



ORIGINAL


## Care for patients with delirium in the intensive care unit: the nurse's view

Cuidado ao paciente com delirium na unidade de terapia intensiva: o olhar do enfermeiro  
Cuidado al paciente con delirium en la unidad de terapia intensiva: la visión del enfermero


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### ABSTRACT

**Objective:** to analyze the care for patients with delirium in the Intensive Care Unit through the eyes of the nurse. **Methodology:** qualitative, exploratory, and descriptive study carried out in two adult ICUs of a public hospital in Bahia, Brazil. Twelve nurses who met the inclusion criteria participated in the study. Data were collected through semi-structured interviews and analyzed using content analysis. **Results:** the results were organized into categories which reveal that the aspects of care for patients with delirium involve acting before the prevention of delirium, the use of instruments for its identification, the interventions for the care directed to the patient, and the facilities and difficulties of nurses in the care of patients with delirium in the ICU. **Conclusion:** care for patients with delirium involves preventive measures, the use of instruments for its identification, and pharmacological and non-pharmacological actions for its treatment. Also, the performance scenario reveals facilities and difficulties related to approaching the theme, with the support provided by the health service for its performance, as unfavorable and knowledge, as a facilitator/hindrance for the management of delirium.

**Descriptors:** Nursing Care. Critical Care. Delirium. Nurses. Intensive Care Units

### RESUMO

**Objetivo:** analisar o cuidado ao paciente com delirium na Unidade de Terapia Intensiva através do olhar do enfermeiro. **Metodologia:** estudo qualitativo, exploratório e descritivo, realizado em duas UTI adulto de um hospitalar público, Bahia, Brasil. Participaram do estudo 12 enfermeiros que atenderam aos critérios de inclusão. Os dados foram coletados através de entrevista semiestruturada e analisados por meio da análise de conteúdo. **Resultados:** os resultados foram organizados em categorias os quais revelam que os aspectos do cuidado ao paciente com delirium envolvem atuar, perante a prevenção do delirium, o uso de instrumentos para sua identificação, as intervenções para o cuidado direcionado ao paciente e as facilidades e dificuldades do enfermeiro no cuidado ao paciente com delirium em UTI. **Conclusão:** o cuidado ao paciente com delirium envolve medidas de prevenção, uso de instrumentos para a sua identificação e ações farmacológicas e não farmacológicas para o seu tratamento. Ademais, o cenário de atuação revela facilidades e dificuldades relacionadas à aproximação com a temática, estando o suporte fornecido pelo serviço de saúde para sua atuação, como desfavorável e o conhecimento, como facilitador/dificultador para o manejo do delirium.

**Descritores:** Cuidados de Enfermagem. Cuidados Críticos. Delírio. Enfermeiras e Enfermeiros. Unidades de Terapia Intensiva

### RESUMÉN

**Objetivo:** analizar el cuidado al paciente con delirium en la Unidad de Terapia Intensiva a través de la visión del enfermero. **Metodología:** estudio cualitativo, exploratorio y descriptivo, realizado en dos UTI adulto de un hospital público, Bahia, Brasil. Participaron del estudio 12 enfermeros que atendieron a los criterios de inclusión. Los datos fueron recogidos a través de una entrevista semi-estructurada y analizados por medio de análisis de contenido. **Resultados:** los resultados fueron organizados en categorías los cuales mostraron que los aspectos del cuidado al paciente con delirium envuelve actuar frente a la prevención del delirium, el uso de instrumentos para su identificación, las intervenciones para el cuidado dirigido al paciente y las facilidades y dificultades del enfermero en el cuidado al paciente con delirium en la UTI. **Conclusión:** el cuidado al paciente con delirium envuelve medidas de prevención, el uso de instrumentos para su identificación y acciones farmacológicas y no farmacológicas para su tratamiento. Además, el escenario de actuación revela facilidades y dificultades relacionadas a la aproximación con el tema, donde el soporte fornecido por el servicio de salud para su actuación, como desfavorable y el conocimiento, como facilitador/dificultador para el manejo del delirium.

**Descriptor:** Atención de Enfermería. Cuidados Críticos. Delirio. Enfermeras y Enfermeros. Unidades de Cuidados Intensivos

## INTRODUCTION

Delirium is an acute neurological disorder characterized by changes in consciousness, attention, cognition, and perception, frequently observed in patients admitted to the Intensive Care Unit (ICU). It has a high incidence rate and changes the patient's ability to receive, process, store and recall information, causing disorientation and language disturbance. It can affect patients and their families indirectly and is associated with increased morbidity and mortality, length of stay in the hospital environment, expenses with hospitalization, and development of cognitive impairment after discharge from intensive care. <sup>(1-3)</sup>

The term delirium comes from the Latin "delirare", which means "to be out of place". Currently, there is a consensus that it occurs in a short period (hours or days), usually reversible, and maybe a consequence of a clinical condition such as high blood pressure, smoking, hyperbilirubinemia, intoxication syndrome, or abstinence caused by the use of alcohol or drugs even in therapeutic concentration. <sup>(1)</sup>

Despite the perception of the onset of delirium and its high prevalence, many cases are not properly diagnosed and treated due to the devaluation and/or non-recognition by the health team, leading to an underdiagnosis. Faced with this reality, the nursing team can undervalue delirium and erroneously not prioritize it in the care plan. In addition to these issues, critical patients with signs and symptoms of delirium tend to have complications considered indicators of quality of nursing work such as accidental extubation, removal of tubes and catheters, falls, increased number of days on mechanical ventilation, and self-injury. <sup>(4)</sup>

This reality and the negative implications for the individual, family, and health services demand specific attention from the multidisciplinary team to these patients, especially by nurses since the care offered by the nursing team is essential for the prevention and monitoring of this condition. The nurse who works in the ICU, when caring for people in critical condition, needs to have scientific knowledge, develop clinical and critical reasoning, and be attentive to the biological and cognitive changes peculiar to the illness and hospitalization process, which are related to the occurrence of delirium in this population to enable qualified assistance.

Thus, understanding that delirium is a multifactorial condition resulting from predisposing and precipitating factors such as the intensive care environment, <sup>(5)</sup> the early adoption of preventive, diagnostic, and therapeutic actions by nurses working in this scenario are essential. Therefore, acting means critical and specific care for nurses' work through the diagnosis, planning, implementation, and evaluation, which characterizes the work of these professionals in these units.

Knowledge about delirium in the work process of nurses in the ICU needs to be improved in planning and nursing interventions essential for the prevention, screening, detection/monitoring,

documentation, and treatment of delirium. This fact significantly favors patient safety and reduces incidents and adverse events related to delirium.

Based on this, this study follows the research question: how is the care developed for patients with delirium in the Intensive Care Unit in the nurse's view? Considering the relevance of nurses' actions in the face of delirium, this article aims to analyze the care of patients with delirium in the Intensive Care Unit through the nurse's view.

## METHODOLOGY

This is a qualitative, exploratory-descriptive study carried out in two adult ICUs of a public hospital in a city in the interior of the state of Bahia, Brazil.

This institution is the largest public hospital in its network in the interior of the state, and the only one that assists procedures of medium and high complexity in the region, a reference in urgent/emergency clinical, surgical and traumatic areas, and having the specialties of neurology, nephrology, and care for digestive bleeding. <sup>(6)</sup>

Twelve nurses participated in the research who met the following inclusion criteria: being an assistant nurse, in full professional practice in the adult ICU, and with at least six months of experience in intensive care. We excluded all those who were on vacation, on leave, on maternity leave or on medical leave.

Data collection took place between January and February 2019 through a semi-structured interview, based on questions about the strategies used by intensive care nurses for the management of delirium, means used to identify critical patients, and measures adopted for ICU control and reduction. There was no refusal by the nurses invited to participate in the research.

The responsible researcher collected the data after the previous contact with the nurses in the unit to which they were linked. We included the participants in the study after signing the Informed Consent Term (ICF). The confidentiality of the interviews was guaranteed, held in a private environment, at a time and place previously scheduled with the participants, with an average duration of 20 minutes. The researcher recorded the interviews and later transcribed them in full to ensure accuracy and minimize possible errors. The total number of participants was determined by sampling by saturation, so that, after the 13<sup>th</sup> interview, the responses began to repeat. To guarantee rigor in qualitative research, we adopted all stages of the 32 items present in the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ).

We analyzed the data in this research through the content analysis of Bardin<sup>(7)</sup> respecting the three established phases: the pre-analysis stage comprised the floating reading, the constitution of the corpus, the formulation and reformulation of hypotheses or assumptions; the exploration of the material in which we sought to find categories and the significant expressions or words according to which the contents of the speeches were organized through these

categories; and the stage of treatment of the results obtained/interpretation through the classification and aggregation of data, based on the choice of theoretical or empirical categories, responsible for specifying the theme.

The research followed ethical standards, meeting the conformities recommended by the National Health Council (CNS) set out in Resolution number 466/12 and Resolution number 510/2016 and its complementary ones. The project was approved by the Research and Development Nucleus of the institution and later by the Ethics and Research Committee of the State University of Feira de Santana, under the number of opinion 2,980,732 and CAAE: 00799318.2.0000.0053. We adopted fictitious codenames between E1 and E12 to guarantee the anonymity of the participants.

## RESULTS

The participants of this study were nurses, mostly female, between 29 and 39 years old, with an average graduation time between 11 and 20 years and working in intensive care from 1 to 5 years old. Only four had post-graduation training in intensive care and two had a master's degree.

The data analysis enabled the understanding and identification of four empirical categories, which reveal the acting and doing of the nurse's work in the care of critical patients in a situation of delirium, described below.

### Preventive aspects of delirium in the Intensive Care Unit

For the participants, the nurse's action for delirium involves prevention strategies such as the importance of the family's presence and the dialogue with these patients about their clinical condition, the identification of daily shifts, the maintenance of a favorable environment, and the monitoring of vital signs and electrolyte imbalance, as primary factors for the prevention of delirium, reflected in the following statements:

Leaving the environment quieter, less stressful, having a closer relationship with the patient, promoting a closer relationship with the family at the time of the visit [...]. (E2)

Talking to the patient, trying to guide him, guiding the family too, at the time of the visit, talking to the patient, situating him, where he is and what happened, how the house is, in short, bringing the outside world to the patient [...]. (E10)

[...] what we have today helping to improve is the presence of the family, keeping the patient well, as much oxygen as possible, because the issue of hypoxia interferes, paying attention to some medications that they can control to prevent [...]. (E9)

For example, leaving the patient always hydrated, always fed, correcting the cause, the electrolyte deficiencies that may be

happening to that patient, always being aware of vital signs [...]. (E6)

[...] that is why we have an extended visit because when the patient wakes up, the need to extubate is evaluated, the sedation is removed, the patient often wakes up without knowing where he is, what happened, without a place in space and the environment, then he ends up going into delirium. (E7)

### The use of instruments for the identification of delirium in an Intensive Care Unit

The nurses' statements express the use of a specific scale as a screening method for delirium in the ICU, according to the following narratives:

We use the CAM-ICU scale here in the ICU, interns always apply it, even we sometimes apply it. (E1)

[...] we carry out assessments, scales for assessment, to see the level of consciousness, and, apart from these scales for assessing the level of consciousness, we observe the degree of agitation, what he is showing, a change in vital signs, we analyze the monitoring data [...]. (E3)

Yes, there is the scale we apply here, some doctors do more, as well as interns and residents who apply it once a day, for sure [...]. (E8)

In the content of the statements, we observed methods of identifying delirium that does not correspond with the implementation of validated scales such as the survey of empirical data, that is, through the observation and systematic monitoring of signs of impairment of mental state, which can contribute to the underdiagnosis of delirium in critically ill patients, as we can see in the statements below:

Psychomotor agitation, agitation when he is out of the tube, when he verbalizes, wanting to get out of bed, they want to pull everything, all catheters, and tube, tube, especially when he is leaving sedation, and, usually, if he is a user of some illicit drug, it contributes a lot. (E4)

Sometimes, we don't even need to interrogate the patient, he already wakes up saying things that don't have any connection, they answer other things, you already identify quickly, he starts saying things that don't exist. I keep asking, and he keeps saying things without meaning, probably because he is disoriented [...]. (E5)

So, there are some questions that you ask the patient to know if he is oriented in time and space, evaluating vital signs, monitoring the patient all the time, observing if he accepts the diet, if he is taking the medications at the correct times [...]. (E6)

Delirium is a predictor of severity [...] when the patient is agitated, it signals that there is something wrong, requiring special attention. (E11)

### Interventions for care directed to patients with delirium in the Intensive Care Unit

The participants mentioned interventions for the care directed to the critical patient with delirium, with emphasis on non-pharmacological therapy such as the investigation of the baseline cause, promotion of a less stressful environment, the presence of a family member, guidance to the patient, and avoiding invasive measures, as we see in the following statements:

The measures that we take in the ICU are the implementation of the extended visit, we try to discourage the patient as early as possible, we leave the maximum time without sedation, we avoid invasive measures and promotion of a safe environment. (E1)

I try to correct the causes, first, we investigate, we observe what was the cause that led that patient to delirium [...]. (E6)

We are always answering doubts to the patient, even intubated. We try to remove the sedation early, informing the whole process that he is being involved. (E7)

Some participants mentioned the use of drugs as an exclusive form of treatment for delirium, others highlighted the need for non-pharmacological conduction; however, based on environmental adjustments and attention to stimuli, others highlighted the use of mechanical restraint as a tool for handling delirium, as we observe here:

Psychotropic medications are used, and also psychological support. When you recognize that the patient is experiencing delirium, medications are used even haloperidol, which is a psychotropic [...]. (E4)

When we can identify it, we usually do drug treatment, pharmacological treatment. (E9)

We use mechanical restraints if the patient has also evolved to agitation, not just verbalization. Mechanical restraint and, sometimes, also chemical restraint, the doctor ends up entering the picture with more common medications [...]. (E10)

### Nurses' facilities and difficulties in caring for patients with delirium in the ICU

Considering the complexity of delirium in the work process of the intensive care nurse, we identified the difficulties and facilities in the statements. The difficulties presented were the absence of institutional subsidies to perform the work, the patient's clinical condition, the lack of professional interest in the delirium theme, the

difficulties in time management, as seen in the statements below:

[...] the difficulty is precise because the scale is usually implemented by the medical team and there is no nursing protocol to find out and identify whether or not this person has such a diagnosis. (E2)

Generally, it is not very easy for you to identify, because if the patient has delirium, he will not know how to answer what you ask. If the patient is intubated and sedated, for example, he will not tell you what he is feeling, what he can do to improve, so that would be a difficulty. (E6)

[...] the fact that people in the ICU work a lot with the sedated, intubated patient and that there is no interaction [...], even if we become addicted to a posture and not having this conversation, this dialogue, because we take care, most of the time, of patients who are sedated, who are on ventilation and who are not responding to what we ask. (E3)

[...] now the difficulty is that I was never interested in the topic even when I had this patient, and you spoke about a relevant topic, that most people do not give importance to the real meaning, generally, most professionals do not. (E4)

[...] So, this is a difficulty, time, convincing the team that this is important is another difficulty, sometimes technical knowledge, as I already said, we think this is not ours, we think that this is from psychology, psychiatry and not from the nursing area, which is not true, so we also delegate to other areas, something that you should be doing to help the patient. (E10)

I think that we would rush to work, rush home, work, like that, I'm just for everything, I think it makes it a little difficult to dedicate time to study, to go deeper into this type of subject, I think that this complicates a little [...]. (E5)

I think, difficulty, because I read, I took a course now being updated in the ICU that had this theme, but it is not something that goes much deeper, more superficial [...]. (E8)

Time to study more, read more, participate in events that address this topic, but as far as possible we have been working on it. (E12)

[...] And difficulty, most of the time, it's time, the time in the ICU is very busy, there are times when you arrive and you leave the same way you arrive, you don't even have time for nothing, you can't drink water. (E1)

Regarding the facilities, we highlight the daily and direct contact with the patient, the previous knowledge about delirium, a taste for specialized reading reported by some interviewees, and also the work on the mental health of patients, as shown in the following statements:

The facilities are for you to work in mental health, not to have this stigma, you are always evaluating with the delirium scale, asking basic

questions, trying to observe if the patient is experiencing delirium [...]. (E2)

The facility is because it is already a daily activity, we know how to provide this assistance [...]. (E7)

[...] Facility is because we already know what can lead the patient to have that, so, if we have it in our head, the knowledge that delirium can be caused by it, then, I will act according to what the protocol says. (E6)

[...] Facilities, I like to read, this is good. (E4)

## DISCUSSION

The participants of this study think that nurses' actions for delirium involve prevention strategies, the use of instruments for their identification, and interventions for safe and targeted care for them. We could observe the difficulties and facilities that permeate the action of these professionals because of the need for an adequate assessment in the face of the changes presented by patients to instrumentalize them for the identification of delirium in intensive care.

Specifically, in the preventive aspects of delirium in the ICU, nurses assume an extremely important position due to the bedside care developed daily, reflecting a closer relationship with the patient and the consequent identification of this syndrome, enabling the improvement of quality of care and its results. <sup>(4)</sup>

The participants of this study mentioned the presence of the family, the care of cognitive guidance/identification of daily shifts, the maintenance of a comfortable environment, and the monitoring and control of vital signs as delirium prevention measures, according to the literature. However, other care developed by the multidisciplinary team stands out, especially the nursing team for the prevention of delirium in critically ill patients, such as the application of validated scales for the performance of early diagnosis, management of sedation and analgesia, mobilization in bed, guidelines to control agitation and promote sleep. <sup>(8)</sup> In this context, communication skills between the team/patient/family should be highlighted and valued in the same way as clinical skills.

The ICU environment already represents a risk factor for delirium. In this sense, the continuous monitoring of these factors is an important practice for prevention. Nurses reinforced in their speeches, the relevance of monitoring, especially in the control of vital signs, maintenance of oxygenation, correction of hydro electrolytic disorders, care with food, and reduction of stressors. A study carried out in the ICU with the participation of 157 patients corroborates the findings of this study and indicates that the monitoring of risk factors for delirium is important for obtaining preventive and patient safety measures and reducing accidental injuries. <sup>(9)</sup>

Risk factors are presented before the ICU admission and/or during a hospital stay, related to advanced age (age  $\geq$  65), underlying cognitive

impairment, previous comorbidities (SAH), trauma, and surgery before admission. During hospitalization, they are linked to the severity of acute illness, use of sedatives/vasopressors, analgesics, acute brain damage, invasive procedures, pain, emotional stress, abuse of alcohol or illicit drugs, and also metabolic disorders and mechanical ventilation. <sup>(10-11)</sup> Considering that there are countless risk factors associated with delirium, nurses need to broaden their view to identifying these factors to prevent delirium in intensive care.

Despite not scientifically describing all measures to prevent delirium, nurses knew about some fundamental aspects to reduce the manifestation of delirium. On the other hand, a study carried out with 14 intensive care nurses from a public hospital in the state of Santa Catarina pointed out that the participants are unaware of the importance of preventing delirium for the outcome of the critical patient, also demonstrated that the underdiagnosis of the syndrome is closely linked to the little knowledge, combined with the succession of wrong practices, such as the inadequacy of the environment and the abusive use of sedation. <sup>(12)</sup> In this context, the nursing management must detect the weaknesses of knowledge of the team in the identification and prevention of delirium to provide in-service education actions for these professionals, subsidizing the care that nurses provide to patients with delirium in the ICU.

The process of identifying delirium was revealed in the second category, representing a practice for the potential early recognition of the risks and symptoms of delirium, using systematic and non-systematic observation and the application of specific scales for its evaluation. Corroborating with the data found in this study, we identified that nurses use reliable instruments in their practice for detecting delirium, which is considered relevant in clinical practice, providing a correct diagnosis and safe and quality care based on science. <sup>(13)</sup>

According to the nurses' statement, the application of the instrument (CAM-ICU) was observed in the assessment of delirium for patients under their care in the ICU. Studies show that the Confusion Assessment Method for Intensive Care Unit (CAM-ICU) is a validated instrument with high sensitivity and specificity, more widely used in the intensive care unit, and manipulated by all members of the multi-professional team, with application between 2- 3 minutes. <sup>(13-14)</sup>

The nurse is the professional who provides continuing assistance to the critical patient so he needs to be qualified and instrumentalized to carry out the prevention, early detection, treatment, and differential diagnosis of the disorder to minimize the unfavorable clinical outcomes that can impact directly in the length of stay, worsening of the prognosis and increased costs of hospitalization. <sup>(13)</sup>

Even with the routine of using validated scales for the diagnosis of delirium at times, there is the application of strategies aimed at raising the symptomatic picture in a non-systematic (observational) manner, supported by empirical findings that cannot represent the syndrome. A study

reinforces that the nursing team should not rely only on empirical data to assess and diagnose the syndrome. We need to use well-defined, systematic protocols with a theoretical and scientific basis to early identify signs and characteristics of the disease.<sup>(9)</sup>

The interviewees reported several interventions for safe care directed to critically ill patients with delirium, practices that converge with the specific recommendations of this area. The broadening of the view of the professional nurse during the management of the patient with delirium for non-pharmacological measures demonstrates an advance towards the promotion of a new perspective of care, which involves low cost and is not focused on the model of the medicalization of health. In this context, management guidelines recommend the use of multicomponent and non-pharmacological interventions to control delirium. We highlight strategies to reduce or shorten delirium, with reorientation, cognitive stimulation, use of clocks; improve sleep, minimizing noise and light; improve wakefulness; promote early mobilization; reduce hearing and/or a visual impairment, which allows the use of devices such as hearing aids or glasses.<sup>(15)</sup>

We also need to highlight in the nurses' statements and in line with the recommendations in the intensive care, the policy of making visiting hours more flexible, to allow the presence of the family member in different periods, which has the potential to reduce symptoms of delirium and anxiety among patients and improve family satisfaction. However, the importance of directing attention to professionals who may have their work demand altered sometimes increased as this visitation practice may be associated with an increased risk of Burnout among the ICU multi-professional team.<sup>(16)</sup> In this sense, we need a cultural change to enable greater preparation based on protocols, educational programs aimed at preparing the family member about the routines inherent in the intensive care environment, so as not to interfere in the work process of the multidisciplinary team.

Thus, non-pharmacological management aims to act on modifiable risk factors. Similar to the statements of the participants of this study, the non-pharmacological measures used in the management of delirium were reported as a practice in the work of nurses working in intensive care, with emphasis on dialogue with cognitive guidance, use of equipment such as television, clock, windows with the incidence of sunlight to locate the patient in time and space, maintain sleep, control light and noise in the environment, restrict the use of mechanical restraint and facilitate the presence of the relative next to the patient, in addition to the benefits of non-pharmacological interventions in the treatment of delirium recognized and promoted by nurses.<sup>(17-18)</sup> However, despite the recommendation to restrict mechanical restraint, this study revealed that the intervention is frequently used in nursing care.

In this sense, we highlight that the care for the prevention and treatment of delirium should not be limited to isolated and individual factors, as these actions are comprehensive, considering the

multifactorial character of this affection. Thus, we reinforce the need for multi-professional engagement. Furthermore, the importance of professional accountability in each specific area is reinforced for the non-transfer of activities to other team members. Thus, aiming at strengthening individual and collaborative practices in the care of critical patients, it is necessary to use protocols with theoretical and scientific bases directed and delimited by each professional area.<sup>(9)</sup>

The interviewees also present other perspectives for approaching patients with delirium, such as pharmacological treatment and containment, which have not been stimulated by scientific evidence. The recommendations discourage the routine use of antipsychotic agents in the treatment of delirium,<sup>(15)</sup> demonstrating that the use of physical restraint has increased the risk of developing delirium.<sup>(19)</sup> Thus, the search for knowledge for the management of Delirium by nurses is essential to improve the management of these patients.<sup>(20)</sup>

We found some barriers in the daily practice for the prevention and management of delirium, such as difficulties due to the absence of institutional subsidies for carrying out the work, the clinical condition of the patient, mostly intubated, sedated, and with a low level of awareness. Also, there was a lack of time to improve knowledge and provide better assistance, the lack of nursing protocols that guide the patient's diagnosis, and also technical difficulties.

As a way to minimize the difficulties found, we emphasized the importance of raising awareness with the instrumentalization of these professionals.<sup>(21)</sup> In this context, the existence and implementation of a protocol and guidelines as a management proposal allow the team to plan the care for the patient, who has the risk of developing delirium, directing this care to control and balance it.<sup>(14,22)</sup> Because, in addition to directing assistance, it helps in reading the results, comparing them with indicators and other standards of care.<sup>(4)</sup>

We also listed the facilitating aspects such as daily contact, knowledge about the patient's history, previous understanding regarding the theme, the taste for specialized reading, as well as satisfaction with the work focused on patients' mental health. The knowledge to identify and prevent symptoms is important, as well as the presence of family members to promote greater patient safety. Knowledge about delirium is essential to enable preventive and control measures.<sup>(17)</sup> Therefore, the use of educational intervention contributes to the expansion of knowledge and improvements for new practices for the prevention and monitoring of delirium in patients in intensive care.<sup>(23)</sup>

In the clinical management process of these patients, communication is fundamental; however, it can be challenging with delusional patients, especially hyperactive ones.<sup>(18)</sup> In this sense, we need to promote in-service education activities for the qualification of professionals to spread knowledge about the theme and instrumentalize them to apply specific scales to support care.

There is an appreciation of delirium and its recognition by the participants as an important clinical condition in the context of intensive care. However, despite this recognition, they do not feel qualified to do so and there is a delegation of identification and care in the delirium to other health professionals, as we can see in their statements. Therefore, there is an evident need to strengthen communication between management and the nursing team, with emphasis on the importance of carrying out training and continuing education activities on the topic, so that the entire team knows the care in the prevention and management of delirium.

This study was carried out in a general ICU and a specific context, revealing the experience of the participants. Therefore, we found limitations in generalizing the results. On the other hand, we expect to collaborate, as a starting point, to carry out new research in other scenarios, with similar themes. We recommend looking more broadly at the findings by interacting with other research, in different scenarios, to create protocols, encouraging the initiative by nurse managers to promote improvement courses and realistic simulations in loco, to strengthen the nursing team's actions and actions in the care of critical patients with delirium in intensive care.

## CONCLUSION

With these exposed results, we observed that the nurse's care for patients with delirium is linked to the institution of preventive measures and to the proposals for nursing interventions and the health team in a systematic way. As prevention aspects, we highlight the importance of the family in the care process, the establishment of effective communication, and the promotion of a favorable care environment for the non-triggering of delirium.

In this sense, nurses consider that some preventive aspects can also be used after the diagnosis of delirium as intervention measures aimed at the recovery of this patient. In the identification process, they mentioned the relevance of the scales as a way to systematize the monitoring process and pharmacological and non-pharmacological interventions, with emphasis on non-pharmacological actions as treatment strategies.

Also, the performance scenario reveals facilities and difficulties related to approaching the theme, with the support provided by the health service for its performance as unfavorable and knowledge as a facilitator/hindrance for the management of delirium.

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