

Delirium: Why Are Nurses Confused?

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Delirium is a serious, costly, potentially preventable complication for hospitalized patients age 65 and older (Wofford & Vacchiano, 2011). This acute, short-term disturbance of consciousness may last from a few hours to as long as a few months. It is characterized by an acute onset of inattention, disorganized thinking, and/or altered level of consciousness.

Delirium can be categorized as hyperactive, hypoactive, or mixed based on symptoms that can fluctuate and change during the course of the disorder. *Hyperactive* or excited delirium involves agitation and hallucinations (American Psychiatric Association, 2011; Holly, Cantwell, & Jadotte, 2012). Patients with hyperactive delirium are more likely to receive earlier treatment than patients who exhibit the less easily recognized signs of *hypoactive* delirium: lethargy, drowsiness, and inattention. In addition, patients may show signs of both hyperactive and hypoactive delirium in a condition described as *mixed variant delirium* (Holly et al., 2012). Health care providers often confuse delirium with depression and/or dementia (Fick, Hodo, & Lawrence, 2007; Holly et al., 2012; Voyer, Richard, Doucet, Danjou, & Carmichael, 2008). Unlike delirium, which happens suddenly over a few hours or days, dementia usually develops gradually over months or years, while depression generally develops over weeks or months, or, less often, after a sudden event (Holly et al., 2012; Young & Inouye, 2007) (see Table 1).

Delirium is a common multifactorial disorder that involves a vulnerable patient with predisposing

Nurses have a key role in detection of delirium, yet this condition remains under recognized and poorly managed. The aim of this study was to explore nurses' knowledge of delirium-related information as well as their perception of their level of knowledge.

factors and exposure to precipitating factors (Sendelbach & Guthrie, 2009). It can occur at various ages. However, older adults are particularly vulnerable to delirium, especially when they are ill (Featherstone & Hopton, 2010) (see Table 2). Underlying risk factors are often contributory to delirium in older adults. Common triggers are infection, medications, general pain, constipation, dehydration, and environmental factors (Dahlke & Phinney, 2008; Quinlan et al., 2011). Although delirium occurs commonly in acute care settings, older adult residents of long-term care and assisted living homes are vulnerable as well. Rates of delirium in long-term care settings range from 1% to 60% (Lee, Ha, Lee, Kang, & Koo, 2011; Siddiqi, Young, & Cheater, 2008). Delirium is associated with poor patient outcomes that include longer hospital stays, increased costs, increased need for

post-acute care, and significant stress for patients and families (O'Mahony, Murthy, Akunne, & Young, 2011). At least 20% of the 12.5 million patients age 65 or older hospitalized each year have delirium as a complication, causing a \$9,000 to \$15,000 increase depending on the severity in hospital costs per patient. Delirium attributes to annual estimated cost of \$38 – \$152 billion (Kalish, Gillham, & Unwin, 2014; Young & Inouye, 2007).

The prevalence of delirium varies from 1% to 80% depending on population, the time of delirium assessment, and the assessment method. In addition, the documented incidence of delirium extended from 3% to 61% (Kalish et al., 2014; Young & Inouye, 2007). Additionally, the prevalence of this condition reported in medical and surgical intensive care unit cohort studies varied from 20% to 80% (Girard, Panharipande, & Ely, 2008; Kalish

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TABLE 1.
Comparison of Delirium, Dementia, and Depression

	Delirium	Dementia	Depression
Onset	Sudden: Hours or days	Gradual over months or years	Gradual over weeks or months, or after an event
Alertness/Attention	Fluctuates: Sleepy or agitated, unable to concentrate	Generally stable	Generally stable, some difficulty concentrating
Sleep	Sudden changes in sleeping pattern, unusual confusion at night	Can be disturbed, with habitual night-time wandering	Early morning waking
Thinking	Disorganized, rambling	Specific, difficulty with short-term memory	Preoccupied with negative thoughts, hopelessness, helplessness, self-depreciation
Perception	Delusions, hallucinations common	Generally normal	Generally normal

Source: Holly et al., 2012

TABLE 2.
Predisposing and Precipitating Factors for Delirium

Predisposing Factors	Precipitating Factors
Age ≥ 65	Use of sedative hypnotics, opioids, or anticholinergic drugs
Male sex	Stroke
Co-existing dementia/cognitive impairment	Infections
History of delirium	Hypoxia
Depression	Shock
Functional dependence	Fever or hypothermia
Immobility	Anemia
Low level of activity	Poor nutritional status
History of falls	Recent surgery (major/minor)
Visual impairment	Admission to an intensive care unit
Hearing impairment	Use of physical restraints
Dehydration	Use of indwelling urinary catheter
Malnutrition	Multiple procedures
Polypharmacy	Pain
Alcohol/drug abuse	Emotional stress
	Prolonged sleep deprivation

Source: Sendelbach & Guthrie, 2009

et al., 2014). Delirium is common among elders in long-term care (LTC) facilities, with its prevalence ranging from 9.6% to 89% (Voyer et al., 2008).

Although common, delirium often is under-recognized and under-diagnosed (O'Mahony et al., 2011). Because of the high incidence and costs associated with delirium, prevention should be a high priority for health care professionals, especially nurses (Harris, Chodosh, Vassar, Vickrey, & Shapiro, 2009).

Nurses spend more time with patients, allowing them to observe any changes in patients' attention, level of consciousness, and cognitive function (Brixey & Mahon, 2010). As a result, frequent assessments by nurses are crucial for early detection of delirium (Girard et al., 2008).

Literature Review

A comprehensive review of the literature was conducted of all original research published 2001-2014

using MEDLINE, CINAHL, and ProQuest Psychology Journals. Search terms included *delirium* or *acute confusion* and *nurses, nurses' recognition, nurses' identification, or nurses' knowledge*. Exclusion criteria were studies not reporting primary data and studies that did not include measurement of nurse recognition or knowledge of delirium. Although now dated, the selected research specifically evaluated nurses' knowledge deficit for delirium in studies of various designs. In addition, fewer studies actually assessed the levels of knowledge about delirium factors, such as definition, available and appropriate assessment scales/tools, and risks (Hare, Dianne, Sunita, Ian, & Gaye, 2008).

Many studies of delirium focused on the advantages of educated intervention, such as prevention practices, increased early detection, and proper medical management (Bergmann, Murphy, Kiely, Jones, & Marcantonio, 2005; Featherstone & Hopton, 2010; Rapp, Menten, & Titler, 2001). Researchers also found a positive correlation between use of an educational intervention for nursing and medical professionals and positive patient outcomes such as decreased length of hospital stay (Meako, Thompson, & Cochrane, 2011; Tabet et al., 2005). Fick and co-authors (2007) found using case vignettes could evaluate nurses'

knowledge of delirium in patients with dementia.

Hare and colleagues (2008) targeted 1,097 clinical nurses in a hospital setting with a questionnaire to assess their knowledge of delirium and its associated risk factors. Of the 338 (30.8%) returned responses, 64% ($n=217$) scored 50% or better on the questionnaire. In addition, 36.3% ($n=123$) scored 50% or better for the risk factor questions while 81.9% ($n=227$) scored 50% or better for the knowledge questions. Findings indicated orthopedic nurses who had participated in a delirium education forum prior to the research scored better on the general facts portion of the questionnaire when compared to nurses having no pre-survey educational intervention. However, the orthopedic nurses did not score higher compared to other surveyed nurses on the risk factor questions. The researchers thus found nurses were not as knowledgeable about delirium risk factors as they were about general facts concerning delirium.

Fick and co-authors (2007) also assessed nurses' knowledge of delirium but more narrowly focused on delirium superimposed on dementia (DSD), with the goal of determining if nurses were able to recognize these conditions using case vignettes. The case vignettes were designed to evaluate knowledge of delirium, its risk factors, and management. The study also assessed nurses' geropsychiatric knowledge using the Mary Starke Harper Aging Knowledge Exam (MSHAKE), a tool that measures general geropsychiatric knowledge. Of 29 participating nurses, 41% ($n=12$) were able to identify dementia correctly in the dementia vignette but had difficulty differentiating delirium factors from DSD factors and specifically identifying hypoactive delirium. While this study had a small sample size, its findings suggested nurses are more likely to distinguish dementia and hyperactive delirium than DSD and hypoactive delirium alone.

Dahlke and Phinney (2008) evaluated how nurses assess, prevent, and treat delirium in older hospitalized patients, and identified deliri-

um-related challenges and barriers faced by nurses when caring for patients with delirium. This descriptive qualitative study comprised interviews with nurses who worked in a hospital. A convenience sampling included 12 registered nurses in a mid-sized regional hospital in western Canada who had managerial, educational, and bedside roles and worked in various areas such as medical and surgical units. The nurses in the study had 6–43 years of nursing experience. Level of professional education included diploma ($n=7$), baccalaureate ($n=4$), and master's degree ($n=1$). Each respondent was interviewed for approximately 1.5 hours with open-ended questions about his or her clinical and personal experience with delirium assessment, recognition, and intervention. Analysis of the recorded interviews yielded three main delirium-related strategies: Taking a Quick Look, Keeping an Eye on Them, and Controlling the Situation.

Taking a Quick Look suggested nurses quickly assess patients because of the limited time generally available in a fast-paced acute care setting (Dahlke & Phinney, 2008). *Keeping an Eye on Them* recommended frequent rounding and monitoring of patients assessed to be at risk for delirium. *Controlling the Situation* focused on intervening as needed to prevent injury and provide appropriate therapy. Authors found nurses repeatedly reported having little to no formal education about older adults and had sparse formal knowledge of delirium; they concluded nurses would benefit from increased delirium-related educational support.

Additional research assessing nurses' knowledge of delirium has been completed in LTC settings. Voyer and co-authors (2008) assessed nurse detection of delirium in older adults. This prospective study identified the signs and symptoms most challenging to distinguish, as well as delirium factors most likely to go unnoticed. At three LTC facilities and a large regional hospital LTC unit over two 7-day periods, trained research assistants (nurses who had complet-

ed 15 hours of instruction on delirium and dementia detection) interviewed 160 consenting patients age 65 and over with no history of psychiatric illness. Investigators collected relevant demographic and health information and assessed patients for delirium as part of their interviews. Nurses were questioned about their ability and experience in assessing delirium in patients. The incidence of delirium among patient participants was 71.5% ($n=108$); of those, nurses identified delirium in just 13% ($n=14$). Authors concluded nurses under-recognize delirium in older adults in the LTC setting.

Purpose

Nurses' failure to differentiate and recognize delirium early may be due to lack of knowledge about delirium, risk factors, preventive measures, and treatment. Therefore, the purpose of this study was to assess nurses' knowledge of delirium and its risk factors, and correlate findings to demographic variables, such as nurses' years of experience, level of education, and area of practice. The study also was designed to evaluate nurses' perception of their own level of competency related to delirium recognition and management.

Research Questions

Research questions addressed in this study included the following:

1. What was nurses' level of knowledge of delirium?
2. What was nurses' level of knowledge of delirium risk factors?
3. Was there a correlation between nurses' years of experience, education, and practice area, and their knowledge of delirium and its risk factors?
4. How did nurses perceive their own knowledge competency related to delirium?

Hypotheses

1. Nurses have insufficient knowledge of delirium and its risk factor as evidenced by scoring less than 75% on the questionnaire.
2. A high correlation exists between a nurse's level of experience, education, and area of

practice, and his or her knowledge of delirium and its risk factors.

Methods

After receiving institutional review board approval from the affiliated hospital and university in the Southeast region of the United States, researchers sent an announcement about the study by mass email to potential respondents who were nurses employed at this hospital. This nonexperimental, descriptive study was conducted over a 2-week period. Researchers manually distributed 150 questionnaires to every hospital unit (medical-surgical, orthopedic, oncology, progressive care, neuro-intensive care, medical-surgical intensive care, cardiac care) to nurses who volunteered to participate in the study.

Instrumentation

The research instrument used in this study was used previously in a similar study (Hare et al., 2008). Permission to use the questionnaire was obtained from its original developers (M. Hare, personal communication, March 15, 2011). The questionnaire, which was untitled in the previous study, was labeled for the current study as Nurses' Knowledge of Delirium (NKD) (Hare et al., 2008). The NKD questionnaire has neither been validated nor had its reliability established (M. Hare, personal communication, September 22, 2011). However, the developer explained many other researchers and organizations worldwide, such as National Health Service in the Great Britain, have utilized all or part of the questionnaires subsequent to the original study; thus, validation and reliability may have been established without the knowledge of the developers (M. Hare, personal communication, September 22, 2011).

The NKD questionnaire has two sections: a 10-question section for demographic data collection and 36 specific delirium-related questions called the *knowledge* section. The demographic section required par-

ticipants to provide age, sex, practice setting, specialty, level of education, and years of nursing experience. Participants also were asked if they had experience in caring for a patient with delirium; if so, how frequently had they provided care and had they received any formal delirium-related continuing education? Respondents also were asked to provide their perceptions of their current personal knowledge of delirium by selecting one of the following descriptors: *lack competency, minimal competency, average competency, above average competency, advanced competency, or expert competency*. The demographic section required written responses and contained multiple-choice questions except respondent age.

In the knowledge section of the questionnaire, participants identified the definition of delirium in a multiple-choice question, and seven scales/tools commonly used when assessing patients with delirium, dementia, and/or depression. All 28 remaining questions in this section assessed respondents' general knowledge of delirium and its risk factors using a Likert-scale (*agree, disagree, or unsure*). This section contained one definition question, seven scales/tools questions, 14 general questions about delirium, and 14 questions about risk factors in a randomly mixed sequence. Participants independently completed just one of the forms in its entirety and placed finished questionnaires in a collection folder located in the nurses' lounges on each unit. The tool did not request any identifying information from participants so anonymity was maintained.

Collection of Data and Analysis of Data

Once the questionnaires were collected, answers were compared to a codebook or key created to provide quick, accurate assignment of numerical values to the different answers for analysis. Completed questionnaires were crosschecked manually with the answer key and entered into an Excel spreadsheet to construct a database. Percentages

and means were used to describe the demographic variables. The completed database then was exported to SPSS version 15 (IBM, Chicago, IL) for detailed analysis. Researchers used analysis of variance (ANOVA) to determine if a correlation existed between nurses' demographic characteristics and their knowledge of delirium and delirium risk factors, and nurses' perceptions of personal competency related to delirium. For the purpose of this study, $p \leq 0.05$ indicated statistical significance.

Findings

Demographics

Of the targeted 150 potential nurse participants, 60 (40%) completed survey questionnaires; one questionnaire was excluded as completed by a non-nurse. Researchers categorized respondents by age: 19 respondents (31.67%) were ages 20-30, 17 (28.33%) were ages 31-40, 10 (16.67%) were ages 41-50, and 14 (23.33%) were age 50 or older. Eighty-three percent of respondents were female.

Thirty-four respondents (56.67%) held a BSN degree, 18 (30%) held an ADN degree, six (10%) held an MSN degree with preparation as either a nurse practitioner or clinical nurse specialist, and two (3.33%) indicated they held a diploma in nursing.

Twenty respondents (33%) indicated they had practiced as nurses 4-7 years, 14 (23.33%) had practiced 20 years or more, and nine (15%) less than 3 years. All respondents worked in an acute care setting; 35 (58.33%) practiced on a medical-surgical unit, 20 (33.33%) in a critical care unit, two (3.33%) in a surgical area, two (3.33%) in "other" areas (e.g., rehabilitation or primary care area), and one (1.67%) in a post-anesthesia care unit. Forty-two (75%) respondents reported having received no prior delirium-related education and 50 (83.33%) indicated they would be interested in receiving education about delirium. Finally, 51 respondents (85%) said they had provided care previously to patients with delirium.

Knowledge and Risk Factors Scores

Of 36 questions on the NKD questionnaire, respondents answered an average of 23.10 (64.17%) correctly. Only 12 respondents (20%) scored 75% or greater on the questionnaire. Total knowledge and risk factor scores included only respondents who correctly answered questions, not those who responded incorrectly or "unsure."

Research Question 1: *What is nurses' level of knowledge of delirium?* Twenty-two questions specifically required participants to answer general knowledge questions about delirium. The average number of knowledge questions answered correctly was 15.32 (42.55%) (see Table 3). Twenty-one (35%) respondents scored 75% or greater on the delirium questions.

Research Question 2: *What is nurses' level of knowledge of delirium risk factors?* Fourteen questions required correct identification of delirium risk factors. The average number of risk factor questions answered correctly was 7.78 (21.62%). However, only six (10%) respondents scored greater than 75% on this group of questions (see Table 4).

Research Question 3: *Is there a correlation between nurses' years of experience, level of education, and practice area, and their knowledge of delirium and its risk factors?* No significant correlation was found between the level of education and the number of correct answers to general delirium questions ($p=0.063$) or risk factor questions ($p=0.629$). Researchers found no statistical significance in correlating the number of years of nursing practice and the number of correct answers in general delirium questions ($p=0.217$) and risk factor questions ($p=0.809$). Finally, no significant correlation existed between the correct answer of delirium questions and risk factor questions and the specific areas of practice ($p=0.823$ and $p=0.560$).

Research Question 4: *How do nurses perceive their own competency of delirium?* Just one (1.67%) participant self-described as having advanced competency. Nine (15%)

considered themselves to have above average competency about delirium, 33 (55%) perceived themselves of average competency, 11 (18.33%) reported minimal competency, and six (10%) said they lacked competence. Less than half the participants scored at least 75% on both the general delirium and risk factor questions. No statistical significance was found between knowledge and nurses' level of education, experience, or area of practice. In addition, researchers found no significant correlations between knowledge (general and risk factors) and receipt of previous education about delirium ($p=0.352$ and $p=0.270$). However, this study incidentally determined a statistically significant difference in nurses who previously had cared for patients with delirium and the number of correctly answered general knowledge questions ($p=0.028$). However, there was no statistical significance for the risk factor questions ($p=0.212$).

Nurses had a significant lack of knowledge about delirium and its risk factors. Only 12 of 60 respondents (20%) scored at least 75% to be considered generally knowledgeable. Further, the study found no correlation between education level, years of experience, or area of practice, and nurses' general knowledge of delirium and its risk factors. However, nurses with experience caring for patients with delirium scored higher in the general delirium knowledge than those who lacked that experience. While more than half the respondents described themselves as having an average knowledge of delirium, exactly 80% ($n=48$) failed to score 75% (having average competency).

Limitations

The study tool was not validated formally. However, the questionnaire's authors explained all or part of the instrument had been used in other studies and programs, and may in fact, have been validated elsewhere. In addition, this study was conducted in only one hospital and, as a result, response rates were too low to achieve statistically significant results.

Nursing Implications

Because delirium may be difficult to recognize, it subsequently is under-recognized and under-treated by health care professionals (O'Mahony et al., 2011; Rice et al., 2011). However, all nurses have the responsibility to identify risk factors and signs and symptoms of delirium to lessen complications in acute and primary care settings (Rice et al., 2011). Completing routine assessments, recognizing predisposing and precipitating risk factors, and using delirium scales for prevention and treatment are key nursing responsibilities.

Assessing the knowledge of nurses is a crucial step toward quantifying any knowledge deficit before creating appropriate remedial education programs. Hare and colleagues (2008) determined the nursing delirium risk factors knowledge deficit was lower (46.15%) than general knowledge (64.91%). This finding also was confirmed in this study where the average risk factor questions answered correctly was 7.78 (21.62%) and the average knowledge questions answered correctly was 15.32 (42.55%). The current study findings differed from those of Hare and colleagues in that scores on both risk factor and general knowledge questions were lower than those reported by Hare. Nurses must continue to expand their knowledge of delirium in order to provide frequent and accurate assessments required to intervene before delirium further complicates patients' health (Martinez, Tobar, Bedding, Vallejo, & Fuentes, 2012).

Conclusion

Delirium is a common disorder. If the condition is not treated properly or if preventive interventions are delayed, the patient may continue to deteriorate and become functionally impaired. This could lead to long-term care placement and even death. In this study, a nursing knowledge deficit regarding general characteristics of delirium and its risk factors was identified. Education of nurses in all care settings is vital for future

TABLE 3.
Questionnaire Results for Knowledge of Delirium

Question		Correct Answer n (%)	Incorrect Answer n (%)	Unsure Answer n (%)
2.1	Delirium: an acute confusion, fluctuating mental state, disorganized thinking, altered level of consciousness.	51 (85.00%)	9 (15.00%)	0
2.2	Mini Mental State Examination (<i>Delirium/Dementia</i>)	9 (15.00%)	51 (85.00%)	0
2.3	Glasgow Coma Scale (<i>None</i>)	43 (71.67%)	17 (28.33%)	0
2.4	Delirium Rating Scale (<i>Delirium</i>)	51 (85.00%)	9 (15.00%)	0
2.5	Alcohol Withdrawal Scale (<i>Delirium</i>)	25 (41.67%)	35 (58.33%)	0
2.6	Confusion Assessment Method (<i>Delirium</i>)	16 (26.67%)	44 (73.33%)	0
2.7	Beck's Depression Inventory (<i>Depression</i>)	50 (83.33%)	10 (16.67%)	0
2.8	Braden Scale (<i>None</i>)	52 (86.67%)	8 (13.33%)	0
2.9	Fluctuation between orientation and disorientation is not typical of delirium. (<i>False</i>)	43 (71.67%)	11 (18.33%)	6 (10.00%)
2.10	Symptoms of depression may mimic delirium. (<i>True</i>)	36 (60.00%)	17 (28.33%)	7 (11.67%)
2.11	Treatment for delirium always includes sedation. (<i>False</i>)	43 (71.67%)	6 (10.00%)	11 (18.33%)
2.12	Patients never remember episodes of delirium. (<i>False</i>)	43 (71.67%)	4 (6.67%)	13 (21.67%)
2.13	A Mini Mental Status Examination (MMSE) is the best way to diagnose delirium. (<i>False</i>)	28 (46.67%)	11 (18.33%)	21 (35.00%)
2.15	Delirium never lasts for more than a few hours. (<i>False</i>)	51 (85.00%)	4 (6.67%)	5 (8.33%)
2.28	A patient who is lethargic and difficult to rouse does not have a delirium. (<i>False</i>)	29 (48.33%)	16 (26.67%)	15 (25.00%)
2.29	Patients with delirium are always physically and/or verbally aggressive. (<i>False</i>)	52 (86.67%)	3 (5.00%)	5 (8.33%)
2.30	Delirium is generally caused by alcohol withdrawal. (<i>False</i>)	35 (58.33%)	18 (30.00%)	7 (11.67%)
2.31	Patients with delirium have a higher mortality rate. (<i>True</i>)	41 (68.33%)	7 (11.67%)	12 (20.00%)
2.33	Behavioral changes in the course of the day are typical of delirium. (<i>True</i>)	48 (80.00%)	6 (10.00%)	6 (10.00%)
2.34	A patient with delirium is likely to be easily distracted and/or have difficulty following a conversation. (<i>True</i>)	56 (93.33%)	2 (3.33%)	2 (3.33%)
2.35	Patients with delirium will often experience perceptual disturbances. (<i>True</i>)	59 (98.33%)	0	1 (1.67%)
2.36	Altered sleep/wake cycle may be a symptom of delirium. (<i>True</i>)	58 (96.67%)	0	2 (3.33%)

TABLE 4.
Results for Questions Relating to Risk Factors for Delirium

Question		Correct Answer n (%)	Incorrect Answer n (%)	Unsure Answer n (%)
2.14	A patient having a repair of a fractured neck or femur has the same risk for delirium as a patient having an elective hip replacement. (False)	12 (20.00%)	40 (66.67%)	8 (13.33%)
2.16	The risk for delirium increases with age. (True)	52 (86.67%)	5 (8.33%)	3 (5.00%)
2.17	A patient with impaired vision is at increased risk of delirium. (True)	36 (60.00%)	11 (18.33%)	13 (21.67%)
2.18	The greater the number of medications a patient is taking, the greater his or her risk of delirium. (True)	55 (91.67%)	2 (3.33%)	3 (5.00%)
2.19	A urinary catheter in situ reduces the risk of delirium. (False)	45 (75.00%)	8 (13.33%)	7 (11.67%)
2.20	Gender has no effect on the development of delirium. (False)	27 (45.00%)	15 (25.00%)	18 (30.00%)
2.21	Poor nutrition increases the risk of delirium. (True)	52 (86.67%)	2 (3.33%)	6 (10.00%)
2.22	Dementia is the greatest risk factor for delirium. (True)	16 (26.67%)	30 (50.00%)	14 (23.33%)
2.23	Males are more at risk for delirium than females. (True)	14 (23.33%)	13 (21.67%)	33 (55.00%)
2.24	Diabetes is a high risk factor for delirium. (False)	7 (11.67%)	34 (56.67%)	19 (31.67%)
2.25	Dehydration can be a risk factor for delirium. (True)	58 (96.67%)	0 (0.00%)	2 (3.33%)
2.26	Hearing impairment increases the risk of delirium. (True)	37 (61.67%)	12 (20.00%)	11 (18.33%)
2.27	Obesity is a risk factor for delirium. (False)	38 (63.33%)	4 (6.67%)	18 (30.00%)
2.32	A family history of dementia predisposes a patient to delirium. (False)	18 (30.00%)	29 (48.33%)	13 (21.67%)

prevention and recognition of delirium. Education should incorporate assessment and prevention strategies in caring for patients with delirium or those who have an increased risk for developing delirium. Education can provide nurses the foundation they need to become more proactive in addressing this under-recognized condition (Conley, 2011; Rice et al., 2011). **MSN**

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Bathing Persons with Dementia

continued from page 14

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AMSN President's Message

continued from page 5

All Nurses Are Leaders

Developing leadership skills is challenging as well as rewarding. Throughout my career, I have had mentors who have provided guidance. I believe it is our responsibility as nurse leaders to share our wisdom with our colleagues. Take the time to seek a mentor and discuss your career plans. That person will have a wealth of knowledge to share and may spark an interest in a path you have not considered previously. If you are currently a seasoned nurse, seek mentoring opportunities. Taking an active part in developing nurses for future leadership roles has been a personally rewarding component of my career.

I challenge you to find opportunities to continue to develop your leadership skills. The AMSN Clinical Leadership Development Program is a course I strongly encourage you to complete. Maybe this is the right time in your life to participate in a hospital council as a member or chair. Answering a call to volunteer for AMSN may be in your future for 2015. Seek new experiences. Rely on mentors for advice and guidance. Become an active participant in the redesign of health care. Wherever you are in your career path, remember, *all* nurses are leaders. **MSN**

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Call for 'Clinical How-To' Submissions

Are you a clinical expert? Share that expertise through the "Clinical How-To" column in *MEDSURG Nursing*. Desired topics for this column in the coming year include tracheostomy care, care of the patient with a chest tube, IV access devices, total hip protocol to avoid dislocation (posterior approach), and neurovascular assessment. Please contact journal Editor Dottie Roberts (drobertscns@gmail.com) to discuss your interest and a possible timeline for submission.

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