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SHORT RESEARCH ARTICLE

Intensive Care Nurses' Views and Practices Regarding Delirium: A Descriptive Qualitative Study

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ABSTRACT

The aim of this descriptive qualitative design study is to clarify the views and practices of nurses working in intensive care about delirium. The study was conducted with 20 nurses. Thematic analysis revealed four themes: (1) perceptions about delirium, (2) care of the individual with delirium, (3) the effects of caring for the individual with delirium and (4) coping and not coping with delirium-related challenges. Regular training and the mandatory use of standardised screening tools are critical to increasing nurses' knowledge and confidence levels regarding the recognition, prevention and management of delirium. Healthcare administrators should support nurses by developing a clear delirium assessment and care protocol in intensive care units, thereby contributing to more consistent and higher-quality patient care.

1 | Introduction

Delirium is a common complication of surgical interventions, particularly in intensive care units following cardiac surgery [1]. The incidence of delirium in patients undergoing cardiac surgery has been reported to range between 3% and 70% [1]. Delirium is known to be associated with prolonged mechanical ventilation, intensive care stays and hospitalisation [2–4]. In addition, a meta-analysis confirmed the association between delirium and mortality and underscored the urgent need for effective delirium treatment [5].

Patients with delirium require increased nursing care, and the presence of patients with delirium can lead to high healthcare costs [2]. The literature reports that delirium is often underdiagnosed and overlooked [6]. The knowledge, perceptions and emotions of nurses, who are considered the primary care providers in delirium management, are known to influence delirium care and diagnosis [7]. Current international studies emphasise that non-pharmacological, multi-component, nurse-led interventions have strong evidence supporting their effectiveness in preventing delirium. However, they have revealed that addressing barriers is necessary for their full integration into routine clinical practice [8].

There are many studies in the literature on nurses' delirium management [7–14]. Despite extensive quantitative evidence regarding delirium outcomes, there are only a limited number of qualitative studies examining intensive care nurses' lived experiences of delirium and their daily clinical decision-making processes. This qualitative study was conducted to clarify the views and practices of nurses working in intensive care about delirium.

2 | Methods

This study is a descriptive qualitative study. This study was conducted in the cardiovascular intensive care unit of a university hospital in western Türkiye between November 2022 and May

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Impact Statements

- What is already known about this topic?
  - Delirium is a serious clinical condition frequently seen in patients admitted to intensive care units, increasing mortality and morbidity.
  - Intensive care nurses, as healthcare professionals who spend the longest time with patients, have a key role in the early recognition and management of delirium.
  - The literature indicates that nurses' knowledge and application skills regarding delirium are often insufficient, and delirium is frequently overlooked.
- What this paper adds
  - Training and the mandatory use of standardized screening tools should be implemented to improve delirium management.
  - The need to establish psychosocial support systems for nurses has come to the forefront.
  - These findings will guide the development of delirium protocols in intensive care units, contributing to more consistent and high-quality patient care, and thus improving patient safety.

2023. At the time of the study, there was no standardised protocol or diagnostic tool for delirium assessment in the unit. Data saturation was reached at the end of interviews with 20 nurses. Nurses were selected using purposive sampling. The inclusion criteria required nurses to have at least 6 months of experience in a cardiovascular intensive care unit and experience caring for individuals with delirium. Nurses were approached in their units, and face-to-face interviews were conducted based on their availability. Data were collected through face-to-face, individual in-depth interviews using an introductory information form and a semi-structured interview guide, with all sessions audio-recorded to explore nurses' experiences in detail. Individual in-depth interviews were conducted, with a mean duration of approximately 17 min. Data were analysed following Braun and Clarke's six-step inductive reflexive thematic analysis approach [15]. This inductive process allowed for a deep exploration of meanings, with three authors independently coding the transcripts to ensure analytical rigour and reflexivity. Interview data were analysed independently by three authors. Transcripts were read repeatedly, notes were taken, initial codes were generated, grouped into meaningful clusters and potential themes were developed. Following individual analyses, the researchers met to discuss and refine the emerging themes and subthemes. Trustworthiness was enhanced through the use of illustrative quotations and team discussions. To ensure reliability, the second and third researchers critically reviewed all stages of the study and provided feedback to the first researcher (expert review). After data analysis, the extracted meanings and interpretations were shared with the nurses for accuracy checking (member checking). All researchers are women, have taken qualitative research courses and have conducted qualitative studies. The first researcher has 5 years of experience working in the intensive care unit where the interviews were conducted and has experience working with some members of the team. The first researcher works as a nurse in a unit, the second researcher is a professor at a university, and the third researcher is an associate professor at a university.

Permissions were obtained from Dokuz Eylul University Non-Interventional Research Ethics Committee (decision number 2023/05-37 on 22.02.2023) and the relevant institution. Ethical approval was obtained before the study, and all participants gave informed consent. Confidentiality and data protection were ensured by removing identifying information from the interview transcripts and limiting access to the data to the research team.

3 | Results

Descriptive information of the nurses is given in Table 1. As a result of the analysis, four themes were identified.

3.1 | Theme 1. Perceptions About Delirium

Regarding the theme of positive perceptions, some nurses noted that individuals with delirium do not consciously engage in challenging or non-compliant behaviours. However, the majority of staff perceived caring for these patients as a negative and demanding experience, describing the process as arduous, exhausting and burdensome:

> I think taking care of a patient with delirium is a very difficult and difficult situation to deal with, unfortunately.
>
> (N20)

3.2 | Theme 2. Care of the Individual With Delirium

Most nurses stated that they made observations and asked questions to diagnose delirium and that they primarily noticed the symptoms of hyperactive delirium. Two nurses reported that they recognised delirium when individuals became stagnant and apathetic, which are symptoms of hypoactive delirium. Nurses tended to focus on interventions after delirium had developed rather than adopting preventive approaches. Four nurses reported that they believed delirium could not be prevented in general:

> I don't think we can prevent it with nursing practices. I mean we can alleviate the situation.
>
> (N12)

Some nurses reported controlling environmental stimuli, such as light and noise at night, informing patients about procedures and providing frequent orientation reminders. A few nurses also described involving relatives, ensuring privacy and minimising medication as additional preventive approaches:

> What we do for prevention, if the environment is suitable, is to bring in one of their relatives.
>
> (N6)

TABLE 1 | Descriptive information of the nurses.

Nurse no	Age	Gender	Marital status	Educational status	Working time in intensive care unit (years)	Status of receiving education on delirium
N1	35	Female	Married	Bachelor	10	Yes
N2	31	Female	Single	Bachelor	5	No
N3	24	Male	Single	Bachelor	5	No
N4	28	Male	Married	Bachelor	5	No
N5	29	Male	Married	Bachelor	5	No
N6	29	Male	Single	Bachelor	9	Yes
N7	26	Female	Married	Bachelor	4	No
N8	32	Female	Married	Bachelor	5	No
N9	36	Female	Married	Bachelor	12	No
N10	28	Male	Married	Bachelor	3	No
N11	27	Male	Single	Bachelor	1	No
N12	25	Female	Single	Bachelor	4	No
N13	29	Female	Married	Bachelor	7	Yes
N14	28	Female	Single	Bachelor	5	Yes
N15	23	Female	Single	High school	4	No
N16	23	Female	Single	Bachelor	1	No
N17	27	Female	Married	Bachelor	2	No
N18	25	Female	Married	High school	4	No
N19	42	Female	Married	High school	17	No
N20	26	Female	Single	Bachelor	3	No

Nurses reported that interventions were primarily initiated following the onset of delirium, utilising both pharmacological and non-pharmacological approaches. Pharmacological strategies were implemented based on physician orders or consultations with psychiatry and neurology departments; these included pain management, fluid and electrolyte stabilisation, chemical restraint (e.g., sedation and antipsychotics) and the regulation of psychotropic medications, particularly in cases involving substance dependence:

> They can be tranquilized. Psychiatrists can be consulted. Medications are started as recommended by them. Or if there are medications he uses himself, their continuity is ensured.
>
> (N19)

3.3 | Theme 3. The Effects of Caring for the Individual With Delirium

Most nurses experienced low motivation, burnout and disengagement from the profession while caring for individuals with delirium. They stated that the presence of a patient with delirium affected the entire team and increased workload in the intensive care unit:

> I mean, sometimes we give care with two people and sometimes with four. This increases workload, but the main difficulty is communication rather than physical fatigue.
>
> (N6)

Nurses reported that caring for patients with delirium was both mentally and physically exhausting. Some nurses expressed happiness when delirium improved, while a few reported surprise. When caring for individuals with hyperactive delirium, most nurses reported feelings of anger and fewer reported fear or anxiety:

> I do not shout at them, but I am really scared when I see that they might physically harm us.
>
> (N16)

3.4 | Theme 4. Coping and Not Coping With Delirium-Related Challenges

Most nurses reported difficulty caring for individuals with delirium. Some described avoidant coping behaviours, such as distancing themselves from patients, avoiding care or waiting for the episode to end. Nurses also noted that individuals with hyperactive delirium were frequently subjected to physical restraint, with some nurses reporting a tendency to resort to restraint quickly:

> The level of endurance of long-term workers in intensive care is very low. So understanding does not last long. Sometimes we act in ways that further agitate the patient and put us in conflict with them.
>
> (N9)

Despite these challenges, many nurses reported coping by seeking support from team members

> So first of all, of course, we try to support each other. We try to reduce that stress burden. In such situations, we at least take the patient away from the environment for a while...
>
> (N13)

4 | Discussion

Similar to the literature, this study also found that nurses mostly find caring for individuals with delirium difficult and stressful [16], and despite showing empathy during this process, they predominantly have negative perceptions [17]. Although some nurses view this situation as a positive challenge [13], the overall results emphasise the need for education and resources. In clinical practice, delirium is routinely observed, but the use of standard screening tools is low [18, 19]. Hyperactive delirium is more readily noticeable, while hypoactive cases may be overlooked [7]. At the organisational level, leaving delirium management solely to nurses can mask systemic deficiencies. Establishing delirium protocols at the institutional level and integrating screening tools into routine workflows can reduce variability in care quality. In this context, failure to integrate tools such as the Confusion Assessment Method for the ICU or the Intensive Care Delirium Screening Checklist into standard care protocols may lead to undiagnosed cases of hypoactive delirium. The care process can lead to serious psychological burdens such as anxiety, anger and burnout in nurses [20, 21]. The anxiety and burnout experienced by nurses is not only a professional loss, but also a risk factor that threatens patient safety (falls, medication errors, etc.). In a clinical environment where nurse well-being is not supported, safe patient care is not sustainable. Faced with increasing workloads, nurses may seek social support or resort to avoidance coping strategies such as distancing themselves from patients, physical restraint and scolding [21, 22]. Consequently, improving working conditions and enhancing interprofessional collaboration are essential to prevent nursing workforce losses.

5 | Limitations

This study has some limitations. It was conducted with a small sample and in a single centre. In addition, the findings are based on self-reported data, which may include bias.

6 | Conclusions

The results of this study show the need for structured delirium training and standardised assessment practices to support institutional policies and training programmes. Including regular in-service training and validated screening tools in intensive care protocols can help nurses recognise delirium earlier and provide more consistent and preventive care. Future research could target interventions aimed at reducing the emotional burden on nurses caring for delirium patients.

Author Contributions

Conceptualization: Şerife Sargin Aptioğlu, Neslihan Günüşen, Sevecen Çelik Ince. Data curation: Sevecen Çelik Ince, Şerife Sargin Aptioğlu. Formal analysis: Neslihan Günüşen, Sevecen Çelik Ince, Şerife Sargin Aptioğlu. Methodology: Neslihan Günüşen, Sevecen Çelik Ince. Project administration: Neslihan Günüşen. Visualisation: Şerife Sargin Aptioğlu, Sevecen Çelik Ince. Writing – original draft: Şerife Sargin Aptioğlu, Sevecen Çelik Ince. Writing – review and editing: Neslihan Günüşen, Sevecen Çelik Ince.

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Ethics Statement

Ethical approval to conduct the study was obtained from the Dokuz Eylul University Non-Interventional Research Ethics Committee (decision number 2023/05-37 on 22.02.2023).

Consent

Written informed consent was obtained from all participating nurses. This information is being kept confidential for future reference.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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