Nursing Experiences of Caring for the Geriatric Person with Delirium: An Integrated Literature Review

by

Claudia Kathryn Mynott
BScN, University of Victoria, 2011

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Supervisory Committee

Dr. Elaine Gallagher (School of Nursing)
Professor, Supervisor

Dr. Mary Ellen Purkis (School of Nursing)
Associate Professor, Committee Member
Dean, Faculty of Human and Social Development

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Abstract

This paper explores the extant quantitative and qualitative knowledge that seeks to understand the nursing experiences of caring for the geriatric person with delirium. A comprehensive literature review was conducted and a synthesis of the results form the conceptual framework for this project. An analysis of common themes reveals that nurses' lack adequate knowledge of delirium and that they were frequently unable to recognize delirium. Additionally, attitudes of ageism and organizational culture contributed to these under recognition rates and the provision of adequate care for the geriatric person. The under recognition of delirium predetermined a vulnerability to higher levels of morbidity, institutionalization, and mortality in the older adult. Nurses experienced moral distress, workload stress, the fear of bodily harm, and self-perceived professional inadequacy. The nursing experiences of caring for this population may uncover seminal knowledge that could lead to an increase in delirium recognition rates, enhanced health outcomes for the older adult, and a less stressful work environment for nurses.

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Integrative Literature Review

Purpose and Scope of the Project

The purpose of this project is to explore the literature that relates to the experiences of nurses' caring for the geriatric person with delirium and to formulate a conceptual framework that could guide nursing practice. The extant knowledge of these nursing experiences has the potential to inform current nursing practice and illuminate the facilitators as well as the barriers to caring for this population. The paper will commence with a description of North American aging demographics and the impact this is predicted to have on the health care system as well as a short introduction to delirium also known as an acute confusional state in the geriatric person. The context as well as the assumptions that are foundational to the project will be presented. An in depth discussion of delirium or acute confusion will be followed by a statement of delirium under recognition rates and the significance to nursing, to the health outcomes of the geriatric population, and to the health care system. The methodology of the literature review process will be provided and the resulting conceptual framework will provide links to nursing practice, education, and future research initiatives. Finally, an evaluation of the findings and recommendations will be offered.

Introduction and Background

In North America, the older adult population has been growing, exponentially, over the last several decades. Multiple sources have described these changing demographics (Ham et al. 2007; Hein 2001; Frankel, Speechley and Wade 1996; Miller 1991). In 2007, a Statistics Canada report entitled "A Portrait of Seniors in Canada" stated that "Between 1981 and 2005, the number of seniors in Canada increased from 2.4 to 4.2 million and their share of the total population increased from 9.6% to 13.1%" (p.12). People are living longer than they have in the

past. This changing demographic is frequently attributed to the ever changing technological advancements of biomedicine. This can be chronicled in the vaccine development of the mid 20th century, which effectively eliminated many infectious diseases such as polio and smallpox, to the human genome mapping of the new millennium. Today, it is not uncommon for adults to live to the age of 100 or more in contrast to a life expectancy of 46 for males and 48 for females at the turn of the 20th century (Hein, 2001). A declining birth rate and a baby boom generation that is quickly approaching retirement age are also contributing to the aging of North American society. These changing demographics are predicted to have an ongoing impact on the health promotion of older adults and the sustainability of our current health care delivery system (Hein, 2001; Frankel, Speechley and Wade, 1996).

Many older adults already have or will develop delirium when they are admitted to institutional health care settings. Delirium is also known as an "acute confusional state" (Ham et.al, 2007) and for the purposes of this paper these terms will be interchangeable. Literature abounds with information on the etiology, the predisposing, and the precipitating factors that cause this phenomena and yet very little of this discourse reflects the experiential knowledge of nurses caring for this population. The geriatric person with delirium will be cared for most notably by nurses and unearthing the nursing experiences of caring for these individuals may contribute knowledge that may guide a model of care delivery for this population that could improve the health of older adults, reduce the moral distress of nurses, and contribute to the sustainability of our health care system.

Our health care system presently relies heavily on the nursing workforce and will continue to do so well into the future not only in North America but around the world. Nurses are the "largest single group of health care providers" (CNA, 1998) in Canada and as such they will

be the primary caregivers for the older adult population. A growing shortage of registered nurses in Canada will be a significant predictive factor in the positive health care outcomes of the geriatric population within the context of acute care settings such as hospitals. In 1997, the Canadian Nurses Association reported that by 2011, based on population growth rates, Canada would be short between 59,000 to 113,000 RN's (Ryten, 1997). In 2007 the shortage was estimated at 11,000 FTE's or full time equivalent RNs working in direct care (CNA, 2009). Although, these statistics are not as dire as the report from 1997 this same report projects that by 2022 the shortage of registered nurses will be 60,000 FTE's "If the health needs of Canadians continue to change according to past trends "(CNA, 2009, p. iii)

The nursing shortage can be attributed to declining enrollment rates in nursing schools, the restructuring of health care delivery based on the foregrounding of economics by governments, nurses leaving the profession, and an aging population (CNA, 1998).

Organizational restructuring of health care by federal and provincial governments has most often been justified by the need to generate cost savings. But these changes to the structure of practice coupled with the biomedical advancements in technology have created a practice environment that is unmanageable for nurses and increasingly unsafe for patients. Varcoe and Rodney (2001) stated "The upheaval and change characteristic in Canadian health care at the end of the twentieth century shape the conditions of nurses' work and challenge the viability of that work" (p.102). It is my position that the well-being and health of the geriatric population is dependent on the professional autonomy of nurses to contribute to the decisions that affect the model of care delivered to this vulnerable population.

Context and Assumptions

I have chosen this topic as I believe that the experiences of nurses who care for older adults admitted to hospital may uncover seminal knowledge that could contribute to an increase in delirium recognition. It is my contention that improvements to delirium recognition will lead to enhanced health care outcomes of the older adult suffering from a delirious event and that these in turn, will result in a less stressful work environment for nurses. In my work, as a nursing educator on an orthopaedic unit, a large percentage of the clients are older adults and recently delirium has come to the forefront as a significant issue. My biases, in relation to the older adult population, would firstly be ethical. Nurses are guided, in practice, by the *Canadian Nurses Association Code of Ethics* (2008). This ethical code recognizes that socially disadvantaged population groups are vulnerable to health inequities. The ethical nursing imperative when caring for vulnerable populations is to strive to promote the health of these individuals through actions that interrupt the barriers to positive health outcomes. The nursing decisions that affect the care of the geriatric person suffering from delirium would then be guided by general ethical theories and the bioethical principals of autonomy, beneficence, nonmaleficence, and justice, but also should be inclusive of the "interests of the elderly" (McPherson, p. 106, 2004). This variable suggests the notion of employing contextualism or the use of a "wide reflective equilibrium" (McPherson et al., p. 98, 2004) within the process of ethical decision-making. McPherson et al. (2004) stated "Although gerontology and geriatric medicine have become important new specialties, mainstream healthcare has a long way to go in understanding and, hence, addressing the needs of the elderly" (p.107).

Secondly, as a generalist nurse for many years, and now with the advantage of acquiring advanced practice knowledge, I believe that the voice of nursing has been and is being silenced

as a contributor toward the health outcomes of various populations by the dominant forces of medicine and the foregrounding of economic sustainability over the rights of the Canadian public to adequate health care. Interdisciplinary collaboration is salient to the health promotion of all persons, but is of particular importance for vulnerable populations such as older adults. Hanson and Spross (2009) stated "Patient dissatisfaction with care, unsatisfactory clinical outcomes, and clinician frustration can often be traced to a failure to collaborate" (p.283).

Historically, registered nurses have struggled to gain autonomy over their profession. Nurses, as an oppressed group, (Roberts, 1983) have been socially and politically constrained when it comes to being participants in the decisions that impact their practice environment and the care of clients. This factor could have far reaching implications in regards to the care of diverse populations including the geriatric person with delirium. Roberts (1983) stated "The view of nurses as oppressed is supported by the fact that nurses lack autonomy, accountability, and control over the nursing profession" (p.26). The conceptualization that nurses are an oppressed group (Roberts, 1983) has been one of the foundations for the emergence of scholarly literature that has advocated for changes to the nursing work environment that would increase the autonomy nurses have over their practice and thus their ability to influence the health outcomes of various populations. The nursing shortage has also fuelled the discourse on illuminating the need for strategies that would enhance nursing autonomy.

Several factors have been barriers to the autonomous agency of nurses. In a patriarchal society, the belief that it is a women's natural affinity to "care" has been equated with the perception that nursing does not require any special skill or knowledge base. The education of nurses in hospitals dominated by medicine perpetuated the notion that nurses were the handmaiden of the doctor and that their only role was to carry out the physician's "orders".

Roberts (1983) suggested that nurses themselves as well as nursing leaders need to recognize and understand the implications of nurses as oppressed within a male dominated, westernized, health care culture. She also advocated for nurses to reconnect with their "cultural heritage" (Roberts, 1983, p. 29) of caring through the resurgence of theory development and practice that is based on the resulting disciplinary knowledge. The move of nursing education into the university setting has resulted in changes to the aforementioned educational processes and the knowledge base of nursing but to what degree it has influenced nursing autonomy over the direction of practice is debatable.

In a contemporary context Rodney, Brown, and Liaschenko (2004) extend the concept of nursing autonomy to be inclusive of moral agency as it is enacted within the practice environment. These authors define agency as a characteristic of a person who is "capable of deliberate action and/or who is in the process of deliberate action" (Angeles, 1981, p.6 as cited in Rodney, Brown, and Liaschenko, 2004). These actions can be "with or without moral overtones" (Rodney, Brown and Liaschenko, 2004, p. 155) and in health care the autonomous moral agency of nurses would be seen as advantageous to the well-being of clients including older adults suffering from delirium. Many times, in the reality of practice, clients are discharged from an acute care setting prematurely which leads to a need for an extension to health care services. Frequently, in the case of older adults, this results in a reentry to the health care system through emergency routes if their physician or home health care is not able to meet their needs. Reentry to institutional settings increases the client's susceptibility to nosocomial infections and further decline as they struggle to adjust to the physiological and emotional stress that this situation presents. The plan of care which would include discharge has historically been guided by physicians and has not included the autonomous agency or actions of nurses to advocate for their

clients. Nurses, through the nurse-client relationship, are well equipped to collect substantive knowledge about their clients that may contribute to an interdisciplinary, collaborative plan of care directed toward positive health care outcomes. Purdy et al. (2010) concluded that "challenge, learning, growth and autonomy" (p.902) were viewed as "empowering conditions" of the workplace that promoted "positive outcomes for both nurses and patients" (p.901).

As previously mentioned gender relations also play a significant role in the autonomous agency of nurses. As a predominantly female profession Rodney, Brown, and Liaschenko (2004) assert that "…gender problems threaten nurses' autonomy" (p.155).

Both federal and provincial nursing organizations have taken on the challenge of recommending strategies that would enhance nursing autonomy. The Canadian Nurses Association has developed position statements on the quality of nursing practice environments. One such statement declared that "The quality of nurses' professional practice environments has a direct correlation on job satisfaction, work production, recruitment and retention, the quality of care and ultimately, client outcomes" (CNA, 2001).

In 2005, The College of Registered Nurses of British Columbia published the *CRNBC Guidelines for a Quality Practice Environment* directed at improving the nursing practice environment and promoting nursing autonomy. The third guideline in this document advocates for nurses' to have control over practice through "authority, responsibility, and accountability" (CRNBC, 2005, p. 8).

Currently, the autonomy that nurses have over their own practice remains constrained by the sociopolitical context in which nursing care takes place. Sherwin (1998) has referred to nursing autonomy as relational autonomy (as cited in McPherson et al. 2004). The ability of

nurses to make independent practice decisions is limited by the structures, policies and hierarchal relationships that are dominant in the practice environment.

In the contemporary health care delivery system nurses are left striving to keep pace with constant changes and decisions in which they do not have the ability to participate. Varcoe and Rodney (2001) have acknowledged the corporatism that has pervaded the delivery of health care and stated that " In the corporate culture of health care today, nurses are all too often treated as disposable, while the well-being of patients, families and communities is all too often overlooked" (p. 113).

The inability to act as autonomous moral agents in the delivery of health care services has led to significant moral distress among nurses. Rodney, Brown and Liaschenko (2004) have defined moral agency as "…a construct that focuses on nurses as engaged actors who draw on their various sources of knowledge as they live their nursing work" (p.163). Moral distress, experienced by nurses, is a consequence of not being free to act autonomously within the context of an ethical, caring nurse-client relationship. An inability to act as an autonomous moral agent and the resulting moral distress experienced by nurses, as a result of our current practice environment, may be a barrier to the recognition, intervention, and management of delirium in the geriatric population.

Delirium or Acute Confusional State

The process of aging culminates in changes to the physical, physiological, cognitive, and sensory functioning of the older adult. Diverse theoretical perspectives exist to explain the phenomena of aging. Miller (1999) has elucidated some of these as being based on biology, genetics, and immunology. Ham et al. (2007) has referred to the biologic process of "senescence" (p.14) or the process by which cellular division is lost over time resulting in the

loss of function and growth. Multiple co-morbid conditions are a consequence of the aging process and this makes the older adult increasing likely to be in need of health care services.

The older adult population is vulnerable in our modern health care delivery system. Their healthcare may be compromised by societal attitudes of ageism, issues of health literacy, and the dominance of biomedical culture that has medicalized older age. The political restructuring of health care delivery based on economic rationalism and not on concepts of social justice may accentuate this vulnerability. McPherson et al. (2004) commented on the vulnerability of older adults in our contemporary health care climate. These authors claim that "Current gerontological and ethical literature resounds with warnings that the elderly are bearing the brunt of fiscal policy changes" (p.107). As the baby boom generation approaches their retirement years the older adult population will be the dominant population group in need of health care services.

Many seniors' acute health-care needs are delivered in hospitals. Panno, Kolcaba, and Holder (2000) have commented that "60% of hospitalized patients" (p. 2) are over the age of 65. This statistic has been corroborated by a report from the Canadian Institute of Health Information in 2000-2001. This report states that "seniors are more likely to be hospitalized that younger Canadians" (p.6). The report goes on to say that the hospitalization rates, for seniors, did decrease slightly to 27 per 100,000 in 2000-2001 from 31 per 100,000 in 1994-1995. Additionally, the report states that the length of hospital stay was a predictor for discharge to their home environment. In fact, only"50% of patients with stays of more than 30 days did return home" (p.6). The remaining individuals were "transferred to a nursing home (16%), went to another institution (14%), or died (20%)" (CIHI, 2000-2001, p.6).

Delirium has been identified as a contributor to an increased length of stay in acute care hospitals, increased morbidity, mortality, and the institutionalization for older adults (Lipowski,

1983; Francis & Kapoor, 1990; Eden, Foreman and Sisk, 1998). The American Psychiatric Association (2000) *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) states that the diagnosis of delirium is based on a set of three criteria, firstly individuals have an impaired sense of consciousness and an altered awareness of their environment with an inability to "focus, sustain, or shift attention" (p.136). This makes it difficult to engage the person in coherent conversation. Secondly, they have a change to their cognition that may encompass loss of memory, disorientation, and language or perceptual disturbances. The older adult, with delirium, may have hallucinations and illusions that can be the impetus for aggressive or unsafe behavior such as climbing out of bed, attacking others, and pulling out needed intravenous lines or foley catheters. Thirdly, "The disturbance develops over a short period of time, usually hours to days, and tends to fluctuate during the course of the day" (p.136). These individuals also have interruptions to their sleep-wake cycle that can result in excessive daytime sleepiness and an inability to sleep during the night. Individuals may be very agitated and overly active otherwise known as hyperactive delirium (Chan & Brennan, 1999). Alternatively, individuals may exhibit very lethargic behavior which has been discussed as hypoactive delirium. Furthermore, they may display a combination of both these genres which Ham et al. (2007) has called a mixed form of delirium. Electroencephalograms show an abnormal slowing of brain function in people with delirium.

The pathogenesis of delirium has been hypothesized to occur as a result of certain etiological stresses that induce an imbalance of neurotransmitters in the brain. Ham et al. (2007) stated "The main stress-induced modification of brain neurotransmission in delirium is the presence of a neurotransmission state of cholinergic deficiency and dopaminergic excess" (p. 211). Chan & Brennan (1999) have substantiated this claim "Multiple neurotransmitters likely

are involved, but acetylcholine is probably the most important" (p.2). Human bodily movement and function is regulated by various chemical substances that allow the transmission of messages or impulses from cells or neurons to each other within the nervous system. Acetylcholine and dopamine are both classed as neurotransmitters. It is the physiological imbalance of these neurotransmitters that produces the symptoms of delirium such as confusion, inattention, and visual hallucinations.

The incidence of delirium in the individual hospitalized for medical or surgical reasons is between 10-30% and in older adults the percentage is up to 40% (DSM-IV-TR, 2000). Inouye, Foreman, Mion, Katz, and Kooney (2001) found that 56% of hospitalized older adults experienced an episode of delirium. The incidence of delirium in the hip fracture population is estimated to be 40%-52% (Ham et al., 2007) and older adults are more likely to sustain a hip fracture than younger adults. In fact, 200,000 hip fractures occur in the United States each year (Yarnold, 1999) and in 2007 the Canadian Institute for Health Information reported that "In 2005-2006, there were approximately 28,200 hip fracture admissions to Canadian hospitals" (p.17). It is estimated that 88% of these admissions were in people over the age of 65 (CIHI, 2007).

The physiological stress of a hospital admission along with the consequences of various medical conditions and surgical procedures can precipitate delirium. Younger adults have the ability to readjust to these stressors, but the older adult is vulnerable because they do not have the physiological reserves to adapt to these changes. Segatore and Adams (2001) stated "Chronologic age is the most powerful, nonmodifiable predictor of delirium" (p. 9).

The DSM-IV-TR (2000) has categorized delirium etiology into three specific areas. Delirium may be caused by one co-existing medical condition or by the existence of multiple co-

morbidities. The medical conditions associated with delirium would be central nervous system issues, such as head trauma and cerebrovascular accidents, metabolic disturbances such as electrolyte imbalances and dehydration. In addition, cardiopulmonary irregularities such as congestive heart failure and respiratory failure as well as conditions that would result in systemic illness such as urinary tract infections and septicemia may precipitate a delirious state. As stated previously many older adults experience the ongoing effects of multiple co-morbid conditions and this would make them susceptible to developing delirium.

Secondly, delirium can be induced by the overuse or withdrawal of substances. In this second category, a delirium induced by substance can be classified as produced by intoxication as well as withdrawal of the predominant substance such as alcohol, cannabis or cocaine, or associated with the side effects or toxic exposure to medications. The later is of particular importance when determining the etiology of delirium, in the older adult, as poly pharmacy is frequently employed in the management of various co-morbid conditions.

Thirdly, individuals may present with symptoms of delirium that are suspected to be attributable to a co-morbid condition or to the withdrawal or toxic effects of medication, but insufficient evidence exists to confirm this specific etiology. In all cases “Delirium is a medical emergency, and early resolution of symptoms is correlated with the most favorable outcomes” (Chan & Brennan, 1999, p. 1).

The progression of delirium is usually preceded by prodromal symptoms that may include sleep disturbances, irritability, distractibility, and restlessness. The course of delirium may be as short as a few hours and can extend into several days, but in older adults can be as long as a few weeks and even proceed into months. Most individuals will recover from delirium if the underlying causative factors are detected and treated. If this does not occur the individual

may lapse into a comatose state, experience seizure activity, and death could be the ultimate consequence.

Many health care providers may believe that dementia is synonymous with delirium. Chan & Brennan (1999) have illuminated the fact that "dementia is a recognized risk factor for the development of delirium" (p.3) and stated that "delirium can cause dementia" (p.3). While dementia and delirium are interconnected they differ in their presentation and progression. Davies (1999) stated "Dementia is a symptom complex characterized by intellectual deterioration occurring in the presence of a clear state of consciousness" (p.418) and this differs vastly from the sudden onset and fluctuating course of delirium. An assumption that an individual is presenting with dementia and not delirium could lead to the under detection of the causative factors that can be responsible for the delirium. This in turn could lead to an undesirable prognosis for the person suffering from delirium. Davies (1999) stated "Dementia must be ruled out in the differential diagnosis of delirium…If in doubt, the syndrome should be treated provisionally as delirium" (p.415).

Statement of the Problem

Delirium is under recognized by nurses and physicians. Chan and Brennan (1999) have estimated this under recognition to be between 32-67%, while Steis and Fick (2008) found a 26-83% detection rate. Segatore and Adams (2001) have pegged the under recognition at 67%.The early detection and management of delirium has been articulated as a critical factor in the prognosis of this phenomena (Evans, Kenny, & Rizzuto, 1993; Eden, Foreman, & Sisk, 1998 Chan & Brennan, 1999; Segatore & Adams, 2001). Unrecognized delirium can lead to ineffective management and increased rates of morbidity, institutionalization, and mortality.

This can have a ripple effect on the economic, emotional, and social resources of the client's family as well as placing strain on health care system.

The prognosis for the older adult who develops delirium is not optimistic. The authors of the DSM-IV-TR (2000) estimated that older individuals who develop delirium during a hospitalization may have up to a 75% chance of dying. The cause of death will be the underlying medical condition that is also not detected and treated primarily because of the masking effects of the delirium (Chan & Brennan, 1999; Davies, 1999). If delirium goes unrecognized it can lead to "chronic brain impairment and death" (Davies, 1999). Moreover, patients with delirium have a higher rate of death following discharge from hospital. This mortality has been estimated at 15% within one month after discharge and 25% at 6 months (DSM-IV-TR, 2000). Cole and Primeau (1993) found that the mortality rate at one month after discharge was 14.2 %. Older adults are much less likely to recover their full state of normal functioning after becoming delirious. Cole and Primeau (1993) reported that only 54.9 % of older adults, admitted with a diagnosis of delirium, had "improved mentally" (p.46) after one month of being in hospital. The development of delirium equates to an increased length of time in hospital and this is very troublesome for the older adult. This situation puts them at risk for contracting nosocomial infections, advances their deconditioning, and further decreases their ability to regain normal functioning. An episode of delirium is also a predictor of institutional placement for the older adult. Cole and Primeau (1993) found that the average length of hospital stay for the older adult with delirium was 20.7 days and 46.5 % of individuals were institutionalized within one month of being admitted to hospital.

Voluminous amounts of information have been generated on delirium, its' etiology, prevalence, presentation, management, and prognosis; however, a dearth of research has focused

on the causative factors that lead to the under recognition rates of this phenomena. How can we hope to enhance the health of the geriatric person and reduce strain on the health care system if the barriers to the recognition of delirium are not illuminated?

Nurses are ideally positioned, within the nurse-client relationship, to be instrumental in the recognition and intervention of delirium in the geriatric population. I posit that in order to expand the body of nursing knowledge on the barriers that impede the recognition of delirium, in the geriatric person, it is critical for us to explore the experiences of nurses caring for this population.

Significance of the Topic

The North American demographics of aging will likely equate to an increased incidence of delirium across all health care settings. Francis & Kapoor (1990) stated that "Delirium is probably increasing in frequency among hospitalized patients as an increasingly older and sicker population inhabits our general medical and surgical wards" (p.65).The inability of nurses to recognize delirium has the potential to result in negative health outcomes for the individual and their family as well as increased costs for the health care system. This project has the potential to illuminate the unknown contextual barriers that prevent nurses from recognizing delirium. The acquisition of this new knowledge may be the platform for a trajectory of practice environment changes, educational initiatives, and future research that may benefit the geriatric population, nurses, and the health care system. Multiple sources (Dahlke & Phinney, 2008; Lemiengre et al., 2006; Milisen et al., 2004) have acknowledged the central positioning of nursing to the care of the geriatric person with delirium and yet nurses continue to have a limited amount of autonomy over the conditions of their work environments (Varcoe & Rodney, 2001) that may impact on the recognition of delirium.

Ceci and McIntyre (2001) stated:

> A profound dissonance emerges between what one believes one is called on to be and do, and what the world, and one's relationship to it, allows. This distress deepens when it remains unheard, when what is of concern to nurses remains stubbornly invisible to others (p. 123).

Methodological Approach/Results

A comprehensive literature review was conducted of the extant qualitative and quantitative knowledge on the experiences of nurses caring for the older adult with delirium. The goal of this project was to illuminate a "value-added" (Torraco, 2005, p. 358) contribution to nursing epistemology and to identify opportunities for further research that could have the potential to influence positive health care outcomes for the geriatric person with delirium. As Torraco (2005) stated "…the author may be *interested* in learning more about phenomena *x*, and thus, undertake a review of the literature on this phenomena" (p.358).

The search strategy reflected an in depth search of the computerized databases CINAHL, MEDLINE, PsycINFO, and HEALTH SOURCE: NURSING/ACADEMIC EDITION with the focus of attaining a high degree of "recall and precision" (Conn et al., 2003, p.178) on the nursing experiences of caring for the geriatric person with delirium. This search was augmented by strategies such as ancestry searching, citation-index searching, searching research registries, hand searches of applicable journals, and the creation of a reference indexing system. The search terms employed were delirium, acute confusion, older adults, elderly and nursing care. The inclusion criteria were primary qualitative or quantitative research studies and conceptual sources that focused on the nursing experiences of caring of the geriatric person with delirium. Initially, the search terms yielded 38 articles on delirium care; however, only 20 (N=20) articles

met the inclusion criteria. Of the 18 articles excluded, 1 was focused on working with vulnerable populations, but was from the perspective of the patient; 1 focused on the impact of registered mental health liaison nurses (RMN) to delirium care; 3 were a patient perspective of experiencing delirium; 4 discussed the management of delirium; 2 represented nursing documentation of delirium; 6 discussed only the assessment of delirium and 1 was relevant only to the prognosis of delirium.

The 20 sample articles selected were published most predominantly in the United States 6 (30%) and Australia 6 (30%); the remainder were authored in Canada 4 (20%), Taiwan 1 (5%), Sweden 2 (10%) and 1 article (5%) was a collaborative publication between researchers in Belgium and the United States. The literature spanned the years 1983-2009. It would be optimum to review the literature in the previous three to five years (Krainovich-Miller & Cameron, 2009); however, due to the limits of knowledge on the experiences of nurses caring for older adults with delirium this extended time period is justifiable. Krainovich-Miller & Cameron (2009) stated "…a research project may warrant going back 10 or more years if the topic has not been extensively researched or the historical perspective is important" (p.103).

Conceptual Framework

The process of critical reading, reflection, and dwelling with the literature illuminated the common themes of ageism, moral distress, workload stress, knowledge, and organizational culture as barriers to the recognition and effective management of delirium.

The selected articles were read in full text to glean a preliminary understanding of the main concepts. This was followed by a comprehensive reading, based on a foundational knowledge of gerontology, delirium, and nursing practice that identified emerging predominant

themes. These themes were relevant to the experiences of nurses caring for the geriatric person suffering from delirium and also assessed as barriers to delirium recognition.

Through the analysis of narrative and text, as one emergent theme was identified the remaining literature was read again to locate evidence of thematic repetition. These themes were highlighted and synthesized into the resulting developing conceptual framework. Following this a summary card was written and stapled to each article.

Concepts can be considered the building blocks of theoretical knowledge. Hickman (2002) stated that "A concept is an idea, thought, or notion conceived in the mind" (p. 3) and they are "…the elements used to generate theories" (p. 5). The concepts that arise from this review of the literature may provide the supporting framework for a theory that could be used to guide the nursing practice of caring for the geriatric person with delirium. Moreover, nursing practice which is based on this theoretical development may increase the recognition rates of delirium, enhance the health outcomes for this population and create a less stressful work environment for nurses. The concepts will be defined as stated by Liehr, Smith and Cameron (2009) for "general meaning" (p. 25) and positioned within the extant literature.

Ageism

Ham et al. (2007) have defined ageism as the "…unfair judging of elderly adults simply because of their advanced age" (p. 9). The negative values and beliefs, about the aging process, that permeate western society have been normalized and as such are invisible to a culture that aspires to maintain their youth. A critical review of media messages tell us that older age is not valued in our society. This can be epitomized in constant marketing schemes that promote younger skin, a lack of grey hair, and the sustainability of vigorous youth. Health care providers are not immune to these attitudes and this may spill over into the care of the older adult

population. Ham et al. (2007) has gone on to state "This stereotyping can be so prevalent in society that it is almost invisible, but it can perpetuate negative attitudes that influence behaviors" (p.9). Societal attitudes of ageism or the belief that older adults are worthless, not deserving of time or resources, and that confusion or the symptoms of delirium are a part of "normal" aging may prevent the recognition of delirium, the implementation of intervention strategies, and thus promote institutionalization, increased morbidity or mortality.

In a qualitative study of 12 nurses working on medical and surgical units Dahlke and Phinney (2008) found that ageist beliefs and values were a barrier to the care of the older adult population with delirium. The nurses were cognizant that the devaluing of older age in general society influenced their attitudes toward clients with delirium and equated to "…a tendency to dismiss the seriousness of the symptoms of delirium" (p.45). The nurses also attributed delirium to the individual client's personality and not to a physiologic, pathological condition that presented as a disturbance to cognition. This was reflected in the language used by the nurses to describe the care of the older adult as analogous to caring for children or "like babysitting" (p. 45). These attitudes perpetuate health care for the person with delirium that is subjugated to the needs of younger adults and the system. Dahlke and Phinney (2008) stated "Older adults are viewed as a nurse's burden and an obstacle to the more important work of caring for younger adults" (p. 45). Would prioritization of caring for younger adults be construed as autonomous moral agency or could it be interpreted as nursing that is relational to the increased time pressures of a health care system that does not allow for slower moving, confused older adults? The authors of this study suggest that this perception of nursing burden prevented the nurses from reporting older adult care issues to the nursing managers believing that a "good" nurse

would be competent to care for these clients. The authors of this study conclude that ageist beliefs contributed to nurses not recognizing delirium.

Lou and Dai (2002) in their grounded theory study concluded that the under recognition of delirium was multifactoral and stated "Reasons for not recognizing delirium include failure to identify its clinical features, poor documentation of symptoms, lack of communication about the confused behavior, and acceptance of delirium as normal for older adults" (p.281).

An ageist discourse is reflected in the qualitative the study by Neville (2008) as being disadvantageous to the recognition of delirium. The nurses in this study articulated their experiences that younger individuals would be cared for by a seasoned nurse and yet the care of an older adult with delirium would be assigned to casual staff or inexperienced nurses. Moreover, the care of delirious older adults was reduced to a process of "infantilization" (p.466) through nursing documentation that talked only of care processes that would be congruent with children such as changing diapers and night settling. The study by Neville (2008) illuminates the relationally autonomous positioning of nurses in the delivery of care to older adults. He suggests that nurses have unwittingly perpetuated attitudes of ageism as they have been "interpellated into being social subjects of the ageist discourse and as such offered to older people who have been delirious the subject positions of 'being old doesn't matter' and ' a second childhood' " (p.467). Fussell, McInerney & Patterson (2009) in a qualitative study of graduate nurses' experiences of caring for the aged found that nurses perceived the older adult population as limiting their expertise in acute care skills and professional development. Poole and Mott (2003) also advanced ageism as a barrier to caring for the older adult with acute confusion and found that the stereotyping of older adults was reflected in the nurses' comments of the older adult as being in need of constant care, incontinent, and a burden. These authors stated "This can lead to

erroneous assumptions that illness is due to age, not treatable pathology, thus precluding the speedy reversal of a possible delirium and causing a descending spiral of decline" (p.308).

Ageism was identified in 5 (25%) of the reviewed articles as a barrier to the recognition of delirium. The concept of ageism was implied in some of these articles as "stereotyping" (Poole and Mott, 2003, p. 309) and that caring for the older adult was a devalued area of nursing practice that limited the ability of nurses to expand their "technical nursing skills" and "professional development" (Fussell, McInerney and Patterson, 2009, p. 220, 217). Additionally, nurses failed to recognize delirium as they considered the symptoms associated with this phenomena a part of "normal aging" (Steis & Fick, 2008, p.47). Although, the explicit language of ageism as a barrier to the recognition of delirium, was not found in a larger percentage of the literature; it could be concluded that the stereotyping of older adults, the devaluing of aged care by nurses, and attributing the symptoms of delirium as normal to the aging process are suggestive of ageist attitudes that may promote nursing decisions that attribute confusion, aggression, and/or hallucination to older age and not to delirium. The implications of these decisions could be devastating for the client as the cause or causes of the delirium go unrecognized and interventions are not initiated that may reverse the state of delirium. This can ultimately lead to increased morbidity, mortality and possibly institutionalization for the client as well as contribute to family and/or caregiver stress. Additionally, this can lead to increased costs for the health care system and contribute to a stressful work environment for nurses as the delirium goes undetected.

Moral Distress

The concept of moral distress has been gaining momentum in the nursing literature and has been defined by Keatings and Smith (2010) as "Stress caused by situations in which one is

convinced of what is morally right but is unable to act; results when moral issues are unresolved and when supporting processes are not in place" (p.428). While the terminology of moral distress was not explicitly stated in the articles reviewed much of what was described by the participants related to this concept.

Older adults are a vulnerable population in our society Hein (2001). This vulnerability becomes accentuated when the geriatric person is suffering from delirium. The individual is at risk of injuring themselves as a result of disorganized thinking, an inability to focus or sustain their attention, and visual disturbances that may lead to fear and aggression toward the caregiver or other clients in health care settings. Moreover, the client may experience increased rates of morbidity and mortality.

A delirious state may also pose a risk of harm or make vulnerable the nurse as she/he could be the recipient of unintended aggression that would limit the ability to provide necessary nursing care and accurately recognize delirium. Nursing vulnerability may also be actualized through feelings of professional inadequacy and moral distress as they strive to communicate with clients suffering from delirium. Milisen et al. (2004) found that an inability to communicate, in an effective way, with delirious clients resulted in the nurses and clients experiencing a sense of isolation. These authors hypothesize that this contributed to the strain nurses' felt when caring for a delirious client and suggest that their measure "The Strain of Care for Delirium Index" (SCDI) (p. 782) could provide needed assessments that "can point out the 'pitfalls' of stress" (p. 782). The symptoms of delirium created a situation in which the geriatric person was more "functionally dependent" as well as possibly "aggressive and combative" (p. 775). This increased the amount of time nurses needed to spend with these individuals to accomplish the "goals of care" (p.775) and this was correlated with nursing frustration and stress.

The conclusions of this study indicate that an increased compliment of staff and as well as employing educational methods to increase nursing knowledge specific to psychiatry and geriatric care would be helpful in alleviating the moral distress of nurses caring for this population.

Stenwall, Sandberg, Eriksdotter, Jonhagen, and Fagerberg (2007) found that caring for the confused older patient was a "stressful experience" (p.516). Due to the unpredictable nature of delirium the care givers expressed feelings of "always being on guard" (p.518) and perceived the interaction with a delirious patient as "unforeseeable" (p.518). The third theme identified in this phenomenological study was "using oneself as a tool" (p.518) to communicate or make contact with the patient. When this failed the nurses experienced "themselves as an unreliable tool or a tool which does not work" (p. 518). The nurses were cognizant of providing protection for the patient and attempted to stay connected with the patient and when this did not happen the professional caregivers experienced feelings of inadequacy and moral distress. Stenwall et al. (2007) stated "Caring for confused older patients involves a great responsibility for the professional carers, where both the professional carers as well as the patients are vulnerable and exposed" (p.521).

Andersson, Hallberg, and Edberg (2003) in their qualitative study found that a predominant theme that emerged was the nursing interpretation of "patients being in a divided and/or different world" (p.440) and this was seen as the impetus for the client to be "a threat or risk to themselves" (p.440). This reaffirms the risk of delirium creating an unsafe situation for the client and nurse. An additional theme that was evident in this same study was "Patients being out of reach" (p.440) and this accentuates, once again, the inability of the nurse to connect or establish the nurse-client relationship to provide needed care. "The patients and nurses were on

different levels, the nurses in their reality and the patients in their own world, with the result that they could not establish contact" (Andersson et al., 2003 p.441).

Rogers and Gibson (2002) in a qualitative study of 10 orthopaedic nurses found that the physical safety of nurses caring for the delirious client was a significant concern. This is another exemplar of nursing moral distress that is created during the nurse-patient relationship when caring for this population. "Nine out of ten nurses admitted to having experienced physical aggression including being "slapped", "punched in the head", or "strangled with a stethoscope" (p.14). As a nursing educator, on an orthopaedic in patient unit, I have recently had personal experience with nurses being the recipients of unintended physical aggression by individuals who have developed delirium. The contextual nature of this personal experience came in the form of a delirious patient attempting to choke a nurse with a call bell cord during a night shift. The nurse, being of a large stature, was able to free herself from the cord and luckily was not physically harmed in a significant way. I was not present when this incident occurred, but participated in the subsequent staff education session on the recognition of delirium.

Poole and Mott (2003) have articulated vulnerability and the resulting moral distress in their study of 36 nurses working with older agitated patients. Patient safety and nurse safety in this study was delineated as a predominant theme. The nurses talked of the methods they used to prevent the patient from injuring themselves such as restraints, but they also discussed the concerns they had about their own safety. The nurses felt that they did not have any rights in situations when they may be open to aggressive acts by the patient. "… it is clear that the personal safety of the individual nurse was of great concern" (Poole and Mott, 2003, p.310). The frequency of workplace violence in health care environments is becoming a growing concern for employees, employers, and professional organizations. Nurses are the health care professionals

most at risk of being the recipients of workplace violence. The Canadian Nurses Association and the Canadian Federation of Nurses Unions in a joint statement on workplace violence stated "Research demonstrates that among health-care personnel, nursing staff are most at risk of workplace violence" (CNA, 2008 as cited in ICN, 2006). In an era of severe nursing shortages the impact of violence directed toward nurses from patients, colleagues, visitors, and family members cannot be understated. Inadvertently, the delirious geriatric patient may be a significant source of aggression towards nurses. Nurses have historically been reliant on a biomedical model to manage patient aggression through physical and/or chemical restraint (Duxbury, 1999). Being reactive and not preventative, in the management of aggression, could perpetuate unsafe working conditions for nurses. Educating nurses on the symptoms of delirium and the use of alternative models of care to deal with patient aggression before it escalates into violent acts may ensure an enhanced practice environment which provides safety for nurses and positive outcomes for patients. Duxbury (1999) in a qualitative, exploratory study advocated for "nurses to become more fully prepared and skilled in 'therapeutic communication' and the prevention and/or the diffusion of violence" (p. 111).

Implicitly, moral distress was identified in 8 (40%) of the reviewed literature and as such became a component of the conceptual framework that may guide the nursing practice of caring for the geriatric person with delirium. Although, "moral distress" was not linguistically explicit, the themes of not being capable of connecting with the patient to provide ethical care, the perceived susceptibility to physical harm, and the increased amounts of time required to accomplish the goals of care that resulted in nursing frustration and stress could be construed as the basis for drawing this conclusion. It should be noted that Stenwall at al. (2007) framed the nursing experiences of caring for the geriatric person with delirium as being "vulnerable and

exposed" (p.521) and attribute this to the "unpredictable nature of the illness" and "the patients' perceptual disturbances" (p. 516). Again, an assumption can be made that this situation would be morally distressing for nurses and thus the patient's condition may go unrecognized as delirium. The long term effects of moral distress can lead to moral residue or lingering feelings of professional inadequacy and have been linked to negative outcomes for both nurses and patients (Rodney, Brown and Liaschenko, 2004). Initiatives that reduce the moral distress of nurses in caring for the geriatric person with delirium may contribute to positive outcomes for this population.

Workload Stress

It has long been recognized that the quality of the contemporary nursing practice environment is an obstacle to the provision of safe, ethical, competent client care (Erlen, 2004; Winslow & Herman, 2006; Varcoe & Rodney, 2001; Rodney & Varcoe, 2001; McIntyre & McDonald, 2003). Pervasive technology, health care restructuring, high client acuity, staff shortages, and a lack of effective nursing leadership are all factors said to contribute to a practice environment that is placing unimaginable work stress on nurses.

The need of federal and provincial governments to ensure an adequate supply of health care professionals has resulted in changes to the scope of practice for registered and licensed practical nurses. The Commission on the Future of Health Care (2002) has been one of the platforms upon which provincial governments have implemented legislation that supports these changes. This report recommended that the "traditional scopes of practice" (p.92) be reviewed and possibly revised in order to provide the right mix of skills that would provide Canadians with the type of health care delivery that they value.

In British Columbia, the Health Professions Act (2008) has been the legislation that has guided these changing patterns of practice and interprofessional collaboration. Although, I do not disparage the value of collaboration as beneficial at a micro, meso, and macro level of health care delivery (Hanson & Spross, 2009), the changing scope of practice, for registered nurses, I suggest, has the potential to increase their workload and thus their stress.

The education of licensed practical nurses is not adequate for them to provide nursing care in situations of high acuity or situations in which the patient requires complex nursing care. Exemplars of this type of care would include managing blood transfusions, patient controlled analgesia, epidural anesthesia, regional or perineural anesthetics, peripherally inserted central catheters (PICC) and most recently the changing of PICC dressings; a highly skilled and sterile technique. In these situations the registered nurse must assume the care of the client when the clinical assignment is beyond the scope and expertise of the licensed practical nurse. The management of nursing care would commonly be based upon the model of practice in current use on a particular nursing unit. In a case study of practice model redesign Hayman, Wilkes and Cioffi (2008) found that changing from a "patient allocation" (p.258) model of practice whereby one nurse is assigned to the care of a specified number of patients to a team nursing approach was not successful. To implement this model of practice the ratio of registered nurses was decreased while the ratio of enrolled nurses, equivalent to licensed practical nurses in Canada, was increased which subsequently increased the registered nursing workload. The participants in this study believed that the elimination of registered nurses during the redesign was "detrimental to the ward" (p.262). This area of health care is relatively understudied, but in a meta-analysis of literature on workforce skill mix Buchan & Dal Poz (2002) found that some evidence supported

the premise that models of collaborative practice resulted in"… higher workload for registered nurses" (p.577).

The workload stress that nurses experience is leading to, as discussed earlier in this paper, dissatisfaction, burn-out, moral distress, and the reduced ability to be autonomous in the delivery of health care services. The practice environment is a major contributor to nurses leaving the profession and to the critical shortage of nurses' worldwide (Ceci & McIntyre, 2001; Regan, 2003; Mensik, 2007; White, 1999 as cited in Ceci & McIntyre).

Fast paced contemporary nursing practice environments do not allow the time necessary for nurses to spend with older adults who are slower moving and require more nursing care. This would be, particularly, applicable to the geriatric person with delirium. Lou and Dai (2002) found that nurses identified "stress and feelings of being overloaded" (p.284) when caring for the older adult with delirium and that nursing classification systems did not account for unexpected patient events such as delirium.

Dahlke and Phinney (2008) identified that a predominant theme was the "care environment" (p. 44) and the inadequacies that were perceived by the nurses as barriers to the care of this population. Firstly, the practice environment was not conducive to the care of older adults. Organizationally driven goals of efficiency and speed disallowed the time needed to spend with older adults. This meant that the care of the older adult was dependent on the competing needs of other patients that the nurses perceived as "more acutely ill" (p.44). The nurses also identified a lack of knowledge about the care of older adults as contributory to their workload stress and the ability to balance their time pressures. Secondly, the nurses spoke of "negative beliefs and attitudes" (p. 45) as a barrier to the caring for the older adult with delirium. The societal belief that older adults were "disposable" led to a nursing philosophy that tended to

“ dismiss the seriousness of the symptoms of delirium” (p.45). These authors have recommended that further research initiatives should seek to explore nursing attitudes of ageism and workplace factors that impact on the care of this vulnerable population.

Poole and Mott (2003) found that nursing stress was accentuated when caring for acutely confused older adults. In this qualitative study the participants felt they did not have the time to care for older adults who were incontinent and believed that these individuals should be cared for in other areas. Perhaps this care would be more appropriately assigned to licensed practical nurses thereby allowing the registered nurse more time to spend directing and managing the more complex health care needs of the patient. Moreover, they believed that the increased amounts of time needed to care for the geriatric person, in a confused state, resulted in a limited ability to spend time providing nursing care for other patients. This situation created workload stress for the nurses as they then had to manage complaints from other patients and their families. The nurses spoke of trying to prioritize their time and the burden that the confused client placed upon their workload. Poole and Mott (2003) stated “The pressure of lack of time was evident in many responses” (p.309). Moving these individuals to another area may not be a reasonable option due to a lack of beds or staff shortages within a facility; however, an interesting alternative suggested by the nurses was to “request someone to special the patient” (p. 309) and this could be actualized in the form of care attendants or unregulated health care providers to assist with the patient’s personal care activities such as feeding, toileting, and washing. This concept is worth further examination directed at alleviating nursing workload stress and promulgating the scope of registered nursing practice as being “responsible and accountable for overall assessment, determination of client status, care planning, interventions and care evaluation” (CRNBC, 2007, p. 6).

Rogers and Gibson (2002) in their qualitative study illuminated that caring for the delirious client increased nursing workload. The additional workload was related to providing continual observation, assistance with toileting and feeding as well as restarting intravenous lines or the reapplication of dressings. Stress was also created for less experienced nurses as they tried to decide which interventions would be beneficial for the client with delirium. The stress of the added workload equated with feelings of low self esteem for the nurses as it significantly diminished their ability to finish all their nursing care by the end of the shift.

Communicating with clients who are delirious seems to emerge as a significant contributor to nursing workload and stress. Andersson, Hallberg and Edberg (2003) in a Swedish study of nurses' experiences with confused patients related that during acute confusional states the ability of the nurses to connect with the patient was impaired and that "the communication problems put a strain on the nurses as well as the clients" (p.447). Brajtman, Higuchi and McPherson (2006) in a study of nurses caring for palliative clients, with delirium, experienced significant stress at being present with clients and family members during delirium. It was stressful for the nurses to see the distress of the family members at a time so close to the time of death. These nurses, although experienced in palliative care, saw the phenomena of delirium as "stressful and challenging" (p.155). Stenwall et al. (2007) acknowledged that the nursing experiences of caring for this population were "stressful" (p.516) mostly due to the clients being very unpredictable and having visual as well as auditory disturbances.

Steis and Fick (2008) found that the Delirium Symptoms Interview (DSI) used by nurses in a study by (Morency, Levekoff, and Dick, 1994) led to a reluctance of the client to admit that they were having disorganized thoughts or visual disturbances for fear of being labeled as "crazy" (Steis & Fick, 2008, p. 43). The assumption that the individual was cognitively stable

led to the under recognition of delirium and had the potential to contribute to workload stress of nurses as the delirium progressed.

A review of the literature revealed that caring for the geriatric person with delirium significantly increased the nursing workload. In fact, this concept was identified in 9 (45 %) of the articles. Orthopaedics and palliative care were the only practice areas identified in the articles and one would wonder if caring for this population increased the workload of nurses in other areas. In synthesizing the causative factors of the increase to the nursing workload it appears that nurses had an insufficient amount of time to spend with patients in order to attend to their physical and cognitive needs. Additionally, working in a care environment that was not friendly to the needs of older adults and not being equipped with a sufficient knowledge base of delirium contributed to their workload stress. A contemporary practice environment does not afford nurses the time they need to care for the geriatric person with delirium. This increased the workload stress of nurses as they strived to keep pace with the needs of patients and the stress placed upon them by invasive technology and organizational goals. This workload stress may produce unintentional care rationing by nurses and the subsequent under recognition of delirium.

Knowledge

The Oxford English Dictionary (2005) has defined knowledge as "information and skills gained through experience or education" (p. 418). The body of knowledge specific to nursing has been articulated by Carper (1978) as " …knowledge that serves as the rationale for nursing practice has patterns, forms and structure that serve as horizons of expectations and exemplify characteristic ways of thinking about phenomena" (p.12). The genres of nursing knowledge according to Carper (1978) are the science of nursing or empirical knowledge, esthetic knowledge or the art of enacting the science of nursing into practice, personal knowledge or the

integration of self into the nurse-client relationship and ethical knowledge or the moral component.

The nursing care of the geriatric person with delirium would then be dependent on the pragmatic nursing ability to rely on any of the aforementioned patterns of knowledge (Carper, 1978). It has been observed by Dahlke and Phinney (2008) that nurses had a deficient amount of knowledge in relation to the "best practice protocols" (p.45) for enacting the care of the older adult with delirium. Many times in the contemporary practice environment patients are moved from room to room to accommodate the influx of new patients and they very seldom have the same nurse on two consecutive days. The nursing knowledge of "supportive care" (Chan & Brennan, 1999, p. 4) such as limiting bed moves and providing consistency of nurses, for patients with delirium, would position nurses as contributors to a more holistic model of care delivery for this population through actualizing the art or the esthetic pattern of knowing (Carper, 1978). This may be a challenge in our current health care environment, but may present an alternative to spending an over abundance of time attempting to decide on what interventions may be useful or acting too quickly, out of frustration, with nursing care that is ineffective. The nurses were consumed with the safety of the client in a "care environment characterized by limited time and knowledge" (p.45). The knowledge limitations discussed here would be reflective of the empirical or scientific knowledge patterns (Carper, 1978) the nurses felt they did not possess about the manifestations of delirium in the older adult. The nurses felt a need to be able to calm the situation for the other clients and the staff. This concentration on the nurses being constrained by time and lacking knowledge about delirium also has implications for ethical knowledge or the moral aspects of caring for this population.

Rodney, Brown and Liaschenko (2004) have asserted that knowledge is a vital aspect of moral behavior. The fact that the nurses became anxious and frustrated with not knowing what interventions to use, in caring for the older adult with delirium, points to the fact that they may not have the ability to recognize delirium and intervene to facilitate an optimum prognosis for the client. Their intentions may be altruistic, but in actuality their ability to act as a moral agent is inhibited by "knowledge that would have led them to judge and act differently" (p. 158). A knowledge deficit, in regards to delirium, would also be contributory to increasing levels of workload stress; a concept discussed earlier in this paper. Rodney, Brown, and Liaschenko (2004) tell us that "nurses, physicians, and their colleagues in other disciplines" (p. 159) are the primary moral agents involved in client care. They describe four types of knowledge that these moral agents would need to provide ethical client care. These are "case knowledge" (p. 159) or as described by Carper (1978) the empirical knowledge of delirium, "patient knowledge" (p.159) or comprehending the uniqueness of response to delirium, and "person knowledge" (p.159) or the way in which the person and, in the case of delirium, the family understands the meaning of this phenomena.

Rodney, Brown, and Liaschenko (2004) have also identified "social knowledge" (p. 159) or how the subjective past experiences of the patient influence their reactions to a current health care issue. Social knowledge may also be understood as the relationship between the multidisciplinary health care team members that are involved in the care of the patient. The nurses in the study by Dhalke and Phinney (2008) may have inadvertently relied on this form of knowledge as they sought to care for the delirious patient within the time constraints imposed by the care environment or through the social relationships between the nurses, the organization and other interdisciplinary team members. Rodney, Brown and Liaschenko (2004) commented that

"…both nursing knowledge and nursing work are socially-mediated processes that are part of the contextual realities of nursing practice" (p.160).

Lou and Dai (2002) found in their qualitative study that nurses identified the "concept of ambiguity" (p. 283) or their unfamiliar knowledge position on the phenomena of delirium. They did not have a clear understanding of the "definition, causes, and courses" (p.283) and these authors relate that the provision of increased knowledge pertaining to patients' experiences of delirium "can alleviate stress" (p. 288). Day, Higgins, and Koch (2008) in their participatory action research study found that the under recognition of delirium was attributable to an "education deficit across disciplines" (p.174) and that health care professionals often identified a confused state as dementia.

The lack of delirium knowledge was also evident in the study by Brajtman, Higuchi, and McPherson (2006) of the experiences of nurses caring for palliative clients with delirium. These nurses felt that if they had more information about delirium they would have an increased ability to recognize delirium in its early stages, implement effective interventions, and provide support for the family members of the clients. The nurses suggested that delirium educational programs be initiated with the nurses' learning style in mind and coordinated with their work environment. Stenwall et al. (2007) in their phenomenological study of 13 nurses found that knowledge of the client or as discussed by Rodney, Brown, and Liaschenko (2004) "patient knowledge" (p.159) would facilitate the care of the geriatric person with delirium. In other words knowledge of the uniqueness of the individual, their specific response to delirium, their preferred methods of communication, and awareness of the patient's situatedness within the context of their lives could facilitate a therapeutic connection with the patient. Prior to basing the plan of care on patient knowledge nurses may be supported to first recognize delirium in the geriatric person

with adequate empirical knowledge of the phenomena. “Case knowledge” (Rodney, Brown, and Liaschenko, 2004, p.159) of delirium would be foundational to this recognition. Once delirium has been recognized the nurse would be able to utilize the adjunct of patient knowledge to enhance the connection with the patient. This would be the polar opposite of utilizing methods of communication that were most comfortable for the nurse. Communicating with patients in this way illuminates the value of individualizing patient care to promote positive health care outcomes in delirium care. Establishing a relationship with family members or close friends was viewed, by the nurses, as the method by which they could gain access to this knowledge. Boltz et al. (2008) did not find a significant increase of nursing geriatric knowledge in practice environments that supported older adult care, but did find a significant correlation between an improved quality of geriatric care delivery and organizational resources, values, and collaboration.

A deficit of knowledge regarding the etiology, risk/precipitating factors, symptoms, communication techniques, and the management of delirium was found in 8 (40%) of the reviewed literature. In addition to these knowledge deficits; Neville (2008) highlighted the need for nurses to become knowledgeable about their use of “ageist discourse” (p.463) and the effect this may have on the care of this population. It is clear that nurses require a plethora of diverse knowledge about delirium in order to recognize the phenomena and to intervene with appropriate measures. The acquisition of this knowledge may support nurses to reduce their workload stress in caring for this population and may also promote the positive health outcomes of the geriatric person. Undoubtedly, this education is pertinent for practicing nurses, but we must also be cognizant of the current undergraduate educational content of gerontology. An aging demographic, in North America, will present new graduate nurses with multiple opportunities to

care for this population in acute care settings. It would be prudent that schools of nursing examine their curriculum for gerontological content so that these nurses may be adequately prepared to recognize and manage delirium in the geriatric person.

Organizational Culture

As stated by Rodney, Pauly, and Burgess (2004) "Culture is much more than just ethnicity. It includes individualized as well as shared values and beliefs" (p. 79). Stephenson (1999) has discussed culture in relation to the concept of ethics and the promotion of health. He identifies the broad range of meanings that culture imbues. Culture, for some individuals is "ideational" or of the mind, for others the word holds a "material" or objective (p. 69) significance. Whatever the connotation culture carries Stephenson (1999) claims that "However culture may be defined, as a universal feature of human social life it must apply equally to those who provide services and to those who receive them" (p.69). Westernized societies have, historically, viewed biomedicine as a true science based on the dominance of modern philosophies of truth as derived through sense experimentation. The preeminence of this ideological force has sustained the premise that biomedicine is neutral and free of any cultural component. Stephenson (1999) declares and, I concur, that "Modern medical science will have to recognize that it itself is a culture" (p. 70). To this end, organizational culture shapes nursing practice and health care outcomes. This context is produced through the day to day interactions of nurses with multidisciplinary team members, patients, managers, and the administrative hierarchy of health care institutions. In our contemporary health care climate the goals of these agencies seems to be overshadowed by political, social, and economic influences that strive for efficiency and cost reductions to the detriment of nurses and patients. Rodney, Pauly, and Burgess (2004) claim that the ethics of health care organizations is a relatively new endeavor, but

an argument could be made that the ethical actions needed to promote quality health care, through organizational structure, was first initiated by nursing pioneers such as Florence Nightingale. Whatever critiques may have been written about this legendary figure it is clear that she not only advocated for patients and the development of the nursing profession, but also was concerned with the ethical organization of hospitals. Lobo (2002) stated "Nightingale used her broad base of knowledge, her understanding of the incidence and prevalence of disease, and her acute powers of observation to develop an approach to nursing as well as to the management of hospitals" (p.45). The foregrounding of ethics, in this way, can illuminate the quality of nursing practice environments, changes that may be needed to ground the mission and value statements of institutions, and educational initiatives that may enhance the health care outcomes of various populations.

In this literature review, where there were reports of the organizational culture supporting care delivery models, this did not promote an environment where the older adult was valued and where nurses were supported to provide safe, ethical nursing care to geriatric clients with delirium. The nurses in the study by Dahlke and Phinney (2008) reported that the organizational culture promoted a care environment that valued efficiency, speed, and the ability to care for many different types of patient conditions. The care of the older adult, with delirium, was seen as a hindrance that consumed valuable nursing time. The nurses used strategies of what they called "buying time" (p. 44) or occupying the older adult with small tasks that would allow the nurses to spend more time with clients that they felt were more deserving. This prioritization of care based on the concept of perceived deservedness, at a micro level of the nurse-patient interaction, would be contrary to the *Code of Ethics for Registered Nurses* (CNA, 2008) in promoting justice. In order to maintain this ethical standard nurses would not prioritize care based on the age of the

person. Any form of care rationing would also not be congruent with the ethical functioning of an organizational culture. These nurses believed that the culturally driven values of the organization, health care providers, and society at large that viewed older adults as insignificant and worthless influenced the care that was provided to the geriatric person with delirium. This prioritization of nursing care may be a reflection of the relationally autonomous nursing position and the basis for moral distress when working in an organizational culture that does not support the needs of the older adult population. A care environment that did not address the specific needs of this population was seen as a deterrent to the recognition of delirium. Organizational culture that promotes efficiency and speed has become a reality, in contemporary health care systems, which position the bottom line over the quality of care. Marck (2000) has asserted that "For communities around the globe, issues with the affordability, quality, and ethics of health services relentlessly compound" (p. 62). This preoccupation with economic rationalism, driven by liberalist ideologies in the delivery of health care services, has created a nursing practice environment where the work of nursing can be compared with factory work. Marck (2000) in her dialectic of technology and nursing work revealed that nurses described their practice like being in the "line" or on a "turnstile" (p.70). They had limited amounts of time for doing the caring, healing work of nursing, but rather were overloaded with the movement of patients in and out of beds as well as the completion of pathways and checklists. Varcoe & Rodney (2001) have described the "corporate ideology" (p.103) that has pervaded health care and thus the nature of nursing work. This concentration on economics has equated into reductions to the average length of hospital stay and increases in the number of medical and surgical short stay units thereby increasing turnover and producing a higher acuity on inpatient units. "Nurses find themselves

caring for more acute patients and processing more patients more quickly" (Varcoe & Rodney, 2000, p.105).

Lou and Dai (2002) in their study using a grounded theory methodology found nurses did not feel supported by the system when caring for the delirious client and sought the support of their peers. The nurses in this study felt that "…nurse administrators pay only little attention to this problem" (Lou & Dai, 2002, p.287). Poole & Mott (2003) identified a recurrent theme of a "perceived lack of support" (p.309) particularly from the medical staff, but also from their colleagues. The lack of physician support is substantiated in the findings of a systematic review of delirium recognition rates by Steis and Fick (2008). These authors state that "If physicians are not responding to nurses' reports of symptoms of delirium (and physicians typically do not read nurses' notes), communication between nurses and physicians may be a barrier to recognizing delirium" (p. 43, as cited in Bowler et al., 1994; Laurila et al., 2004). The privileged position of biomedicine, within the organizational culture of health care institutions, has been well documented by several authors (Roberts, 1983; Carter, 1994; Diaski, 2004; Storch & Kenny, 2007) and has contributed to a lack of collaboration with nurses. Storch and Kenny (2007) stated "There has always been a tension between physicians and nurses that has made collaboration difficult" (p.479). This failure to collaborate is believed to have devastating effects on health care outcomes and may have a significant impact on delirium recognition rates. The nurse-physician relationship may be further deteriorated as physicians strive to maintain their historical position of superiority and provide their patients quality health care within a changing health care organizational culture that values cost reductions based on a business model (Frankel, Speechley, and Wade, 1996).The lack of support experienced by the nurses in the study by Poole & Mott (2003) may be a significant finding and reflective of oppressed group behavior as described by

Roberts (1983). The fact that the nurses felt unsupported by the medical staff could be interpreted as symptomatic of the historical disconnect that has existed between nursing and medicine. The dominant discourses of medicine or a valuing of cure have subjugated the care of nursing practice and contributed to a lack of interdisciplinary collaboration. Collaboration is salient to the positive health care outcomes of populations. Hanson & Spross (2009) stated "Indeed, the most important result of failure to collaborate is its negative effect on patient care" (p.295). The sociopolitical perception of biomedicine as superior can be attributed to a cultural predisposition that views medicine as a panacea to all that ails society and the gradual move to institutionalize health care. Economics have also played a role in the modern health care delivery system as medicine maneuvers to attain financial supremacy and the administration of health care agencies strive to achieve efficiency and control of costs. This struggle has alienated medicine economically, organizationally, and technically (Frankel et al., 1996). The competitive interests of these two opposing forces have seen the health of diverse populations being subjected to the concept of iatrogenic illness or "illness that results from medical care" (Frankel et al., 1996, p.81).

Social iatrogenesis, one form of iatrogenic illness, as described by Frankel et al. (1996) refers to the increasing dependence of society on pharmaceuticals, the belief that human beings cannot relieve their suffering without the assistance of medicine, the medicalization of the human life stages, the prevention of disease, and the prolongation of life. These societal values and beliefs can be exemplified in the development of antibiotic resistant organisms and the cost of excessive amounts of preventative health care screening that has turned our society in to what some have termed the "worried well" and, significantly, contributed to the rising and

unsustainable health care costs in Canada. Medicalization or the expanding control of medicine over life transitions is pertinent to older adults. Frankel et al. (1996) stated,

> "More and more aspects of growing old are becoming medicalized. Once we think of old age as a medical issue, we develop policies to perpetuate this view, providing physicians with the power to define the aging process in medical terms and thus to monopolize intervention" (p.90).

These perceptions allow biomedicine to monopolize the interventions nurses use for the detection of delirium. An example of this intervention would be the Confusion Assessment Method (CAM). I do not suggest this diagnostic tool to be without merit, but merely comment that the recognition of delirium can and should also be based on other subjective criteria such as preexisting dementia, co-morbidities, stressful events, and poly pharmacy. A combination of the Confusion Assessment Method as an "objective instrument to guide their assessment" (Steis & Fick, 2008, p. 45) as well as "time with patients, knowledge of the key features of delirium…and the support of leadership within the organization" (p. 45) may facilitate a *nursing* plan of care for older adults with delirium. The use of a singular assessment tool may engender an over concentration on an instrument or objectivity and inhibits the importance of subjectivity, within the nurse-client relationship, for recognizing delirium. In their discussion of relational inquiry Doane and Varcoe (2005) commented that "…nurses end up developing more of a relationship with the assessment tool than the families" (p.220). As stated by Tracy (2009) a blending of individualized and standardized care will result in optimum outcomes for the client and savings to the health system. The blending of biomedical tools such as the Confusion Assessment Method and individualized nursing care may provide a path to delirium recognition and intervention strategies that may support this perspective. Storch and Kenny (2008) suggest that a

blended model of care has yet to be realized due to increasing specialization, driven by technology, which limits nurse-physician collaboration in clinical settings and a medical concentration on fee -for- service that precludes the moral obligations to patient care. Storch and Kenny (2008) stated "The focus on patient safety is one example of the conundrum created by technological growth and specialization at the expense of attention to the human element of quality health care" (p. 479). Individualized and non-pharmacological interventions that can be therapeutic in treating delirium have been discussed by Chan & Brennan (1999) as an "important, but often ignored element in the management of delirium" (p.4). These would consist of limiting the amount of client bed moves, providing familiar items from a home environment such as pictures and clocks, ensuring clients have visual and auditory aids, keeping the client's room bright, and facilitating the continuity of nursing care. Some of these strategies may well be realistic for nurses to accomplish; however, others, such as providing nursing consistency would be contingent on the organizational culture and administrative priorities. Nurses are in a prime position to advocate for changes to the culture of organizations and to their administrative priorities that would see these strategies become a reality. In order to spearhead these initiatives nurses need to become educated in gerontology and specifically in the risk factors, recognition, and management of delirium. They would also perhaps be in a position to influence change if they were versed in the language of the organizational culture which seems to be predominantly based on cost and developing a business case of the effects that these strategies may have on decreasing the length of stay for the patient and preventing further hospital admissions. The clinical leadership and collaboration skills of advanced practice nurses may be required to support nurses in advocating for these changes. Olofsson, Lundstrom, Borssen, Nyberg and Gustafson (2005) have recommended that nurses be instrumental in developing such methods

due to their ongoing contact with clients, which places them in an advantageous position to recognize delirium at an early stage and intervene promptly with appropriate measures.

The participatory action research study by Day, Higgins, and Koch (2008) of eight clinicians on a medical ward of a large urban hospital in Australia found many organizational constraints to caring for the client with delirium. Firstly, lengthy delays from the emergency room to the ward, the average delay being 11 hours, contributed to clients being transferred to their unit after dark and this was seen as an obstacle to the client's orientation. Secondly, organizational policies that limited the ability of friends and family members to stay with the clients during their hospitalization meant that clients were deprived of needed emotional support. These policies did not facilitate the transmission of pertinent history and information about the client's baseline cognitive status, to the health professionals, upon which the early recognition and management of delirium could occur. "Clinicians perceived that management driven by length of a patient's stay was incongruent with best practice delirium care which required more time for older patents to recover from delirium" (Day, Higgins, & Koch, 2008, p. 170). Boltz et al. (2008) examined the nursing perception of the quality of geriatric care and the practice environment. Their data revealed that there was a positive relationship between the geriatric nursing practice environment and the quality of care received by the geriatric person. Organizational support was identified in this study as a necessary component of assisting nurses to "provide care that is special to the needs of older adult patients" (p.287).

The concept of organizational culture that perpetuated policies, guidelines, and procedures that did not support nurses to recognize delirium in older adults was located in 6 (30%) of the literature reviewed. Organizational culture supported the dominance of medicine and thus perpetuated the historical lack of collaboration between nurses and physicians. This led

the nurses to feel that they were unsupported in their efforts to achieve optimal care even though they attempted to communicate with medicine on patient status. The dominance of medical culture within the organizational structure also inhibited the use of holistic care delivery models as objective assessment tools for delirium were imposed upon the nurses without shared decision making and collaboration. Nurses also felt unsupported by their administrative nursing colleagues and perceived that caring for the geriatric person with delirium as *their* burden. Moreover, efficiency, patient turnover, and cost containment were the overriding goals of the organization in comparison to what may have been in the best interest of positive health care outcomes for delirious patients. The nurses perceived that organizational culture did not support ethical care environments that were sensitive to the needs of older adults and the increased amounts of nursing time that were necessary to recognize and manage delirium.

Discussion

Much of the extant knowledge about delirium and its corresponding etiology, risk/precipitating factors, detection, and long term effects on morbidity and mortality focuses on how nurses *should* manage the care of this population. In comparison, this review of the literature has revealed a conceptual framework, based on the *experience* of nurses, that may influence the trajectory of education, research, and clinical practice in relation to the recognition and management of delirium in the geriatric person. How can we influence the health outcomes for this vulnerable population if we do not consider all voices involved in the experience of delirium care? I posit that narrative or the experience stories of nurses can be advantageous to providing a cultural critique of the current state of delirium care. The nursing voice may facilitate a seminal body of knowledge that has the potential to increase delirium recognition rates, produce positive outcomes for the older adult, and reduce the workload stress of nurses. This

position would be analogous to the role of illness narratives Sakalys (1999) that challenge the divide between patient experience and health care culture. Gadow (1995) stated "Situations that nursing encompasses are existential places to be explored, and the only vantage points for exploration are the people living there" (p.214).

A synthesis of the conceptual knowledge gleaned from this literature review reveals that ageism, the moral distress of nurses, workload stress, knowledge deficits, and organizational culture were barriers to the recognition and management of delirium. Ageist attitudes prevented delirium recognition at an early stage especially in the hypoactive and mixed forms as nurses' presumed that confusion and lethargy were part of the "normal" aging process and not attributable to the pathology of delirium. The language of ageism was not explicit in all of the literature reviewed as a barrier to delirium recognition, but rather was framed, by some authors, as stereotyping, a devaluing of aged care that did not facilitate the advancement of technological skills for nurses, and confusion as a component of normal aging.

The concept of moral distress, experienced by nurses caring for the geriatric person with delirium, was implied in this review of the literature. Nurses had feelings of isolation and low self esteem at not being able to connect with the client due to symptoms of aggression, hallucinations, and inattention. They were also fearful of being the object of unintentional harm from the client and perceived themselves to be ill equipped to recognize delirium due to a range of knowledge deficits. These barriers may inhibit the timely recognition of delirium. One author described the nursing experiences of caring for the older adult with delirium to being "vulnerable and exposed" (Stenwall et al., 2007, p. 521). This would leave open to reader interpretation the cause of these feelings; however, the authors do go on to describe the factors that led to their assessment as an inability to connect with patients due to the unpredictably of delirium

symptoms. It is assumed that these feelings would create moral distress for nurses caring for this population.

A predominant theme gleaned from the literature was that caring for the geriatric person with delirium was a stressful event that increased an already heavy workload for the nurses. This concept was recognized in almost half of the articles reviewed and the most prevalent causes of the increased workload for nurses caring for this population were inadequate amounts of time available to spend with these individuals to meet their physical and cognitive needs, working in a care environment that was not conducive to the unique needs of older adults, and knowledge deficits that contributed to a lack of delirium recognition and making informed decisions regarding a model of care delivery for these individuals.

This literature review has also revealed that nurses lack knowledge of the etiology and risk/ precipitating factors of delirium in order to promote more comprehensive recognition. Moreover, nursing awareness and knowledge of the negative impact of attitudes of ageism was illuminated as a barrier to the timely recognition and management of delirium.

The final concept identified was that of organizational culture which perpetuated the dominance of medicine and limited collaboration with nurses about patient status. A lack of collaborative processes inhibited the ability of nurses to be multidisciplinary team members in the decisions that affected the model of care delivery for older adults with delirium. The culture of the organization also influenced the support that nurses felt from their administrative nursing colleagues. An organizational culture that valued efficiency and cost containment created a care environment that did not accommodate the unique needs of the geriatric person.

The limitations of this review are twofold. Firstly, the small number of articles (N=20) retrieved may not have been sufficient to gain a comprehensive picture of the nursing

experiences of caring for this population, but the concepts that have emerged from this literature review, may none the less provide a foundation for future research agendas. Secondly, the use of structured rules for conducting integrated literature reviews and a data collection tool for systematically reviewing and critically analyzing the selected sample (Ganong, 1987) would have strengthened the methodology, rigor, and generalizability of the findings.

A phenomenological study of nurses caring for this population using the method of focus groups may be advantageous in validating these concepts. It may also be beneficial to conduct a qualitative study of clients and families that have experienced the phenomena of delirium to draw conceptualized similarities to the findings of this review. Additionally, research design methodologies that reflect data triangulation (Halcomb, 2005) may be advantageous in validating barriers to delirium recognition. The replication of qualitative studies on the experiences of nurses, caring for the older adult with delirium, or studies incorporating any of the aforementioned concepts, from this integrated literature review, would provide depth to the disciplinary knowledge of the phenomena.

Evaluation and Recommendations

The concept of ageism that emerged, in the literature, was illuminated as a barrier to caring for the older adult with delirium. I believe that attitudes of ageism are virtually invisible to society and to health care providers; consequently, they must be made visible before we can ameliorate their effects on the care of the geriatric population. The revelation of the dominant societal discourses or "regimes of truth" (Manias and Street, 1999) of valuing youth and devaluing older age may lead to the recognition of practice that is exclusionary and unethical.

At a micro level of health care delivery the core competency of clinical leadership, within the role of advanced practice nurses, may facilitate the deconstruction of "normalized" attitudes

that influence the nursing care of this population. The authors of the reviewed literature suggest that research into nursing attitudes toward older adults/linking to gerontological organizations through the internet (Steis & Fick , 2008), staff educational sessions (Poole & Mott, 2003), educators or nurses that specialize in the care of older adults (Fussell, McInerney and Patterson, 2009), lobbying by professional nursing organizations to influence governmental health policy/collaborating with community agencies (Neville, 2008) would constitute measures that could address and ameliorate ageism as a barrier to the care of the geriatric person. The authors are not explicit about the implementation of such initiatives, but all of the suggestions would be relevant to the central and core competency roles of advanced practice nurses. The focus of clinical leadership, for advanced practice nurses, is on clients and families but also provides a supportive network of mentorship for nurses. This relationship may be the vehicle for nurses to be introduced, through educational sessions, to the method of reflective practice (Tracy, 2009) or coming to understand normalized attitudes, such as ageism, and how these philosophies influence their practice. McCarthy (2003) found that the nurses based their clinical reasoning when caring for the older adult on their personal philosophies. "The theory describes how nurses' personal philosophies about aging affect the way in which they evaluate and make decisions about older patients and how their perspectives determine their courses of logic and action" (p.98). Nursing awareness of personal philosophies and the relationship between these and the decisions that are made when caring for older adults may be the first step in an action plan, led by advanced practice nurses, which could assist nurses to recognize delirium. Additionally, McCarthy (2003) recommends that encouraging nurses to change their clinical thinking and decision making based on personal philosophies to a process based on healthy aging

will require the provision of "educational, organizational, administrative, and/or peer support" (p.99) as nursing care is situated within the context of the practice environment.

Advanced practice nursing education prepares practitioners to support and mentor nursing staff and to be able to identify areas of needed change, in the clinical setting, for the enhancement of client care outcomes. In order to facilitate the recognition of delirium, baseline cognitive assessments could be preformed on all adults, over the age of 65, when they are admitted to medical units and emergency departments or in pre-admisssion clinics when elective surgery is anticipated. Additionally, the Confusion Assessment Method (CAM) could be incorporated into surgical pathways and medical chart documentation. This would eliminate the use of multiple forms and reduce the workload stress of nurses. The daily performance of this assessment could contribute to the recognition of delirium by using a preventative approach rather than employing a wait and see attitude. Encouraging family members to stay and be involved in the care of the older adult may also reduce the workload stress of nurses caring for this population and may promote client orientation as well as reduce the effects of physiological stress.

Initiatives targeted at increasing the nursing knowledge base of delirium and its' corresponding risk factors may contribute to recognition thus promoting positive health outcomes for the geriatric person. This strategy may reduce the moral distress of nurses and the vulnerable position of patients with delirium. The promotion of positive health care outcomes for the older adult with delirium could benefit clients, families, and the health care system. Decreasing the moral distress of nurses could contribute to greater job satisfaction and retain nurses in the current practice environment. Clinical nurse educators and advanced practice nurses may be instrumental in facilitating the gerontological learning needs of staff and

recognizing delirium, its' risk factors, and the appropriate interventions. Hare et al. (2008) stated "It is recommended that cognitive assessment in general and delirium in particular be incorporated into nursing education" (p.23). Baumbusch & Andrusyszyn (2002) in their descriptive study of Canadian undergraduate curricula found that "only 8 % of clinical hours had a focus on nursing care of older adults and only 5.5% of students chose geriatrics for their final clinical practica prior to graduation" (p.119). Not only is gerontological content in undergraduate curricula limited, many faculty do not possess expertise in the care of older adults. Baumbusch & Andrusyszyn (2002) found that out of 594 participants, in their study, only 5.7% had educational preparedness in gerontology. It seems clear that in order to prepare the next generation of nurses to care for the growing numbers of older adults we must look at methods of educating the educators. McCleary, McGilton, Boscart and Oudshoorn (2009) organized the Knowledge Exchange Institute for Geriatric Nursing Education and employed the Knowledge-to-Action model (Graham et al., 2006) to enhance the instructional abilities of nursing faculty. It is plausible that this framework could be adopted by other educational institutions. Considerable debate exists on which methods should be used to integrate gerontology into undergraduate curriculums, but Baumbusch & Andrusyszyn (2002) have suggested that "…there is a need to strengthen the connections between academia and clinical practice in order to create and deliver relevant content to students" (p.126).

Providing practicing nurses with opportunities to increase their knowledge base, of delirium, also has the potential to decrease their frustration levels and workload stress. As pointed out by Lou and Dai (2002) "Providing knowledge and clarification can alleviate stress" (p.288).

Other strategies that may reduce nursing workload likely exist at a meso and macro level of health care delivery. Nursing leadership that supports and provides mentorship to nursing staff, at a meso level of health care delivery, is vital to the promotion of team building, self esteem, job satisfaction, and positive health care outcomes. The concept of transformational leadership is useful to envision a change process for effective leadership in nursing. Cameron (2002) suggests that transformational leadership is based on the philosophical beliefs that underpin a health promotion framework. The central tenets of health promotion would include empowerment, advocacy, and collaboration. She further defines transformational leadership as "a complex process of leadership that motivates members to transcend their own self-interest for a shared vision that reflects higher goals" (p. 103). This form of leadership is enacted through the use of various techniques which include being with and "listening" or hearing the issues of concern to nurses. Listening can be accomplished through regular staff meetings, surveys, feedback forums, or one on one dialogue. Leadership that is genuinely transformational does not end at this stage, but rather cycles into a "talking" (p.105) phase whereby the issues at hand are discussed collaboratively. A transformational leader would then be a facilitator of change as envisioned by the team. I believe that nurses have become disillusioned with the possibility of change as they perceive many issues to be nonnegotiable and driven by overarching hierarchical organizational structures. Attempts by organizational agencies to engage the feedback of nursing on issues that affect their work environment have been at best rhetorical.

Advanced practice nurses may also play an instrumental role at the macro level of health care delivery by providing professional and systems leadership. Professional leadership as enacted through professional organizations, at municipal, provincial, and national levels may facilitate the ability of advanced practice nurses to support both nurses and older adults. At a

system level the involvement of advanced practice nurses on ethics committees and boards could illuminate the need for changes to the values and mission statements of organizational agencies that promote social justice for the care of the geriatric person. They could advocate for health care funding that supports special clinical units that are designed to care for the specific needs of this population. Stone, Barbaro, Bhamidipati, Cucuzzo and Simon (2007) found that admitting the elderly hip fracture client to a trauma service versus a medical or surgical unit reduced the overall length of stay from 29 days to 10.27 days and reduced the mortality rate from 16.5 % to 2.1%. Specialized units may further reduce the workload stress of nurses as resources and educational measures would provide support for the nursing staff in their decision making and care of the geriatric person with delirium.

The guidelines for critiquing qualitative research by Streubert Speziale & Cameron (2009) reveals that the phenomena of interest, the purpose of the study and the significance to nursing were clearly articulated in the reviewed articles. However, only one of the articles (Neville, 2008) was underpinned by a critical gerontological philosophical framework. The language of "interrogate" (p.464) under the methodology section of this study would not be congruent with understanding the experiences of nurses caring for the geriatric person with delirium. The justification for using a qualitative design is not consistent in all of these articles; however, Fussell, McInerney and Patterson (2009) do justify a naturalistic inquiry by stating that they would be able to gain "insights into the individual and collective issues confronting graduate nurses in their natural setting" (p.212). The auditability of the studies has been integrated under the stated methodology, sampling process and data analysis methods; however, information as to the credibility of the research articles appears to be lacking. Fussell, McInerney & Patterson (2009) are the only authors that have explicitly discussed fittingness in terms of

"transferability' (p.221) of the findings. The authors have reported their findings within the context of caring for the delirious person and have included these findings in their conclusions but not all of the authors have made recommendations for future educational, practice, or research initiatives. These articles provide quality findings, but the rigor of the qualitative studies could have been strengthened through an increased use of philosophical grounding, the use of language congruent with qualitative inquiry, an explication of fittingness as it relates to delirium care, and proposing recommendations for future education, practice, and research.

Santy and Kneale (1998) provide a framework by which the quality of the quantitative articles contained in this literature review can be critiqued. The articles were published by credible nursing journals; however, the article by Steis and Fick, (2008) does not provide the date of submission to the date of publication. Double blind review is not stated on the publications, but the titles and abstracts are clear with author credibility provided. The literature reviews provided appear to be composed of primary empirical works drawn from a ten year time period prior to the publication. Portions of the theoretical frameworks are addressed in the articles throughout the introduction or the background, but a hypothesis is not clearly defined in terms of two variables in any of the articles. The methods and samples of the studies are clearly stated. Milisen et al. (2004) and Steis and Fick (2008) do not discuss ethical approval, albeit the researchers could have had spatial constraints during publication and pilot studies are not addressed in any of the articles. The articles that do discuss ethical approval could have expanded on their exact methods for the protection of human subjects but again they may have had spatial publication constraints. The reliability and validity of the studies is evident; however, Steis and Fick (2008) address only interrater reliability which would be the basis to establish validity. Most of the studies use statistical methods to analyze the data; however, Steis and Fick

(2008) discuss their analysis through the use of a grading system. Overall, the quantitative findings were presented in the form of text and graphs. In all of the quantitative articles I believe that the results could have been displayed in a more simplified manner for ease of comprehension. The researchers have provided recommendations for practice, education, and future research through the discussion heading or in their conclusions as well as illuminating the limitations of the research. I believe the findings in these studies to be rigorous, but an increased attention to delineating the time period between submission and publication, indicating double blind review, increasing the clarity of the theoretical framework, an expansion on the ethical protection of the participants and simplifying the presentation of the findings would have strengthened these studies.

It should also be mentioned that researcher bias may have influenced the findings in the reviewed studies as they illuminated only the barriers nurses experienced when caring for the geriatric person with delirium without any indication of the facilitators or positive experiences nurses may have encountered when caring for this population.

Summary and Conclusion

A rapidly aging population is changing the demographics of our North American landscape. The incidence of delirium, in the geriatric person, is anticipated to increase across all health care settings. The under recognition of delirium has the potential to produce negative health outcomes for this vulnerable population and their families. Moreover, the under recognition of this phenomena may contribute to the stress as well as the workload of a nursing practice environment that is already under strain and increase the costs for our health care system. This integrated literature has revealed the concepts of ageism, moral distress, knowledge, workload stress, and organizational culture as foundational to a conceptual framework that may

guide the nursing practice of caring for the geriatric person with delirium. Additionally, the knowledge that has been generated from this project has the potential to inform educational initiatives, practice changes, and continuing research that can enhance the health outcomes of this vulnerable population. I believe it behooves the nursing community to continue this vital work.

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Appendix A
Literature Review

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