delirium and its assessment are presented in Figure 1. Nurses' perceptions were that delirium is associated with higher patient mortality (45.7%), patients with delirium usually have symptoms that are (44.7%) and delirium is a problem that requires active intervention on the part of caregivers (43.6%). It is noted that nurses also have some misconceptions about delirium.

Conclusions

This study represents the first findings of nurses' practices and perceptions on delirium assessment in South Africa. The results of the study showed that although nurses are educated in the specialty area of critical care practice they lack knowledge of the principles of best practice guidelines when it comes to delirium assessment and prevention. In light of these findings delirium assessment remains a challenge for nurses working in these South African ICUs hence it can be concluded that the current nurses' practice in this study do not help but actually see a hindrance for delirium assessments in the ICUs.

References