

**AN EXPLORATION OF THE DISCURSIVE PRACTICES THAT SHAPE AND
DISCIPLINE NURSES' RESPONSE TO POSTOPERATIVE DELIRIUM**

by

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ABSTRACT

Delirium is a common, costly, and dangerous condition, especially among older adults. Delirium is a medical emergency, which requires early recognition and immediate evaluation and treatment of the underlying cause(s) to prevent negative outcomes. Although delirium is classified as a medical emergency, it is often not treated as such by health care providers. Perhaps because of the prevailing myth that confusion is a normal change that occurs in aging adults, recognition and prognostic significance of delirium is often overlooked. Powerful discourses have served to construct delirium in such a way that it is approached as less important than other clinical phenomenon.

The aim of this study was to critically examine the language practices and discourses that shape and discipline nurses' care of older adults with postoperative delirium (POD) with a purpose to question accepted nursing practice. By illuminating these great systems, good theories and vital truths and exploring the knowledge/power link through a poststructural, Foucauldian concept of discourse, it is possible to raise questions toward new possibilities of improvements in nursing care and patient outcomes.

The study was based on data collected from face-to-face, in-depth, personal interviews with six nurses (four Registered Nurses and two Licensed Practical Nurses) who work on an acute 37 bed surgical unit which provides postoperative care for orthopedic, urology and neurology patients. This unit is located in a 450-bed tertiary care hospital in Western Canada.

Interviews were conducted at a time and place that was convenient for the participants. Data was digitally recorded and transcribed by the researcher verbatim. Five analytic readings of the data identified two prominent discourses at work in nursing practice, which influenced the care of patients with POD. These were identified as discourses of

legitimacy/illegitimacy and discourses of nursing work. Through the process of poststructural analysis it became evident that one overriding discourse served to direct, legitimize and govern all other discourses. This discourse remains the biomedical/scientific discourse.

The findings of this study have implications for nursing knowledge and practice, education, improved patient outcomes and length of hospital stay.

TABLE OF CONTENTS

ABSTRACT	ii
TABLE OF CONTENTS	iv
ACKNOWLEDGEMENTS	viii
DEDICATION	x
CHAPTER 1: INTRODUCTION	1
1.1 Background of the Study	1
1.1.2 “Don” as a Patient	1
1.1.3 Nurse as a Researcher: Exploration of the Problem	2
1.2 Exploration of Discourse.....	4
1.2.1 Biomedical/Scientific Discourse.....	4
1.2.2 Social Justice Discourse.....	8
1.2.3 Economic Discourse.....	10
1.3 Discourse Analysis.....	10
1.4 Purpose.....	12
1.5 Significance.....	12
1.6 Framework and Research Question.....	13
1.7 Assumptions.....	14
1.8 Organization of this Thesis by Chapters.....	14
CHAPTER 2: EVIDENCE BASED DISCOURSES	18
2.1 Introduction	18
2.2 Literature Review.....	19
2.2.1 Delirium	20
2.2.1.1 Delirium in Hospital Patients.....	21
2.2.1.2 Delirium in Older Adults.....	22
2.2.1.3 Delirium as an Under-recognized Symptom.....	24
2.2.2 Current Nursing Practice in Response to POD	27
2.2.2.1 Nurses’ Perceptions of Caring for Older Adults with Delirium.....	28
2.2.3 Discourse Analysis	29
2.3 Summary	33
CHAPTER 3: RESEARCH METHODOLOGY	34
3.1 Introduction.....	34
3.2 Theoretical Traditions	34
3.2.1 Poststructuralism/Postmodernism	34
3.2.2 Feminism	36
3.3 Design and Methodology	37
3.3.1 Critical Discourse Analysis	37
3.3.1.1 Foucauldian Discourse Analysis	37
3.3.2 Site and Population Selection	38

3.3.3	Ethics and Political Considerations.....	40
3.3.4	Data Gathering Methods	42
3.3.5	Data Analysis Procedures	43
3.3.6	Legitimacy of Findings	45
3.3.6.1	Verisimilitude	46
3.3.6.2	Pragmatic Value.....	47
3.4	Summary	48
CHAPTER 4: FINDINGS		49
4.1	Introduction	49
4.2	Part One: Demographic Data Representing the Nurse Participants	49
4.3	Six Vignettes	50
4.3.1	“Tanya”	50
4.3.1.1	POD	50
4.3.1.2	Respiratory Distress	53
4.3.1.3	Narrative of Difference	54
4.3.2	“Donna”	55
4.3.2.1	POD	55
4.3.2.1.1	Example #1	55
4.3.2.1.2	Example #2	57
4.3.2.2	Chest Pain	59
4.3.2.3	Narrative of Difference	61
4.3.3	“Ivan”	69
4.3.3.1	POD	63
4.3.3.2	Chest Pain.	65
4.3.3.3	Narrative of Difference	66
4.3.4	“Kirsten”	67
4.3.4.1	POD	67
4.3.4.1.1	Example #1	67
4.3.4.1.2	Example #2	69
4.3.4.1.3	Example #3.....	70
4.3.4.2	Chest Pain/Respiratory Distress.....	71
4.3.4.3	Narrative of Difference.....	72
4.3.5	“Lindsay”.....	74
4.3.5.1	POD.....	74
4.3.5.2	Chest Pain.....	75
4.3.5.3	Narrative of Difference.....	76
4.3.6	“Kathy”.....	77
4.3.6.1	POD.....	77
4.3.6.2	Respiratory Distress.....	80
4.3.6.3	Narrative of Difference.....	80
4.4	Part Two: Discourses at Work in the Narratives.....	81
4.4.1	Context.....	82
4.4.1.2	Discourses of Legitimacy/Illegitimacy.....	84
4.4.1.2.1	Discourses of Absence.....	85
4.4.1.2.2	Discourses of Classification	88

4.4.1.2.3 Discourses of Evidence.....	90
4.4.1.2.4 Discourses of Support	92
4.4.1.2.5 Discourses of Resolution	93
4.4.1.2.6 Discourses of Normalization	95
4.4.1.2.6.1 Agism is Normal	96
4.4.1.3 Discourses of Nursing Work	98
4.4.1.3.1 Characteristics of the Disrupted Work.....	101
4.4.1.3.2 Discourses of Competency.....	103
4.4.1.3.3 Discourses of Safety.....	105
4.4.1.4 Surveillance	107
4.4.1.4.1 Implicit Surveillance: The Regulating Professional Body....	108
4.4.1.4.2 Explicit Surveillance	108
4.4.1.4.2.1 Personal and Professional Reflection.....	108
4.4.1.4.2.2 Between Us Nurses.....	110
4.4.1.4.2.3 Learning From the “Experts”.....	112
4.4.1.4.2.4 Focus on the Patient.....	113
4.5 Summary.....	116

CHAPTER 5: DISCUSSIONS OF FINDINGS, IMPLICATIONS, AND CONCLUSIONS

CHAPTER 5: DISCUSSIONS OF FINDINGS, IMPLICATIONS, AND CONCLUSIONS	118
5.1 Introduction	118
5.2 Discussion of Findings.....	119
5.2.1 Theoretical Implications of Poststructural Readings.....	119
5.2.1.1 Revelation of Biomedical/Scientific Discourses.....	120
5.2.2 Description of Biomedical/Scientific Discourses.....	122
5.2.3 Biomedical Discourse Production of Discourses of Illegitimacy/Legitimacy....	124
5.2.3.1 Revelation of Two Usages of Illegitimacy	125
5.2.3.2 Rationale for Illegitimacy.....	125
5.2.4 Biomedical/Scientific Discourse Production of Nursing Work.....	128
5.2.5 Privileging the Biomedical Discourse: Surveillance.....	130
5.2.5.1 Focusing on the Patient: A Unique Gaze.....	131
5.3 Implications of This Study.....	132
5.4 Usefulness of Biomedical/Scientific Discourses	133
5.5 Methodological Implications.....	137
5.5.1 Research Positioning as an Insider.....	137
5.5.2 Positions of the Participants.....	141
5.6 Limitations.....	142
5.7 Suggestions for Future Research.....	143
5.7.1 Research in Education.....	143
5.7.2 Research in Existing Resources.....	145
5.7.3 Research in Shared Resources.....	145
5.8 Conclusions.....	145
5.9 Back to “Don”	146

REFERENCES	148
APPENDICES	166
Appendix A: Letter to Unit Manager.....	166
Appendix B: Statement for Staff Meeting.....	167
Appendix C: Recruitment Brochure.....	168
Appendix D: Nurse Consent and Information Form.....	170
Appendix E: Interview Questions.....	173
Appendix F: Demographic Form.....	174
Appendix G: Demographic Findings	175
Appendix H: University of British Columbia Research Ethics Approval Certificate.....	176
Appendix I: Interior Health Research Ethics Approval Certificate.....	177

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DEDICATION

I dedicate this work to my mother, Aileen Elizabeth Magowan (Massey) who passed away in 1997, before she could see me graduate from university or practice as a Registered Nurse. My mother began her post-secondary education in nursing, however because of poor eyesight, at that time a situation beyond her control, she was unable to continue in the field of health care. She changed her career focus from nursing to education and became a teacher. She named me after her sister Mary who was a Registered Nurse. It is only fitting then, that I have had the privilege of becoming both a Registered Nurse and an educator.

CHAPTER 1: INTRODUCTION

1.1 Background of the Study

1.1.2 “Don” as a Patient

Still, I see him. When someone asks me what lead to my interest in postoperative delirium (POD), I see him. I am walking onto the nursing ward, and there he is, in the hallway. He is disheveled, sprawled into a hard-surfaced reclining chair, wearing a restraint jacket across his chest and additional wrist restraints tied to the arms of the chair. He is working furiously, attempting to pull his hands through the wrist restraints. Meanwhile his buttocks are sliding down the seat of the chair, moving the neck of the restraint jacket closer and tighter toward his trachea, his airway, his throat. His hospital gown is pushed past his waist, revealing an incontinent pad attached at the sides with sticky tabs – a diaper for grownups. His injured ankle protrudes precariously from the chair into the traffic area of the hallway. As I move closer to him he looks up at me. I know this man!

The last time I saw him was a couple of months ago at the local golf course. He had just finished his biweekly round of golf and he stopped to chat with me about his new grandson. He and his wife were flying to Victoria in a few days to spend some time with his daughter and son-in-law and meet the baby for the first time. In the meantime he was looking for someone to take his place in his bridge club while he was away.

Now, his eyes seem to focus on me for a moment. However, immediately he becomes distracted and he looks at the wall squinting and mumbling to something or someone. He calls out “Marion! Get the phone! Call the police!”

Months later I see him again. This time he is walking toward me on the street in our small town. He looks *normal*, walking with only a slight limp. I know he has seen me, but before I reach him he ducks into his car, as if he is too embarrassed to talk to me.

1.1.3 Nurse as a Researcher: Exploration of the Problem

I work as a Registered Nurse and Clinical Practice Educator at the largest health care facility in 'Canora'. It was in this environment, precipitated in part by my experience of caring for Don that I chose to undertake my research study.

Inside this facility, health care providers attempt on a daily basis to manage the crisis of patient overcrowding. The hospital is over one hundred percent occupied on a daily basis (CBC News, March, 2008). It was in this world, working as a staff nurse, that I began to critically examine what I believed to be injustices in my workplace, and I chose to engage in research to provide important insights and knowledge into why nurses practice in a certain way and what are the driving forces that guide that practice.

For example, I noticed differences in care provided to employed, middle aged, (often male) individuals, who presented with the symptom of chest pain, compared to older adults who presented with the symptom of delirium. Both chest pain and delirium are symptoms that indicate a medical emergency. To put it simply, chest pain is a medical emergency because it may signal an attack on the heart. Delirium is a medical emergency because it may signal an attack on the brain. Yet, generally speaking, the response to chest pain results in the immediate attention of health care workers to the symptom, and thereby the patient, while the symptom of delirium does not.

I noted that this hospital provides contracts to six cardiologists and not one gerontologist. I listened to news releases from the Ministry of Health, which announced the

opening of a Neo Natal Unit as well as plans for a new Cardiac Care Center (Ministry of Health & Interior Health, News Release, February 8, 2008). Yet, an increase in long-term care beds remains elusive. In fact, not only does the government avoid responsibility for providing equal care to our aging population, it has been said that the provincial Health Minister has gone so far as to place the blame for the overcrowding issue on the elderly. For example, in a response to hospitals across the province declaring over-capacity alerts, Health Minister George Abbott has been quoted, declaring:

”British Columbia’s aging population is creating the problems that are causing cancelled surgeries and delays in emergency rooms. Older people use the health care system more, and a quarter of B.C. residents will be 65 or more in the next 15 years”.

(CBCNews.ca, March 18, 2008)

In order to investigate and critically evaluate these issues further, I enrolled in postgraduate studies where I was reintroduced to qualitative inquiry. Postmodern and poststructural approaches to research resonated with me, including the questioning of assumptions embedded in enlightenment epistemology. As Cheek (2000) points out, this includes an examination of the question: “Who and what is absent from presentations of health care [as well as] who or what is present?” (p. 5). I identified with the writings of Freire and hooks, who discuss marginalization, oppression and emancipation, and who introduced me to Foucault, (1973) who explains:

before it became a corpus of knowledge, the clinic was a universal relationship of mankind with itself...the decline began when writing and secrecy were introduced, that is, the concentration of this knowledge in a privileged group, and the dissociation of the immediate relationship. (p.55)

Through the course of my study, including continued observations in my clinical practice, I began to question whether there may be discourses at work, directing nursing practice. I wondered if these discourses served to construct delirium in such a way that it was approached as less important than other clinical phenomenon.

1.2 Exploration of Discourse

“Foucault’s notion of discourse refers to overarching systems of meaning that include language, social practices, rituals, and social relations” (Grant, Giddings & Beale, 2005, p. 498). I questioned whether certain discourses, including biomedical/scientific, social justice, economic and evidence based practice discourses had a role in constructing nursing practice, specifically regarding how nurses responded to patients who presented with POD.

1.2.1 Biomedical/Scientific Discourse

In this discourse the patient is the body (Brown & Seddon, 1996), a passive object, a collection of parts and systems manifesting a set of symptoms. A key element of this discourse in nursing care is the gathering of scientific data, through careful and objective observation and measurement, to inform the authoritative, methodical treatment of the patient (Grant, Giddings & Beale, 2004). Most often, in the case of POD, the nursing assessment is not sufficient, and the language used to describe these observations is nonspecific and vague. For example, a nurse may chart: “patient confused”, without any indication as to degree and specifics of confusion. This documentation results from a general, rather than a focused assessment. “Confusion” is a relative term, as is “chest pain”. If a nurse were to chart “patient has chest pain” without any indication of a focused assessment into the cause of the chest pain, that nurse would be labeled incompetent.

Chest pain and confusion are both symptoms of a pathophysiological response. The biological implications to the patient are serious in both instances, yet “chest pain” almost always leads to emergent practices while “confusion” does not. Foucault (1980) described how discourse is defined as language use that focuses around common assumptions and as the ability of certain groups to have power to define how such language use is controlled and shaped. In this case, the assumption is that the symptom of “chest pain” carries power while “confusion” does not.

Chest pain is a symptom that can be investigated systematically, and interventions often include advanced technology. For example, an electrocardiogram (ECG) and blood work specific for cardiac enzymes will reveal a diagnosis of infarct to the heart. If required, pharmacological interventions are geared specific to the area of the heart that is effected, which is proven by empirical testing. This is not the case with delirium. It is not yet possible to obtain a clear picture of the insult to the brain, which results in the symptom of delirium; therefore it is difficult to identify the cause. Effective treatment often involves *basic nursing care* rather than the use of *technology*; for example, you can achieve a 30% reduction in the incidence of delirium with simple measures such as rehydration, nutrition, hearing aides and eye-glasses (Inouye, Bogardus, Baker, Leo-Summers & Cooney, 2000).

While the need for immediate intervention is critical in both cases, chest pain requires a higher degree of technological intervention. Technology is valued; comfort measures are not. Frank (1991) identifies how technology is often used to objectify the body, and by doing so, patients are at risk of loosing themselves. Frank states, “the body I experience cannot be reduced to the body someone else measures” (p. 12). Empirical measures are used to

produce empirical, biomedical knowledge, which is recognized as the only legitimate knowledge.

In the case of a cardiac event, empirical knowledge is available that proves the efficacy of efficient investigations on outcomes. There is a wealth of research on cardiovascular disease, and it is a lucrative industry. Pharmacological research studies have proven the effect of specific medications to improve the efficiency of the heart (Blancett, Flynn, Akers & Smith, 2006; Barclay, Kim & Lee, 2002; Guay, 2003; Taylor, 2003; Tiffany & Barrali, 2000; Zerumsky & McBride, 2006).

In the case of a patient presenting with chest pain or shortness of breath, most nurses understand the need for focused assessment and intervention is emergent because “*time is muscle*”. For example, myocardial ischemia has great potential to cause a myocardial infarct. The end result of an infarct is irreversible damage to the heart muscle, and subsequent impaired cardiac function. The same biological principle applies to delirium: the longer the insult (for example neurological ischemia) to the brain, the greater the risk of permanent damage.

The prevailing ideology is even stronger in the general public. Most individuals understand that *chest pain* or *shortness of breath* signal a medical emergency, because these symptoms may indicate a *heart attack*. The use of an automatic external defibrillator (AED) is now taught in standard CPR classes. Public Access Defibrillation (PAD) is a movement to make AEDs readily available in many public areas such as arenas, airports and shopping centres, and groups such as the Canadian Red Cross are actively training the public to use them effectively (Canadian Red Cross, 2006). The rationale is, the quicker the heart can be restarted, the better the chance of saving a life; all that is required is the right technology (the

AED machine) and knowing how to use it. In other words, all that is required is *knowing what to do*.

On the other hand, the public does not appreciate that *confusion/delirium* should also signal a medical emergency, because this symptom may indicate an attack on the *brain*. In October 2007, Robert Dziekanski, a Polish citizen, arrived in Vancouver airport following a 13-hour flight from Poland and for eight hours “roamed the immigration lounge steadfastly insisting that his mother would soon meet him” (Truscott, 2008). Lost, confused and unable to speak English, he became agitated into a state that has recently been labeled as “excited delirium” (Stanbrook, 2008, p. 1402). The police were summoned and in a stunning sequence of events Dziekanski was pinned to the floor, shot by a taser and eventually died. Looking back on this incident from a nursing perspective informed by biomedical discourses, Dziekanski’s excited delirium may have been precipitated by factors such as dehydration, sleep deprivation, an unknown environment and exacerbated by physical restraints. It appears that no one at the Vancouver airport knew what to do.

In May 2008 an 82-year old hospital patient in British Columbia was tasered after he refused to put down a knife in his hand (BC Local News, May 07, 2008). Often nursing staff are left feeling alone and unsupported in dealing with patients exhibiting disruptive and aggressive behavior. Rogers and Gibson (2002) describe these issues of safety, “Nurses admitted to having experienced physical aggression including being ‘slapped’, ‘punched in the head’ or strangled with a stethoscope. Nurses were also the object of much verbal aggression such as rude remarks, sarcasm and name calling” p. 14). Strategies to manage the behavior of these patients include sitters, medications and restraints. Just as important as managing the behavior is identification and treatment of the underlying cause. However,

unlike identification and treatment of other acute symptoms, such as chest pain, the interventions used for delirium are not as easy to empirically validate.

In the case of POD, it is not as clear which specific interventions are effective, because interventions happen at many levels (for example, correction of electrolytes, infection and/or sleep deprivation to name a few) and by many members of the health care team, simultaneously. In POD studies, it is difficult to isolate the variables in order to obtain the same level of research data that has been gathered in cardiovascular studies. Therefore, the knowledge surrounding POD is not always recognized as legitimate knowledge, because it is not empirically based. Many of the recommendations for pharmacological intervention for managing the behavior associated with POD are based on expert opinion, which is subjective reasoning or theory, in comparison to objective statistics and empirical data. Credible empirical evidence is often generated from randomized clinical trials, which is deemed the gold standard of evidence and valued above all other evidence, including patient experience (Neville, 2005; Neville, 2006).

Frank (1991) describes his personal experience with this discourse and how frustrating it was to have physicians tell him that nothing was wrong. “I wanted to believe them, but my body insisted otherwise” (p.25). Until there was a diagnosis on the body, until X-ray images from an ultrasound revealed the presence of tumors, the subjective, personal data was not credible. Intersecting the knowledge discourse is the discourse of social justice.

1.2.2 Social Justice Discourse

A key aspect of social justice discourse is “cultural safety” (Wepa, 2003) which encompasses all aspects of social difference, for example, ethnicity, socioeconomic status,

disability, age, and gender. Patients are considered vulnerable and disempowered in relation to the medical institution and staff (Grant, Giddings & Beale, 2004).

Doris Marshall (1987) talked about how seniors become vulnerable as their world becomes smaller; this includes vulnerability to delirium. Although POD is not *normal* for the elderly, they are at greater risk for delirium because of cultural and social factors that include decreased social interaction, perhaps precipitated by decreased mobility (Inouye, 2006). In addition, other medical factors include greater fragility of the normal blood brain barrier, higher chronic disease burden, and age related changes to excretion, metabolism and response to medications (Lundstrom, Edlund, Lundstrom & Gustafson, 1999). Loss of control is a significant issue for any patient, but for elderly patients experiencing POD the losses are multiple.

Although the elderly are at higher risk, the impact of ageing on health and functioning is highly individual and, like the general population, there is considerable variation in the rate and extent to which people display evidence of physical, psychological and social health. Contrary to some common stereotypes, there is no severe decline in terms of loss of memory or intellect, or change in personality (Heath & Watson, 2006). It is not normal for people to fail to cope with routine activities unless abnormal changes occur, such as dementing illness (C. Nerdoly, personal communication February 11, 2007).

When this myth about what is 'normal' for aging prevails, and delirium is not recognized and treated, 30% of patients with delirium will not recover (Inouye, Bogardus, Baker, Leo-Summers & Cooney, 2000). Therefore, many elderly patients are unable to return to their homes and active lives and require placement in facilities. Due to the shortage of long term care beds across the province, health authorities scramble to place these

individuals in facilities. Sometimes seniors are separated from their communities, friends and even spouses, as they are placed in the “first available bed” (Interior Health, 2006). This may require a move to another community, sometimes hundreds of miles away, where they are isolated from their support groups. Browne and Smye (2002) discuss situations related to aboriginal women who face similar disadvantages and “individual and institutionalized discrimination on the basis of race, class and gender” (p. 28). Many parallels can be made between the two groups; the historical, social, political and economic inequities constrain the health and health care of both groups.

1.2.3 Economic Discourse

The issue of bed shortages is a daily dilemma for health care providers. There are never enough beds available for the number of patients who require care, and patients are regularly assigned to hallways, alcoves and corridors. Each year, in the United States, 2.5 million hospitalized older patients suffer from episodes of delirium, involving nearly half of all hospital days and accounting for more than 6.9 billion in Medicare expenditures (Inouye, 2006). These patients are often labeled “bed blockers” and hospital administrators are beginning to recognize that prevention, early detection and treatment of delirium will be cost effective. While administrators may use the rhetoric of better patient outcomes, the real driving force is economics. Better patient outcomes means that the length of stay is reduced, and therefore the surgical wait lists are reduced.

1.3 Discourse Analysis

Discourse analysis has potential to illuminate traditional ways of knowing as well as to expose the otherwise hidden and invisible assumptions that shape nursing practice (Cheek & Gibson, 1996). It uncovers aspects of practice that may not become apparent with other

research methods and provides an opportunity for identifying oppressive clinical practices and facilitating more enabling ones (Crowe, 2005). It does this by focusing on the context in which nursing practice occurs, “recognizing that at any one time there are many possible, often competing discourses in operation which vary in their authority” (Cheek & Gibson, 1996, p. 84). The discourses afforded dominance, by the silencing and marginalization of other discursive frames, are “a product of the dynamic interplay between discourses and the power/knowledge nexus from which they result” (p. 84).

There has been only one study (to date) which has investigated POD from a discourse analysis perspective (Neville, 2005). This study utilized a critical gerontology methodology to illuminate a personal discourse of delirium from the perspective of patients and families. In this study Neville also identified another discourse, which consistently provided “detailed descriptions of the pathological changes and current biomedical research findings” (p. 115) and which he titled a nursing discourse of delirium. Neville analyzed written texts including “research articles, posters, textbooks and clinical records” (2005, p. 196) as well as “texts produced from interviews with people over the age of 65 who had been delirious, their families and health professionals (two nurses and one doctor who were involved in providing a delirium service)” (2005, p. 196) in order to interpret the meanings embedded in the discourses surrounding delirium.

My research built on Neville’s work in this understudied area. Neville’s study was directed primarily at patients who had experienced POD and discourses shaping nursing practice approached from the patient perspective. Unlike the two nurse participants in Neville’s study who were members of a specialized delirium team, nurses in this study were specialized orthopedic nurses. This is the first study to conduct a discourses analysis

illuminating nursing's responses to POD through comparison with other acute medical emergencies from a poststructural perspective.

1.4 Purpose

The aim of this study was to critically examine the language practices and discourses that shape and discipline nurses' care of older adults who presented with POD with a purpose to question accepted nursing practice. By illuminating these "great systems, good theories and vital truths" (Burrell, 1988, p. 223) and exploring the knowledge/power link through a Foucauldian concept of discourse, it is possible to raise questions toward new possibilities of improvements in nursing care and patient outcomes.

1.5 Significance

Delirium leads to negative outcomes, which include increased hospital costs, lengths of patient stay and morbidity and mortality. Findings show death (Pompei et al., 1994; Inouye, Rushing, Foreman, Palmer & Pompei, 1998; Stevens, Moore & Simpsom, 1998; Cole et al., 2002; Gillis & MacDonald, 2006), prolonged stay in the hospital (Pompei et al, 1994; O'Keefe & Lavan, 1997; Gillis & MacDonald, 2006), functional decline (Murray et al., 1993; Inouye, 2006), and new nursing home placement after admission (Inouye et al., 1998; Gillis & MacDonald 2006) as independent outcomes of delirium. While delirium can occur at any age, "it is the older population who is most at risk of developing this problem, particularly as a consequence of hospitalization" (Neville, 2006, p. 114).

The population of 'Canora', which is mainly served by 'Canora Jubilee Hospital', consists of a high percentage of seniors compared to other areas of the province (B. C. Stats, May 2007). Delirium has particular importance because patients over 65 years of age account for more than 48 percent of all days of hospital care (Inouye, 2006). Moreover, the incidence

of delirium will probably increase with the aging population. Because of its potential reversibility, efforts for primary prevention, early recognition and prompt treatment of delirium are essential. However, as long as nurses lack consciousness as to how they construct delirium and contribute to its low profile in their day-to-day work with this patient population, positive patient outcomes will remain elusive. Nurses are on the frontlines of health care and are in prime positions to assess these patients and collaborate with other health care providers to reduce the potentially negative outcome of delirium and return the patient to a previous or higher level of mental and physical functioning.

This research serves to raise consciousness and illuminate the discourses that construct and discipline nursing practice of this very significant health challenge. This challenge increases in importance with an aging population. Although POD is a medical emergency it is not treated as such, perhaps because of prevailing discourses that inform nursing practice. Through critical analysis discourses are challenged and reshaped to inform new practice. As actors in these discourses nurses have great power to produce new realities and thereby improve (decrease) the length of patient stay in the hospital and ultimately improve patient outcomes. This study explores why nurses practice in a certain way, and what are the driving forces that guide that practice. This research exposes not only the discourses present in the care of patients with POD, but also identifies the discourses which are absent, and explores reasons why some discourses are given a stamp of approval while others are deemed invisible.

1.6 Framework and Research Question

The framework informing this research was constructed drawing on aspects of poststructuralism/postmodernism, feminism and critical discourse analysis. Thus framed by

a Foucauldian poststructural lens the research question guiding this study was: With a focus on the orthopedic patients on '2A' at 'Canora Jubilee Hospital', what are the key discourses that shape and discipline nurses' response to POD? In other words, how do these discourses implicate practice in terms of how nurses respond to POD? Sub-questions included:

1. What does nursing practice (valid at a certain place and time) consist of, and what discourses shape and govern this practice, including the unspoken and unstated assumptions that are implicit in this practice?
2. How do changing discourses influence the evolution of this practice?
3. How is this practice passed on, and what discourses discipline the dissemination of practice?
4. What function do these discourses have for nursing practice, the constitution of subjects and the shaping of society; how do they operate to marginalize and exclude others?
5. What impact do these discourses have on nursing practice that results on the overall development of society; how do they represent political interests and webs of power?

1.7 Assumptions

Knowledge is a discursive practice. Within nursing knowledge there exist dominant and competing discourses. By identifying these discourses it is possible to examine the productive qualities of discourse in nursing practice.

1.8 Organization of This Thesis by Chapters

Chapter One was the introduction. I introduced postoperative delirium as the topic of my study and positioned myself as a Clinical Nurse Educator engaged in a study situated in a poststructural research paradigm. I explored the problem of POD and connected the problem

to an investigation of discourse. I introduced three discourses that I found to be problematic, and questioned whether these discourses may be at work in nursing practice to construct delirium in such a way that it is deemed less important than other clinical phenomena. Finally, I outlined discourse analysis as a way to investigate this question further and presented the purpose, significance, framework, research question and assumptions of my research study. I conclude the chapter with this summary of the organization of this thesis.

Chapter Two frames the traditional literature review within the context of discourses of evidence based practice (EBP). The focus is on the discursively constituted object of POD, current nursing practice related to POD, and discourse analysis relating to both. It begins not only by situating POD within the EBP discourse, but also exposes EBP as a dominate discourse which has been taken up by nursing. Working within the EBP discourse I explain what we have learned about delirium, giving recognition to both the quantitative and qualitative work that has already been undertaken. I present what the literature states regarding the patient presenting with delirium in the hospital setting and particularly the older postoperative patient. In addition I illustrate what is understood about how nurses *should* and how nurses *actually* care for these patients. Finally, I conclude the chapter by focusing EBP through a poststructuralist lens, and thereby problematizing the continued debate regarding what constitutes *best practice* in caring for patients with POD. In so doing, I identify the need for qualitative inquiry and specifically discourse analysis in order to build further meaning around nursing practice related to POD.

Chapter Three outlines my research methodology, beginning with the theoretical traditions that informed my work; I offer an explanation of the meaning of these traditions including poststructuralism/postmodernism and feminism. I describe my design and

methodology, which incorporated critical discourse analysis. I focus my explanation and discussion of critical discourse analysis through a Foucauldian lens. I illustrate the selection of my site and population as well as data gathering methods and data management including data analysis. I outline the ethical and political considerations and how those were addressed. Lastly I address questions of validity.

Chapter Four is divided into two parts. Part one presents the findings of my research. These findings are introduced by a demographic illustration of the six nurses who participated in my study. Their responses are presented in six vignettes, representing a narrative summary of each of the participant's interviews, and illustrating what nursing practice (valid at the place and time where the study took place) consisted of. Part two presents my analysis of the vignettes, specific to the research question. I identify from the findings what discourses shaped and governed the practice of nurses, including the unspoken and unstated assumptions that were implicit in their practice. Applying a poststructural, postmodern Foucauldian critical discourse analysis lens, I focus my discussion on two prominent discourses at work in the narratives. These include discourses of legitimacy/illegitimacy and discourses of nursing work. Other discourses which move within and between these prominent and dominant discourses are offered as they relate to the research question. I did not attempt to give an overview of each and every discourse at work in the narratives; rather I chose the discourses that are most salient to the research question, relating to nursing practice of caring for patients with POD.

Chapter Five continues the discussion of my findings specific to how these discourses influence nursing practice. I begin with a discussion of the theoretical implications of poststructural theory. By means of this poststructural lens I present the revelation of how

biomedical/scientific discourses were at work in the participant's narratives describing nursing practice. I proceed to reveal how all other discourses identified in the findings relate to these overriding biomedical discourses, and how biomedical discourses influenced the evolution of nursing practice. I discuss how this practice is passed on and how biomedical discourses discipline the dissemination of nursing practice. Congruent with discourses of biomedicine/science I relate my findings to current literature (EBP) regarding the topic of POD and discuss the relevance and value of adding my findings to this body of knowledge. I proceed to a discussion of the implications of my study for nursing practice specific to the care of patients presenting with POD, as well as the overall development of beliefs in society around delirium and I identify needs for further research. Finally I end with a conclusion of this thesis work.

CHAPTER 2: EVIDENCE BASED DISCOURSES

2.1 Introduction

The profession of nursing has generally embraced evidence based practice (EBP) based on the assumption that it will result in *best practice* (Holmes, Perron & O’Byrne, 2006). “As an ideology [EBP] has penetrated the consciousness, discourse and working practice of individuals” (Rycroft-Malone, 2006, p. 95). EBP is in and of itself a discourse and a seductive one at that, as it serves to produce ‘taken for granted’ assumptions that EBP is “the favored path for the development of nursing knowledge” (p. 95), by using language such as “best evidence, best practice, and best quality” (p. 95). This language has great power in nursing practice to produce what constitutes a new regime of truth (Holmes & Gestaldo, 2004). The fixing of a set of *truths* about delirium as focused on the older body is reflected in the published medical and nursing literature (Neville, 2005).

Proponents of the evidence based movement will affirm that what counts as *best* is “always a provisional recommendation, subject to revision as better evidence becomes available” (Holmes, 2006, p. 188). From a Foucauldian poststructural/postmodern perspective it can be argued that it is beneficial to deconstruct and examine the implications of this discourse without discrediting “one method of knowledge development and [leaving] the other as the true method” (Holmes, Perron & O’Byrne, 2006, p. 101). Therefore, the focus of this chapter is to acknowledge the research findings regarding delirium and identify gaps in that literature, while simultaneously illuminating that EBP, constructed as *best practices* are powerful discourses which are historically informed and governed by biomedical discourses.

2.2 Literature Review

Many quantitative studies have been published on the clinical presentation, etiology, risk factors and consequences of delirium constructed according to the biomedical model (Britton & Russell 2003, Fick, Agostini & Inouye, 2002; Milisen, Lemiengre, Braes & Foreman, 2005; Siddiqi, House & Holmes, 2006; Van Rompaey, Schuurmans, Shortridge-Baggett, Truijen & Bossaert, 2007). The importance of this medical knowledge and scientific understanding of delirium must be acknowledged. It was through scientific investigations that delirium was identified as a syndrome (consisting of a number of symptoms) and linked to a number of possible causes including medications (particularly medications with anticholinergic effects), infection, sleep deprivation, hypoxia, malnutrition and electrolyte and fluid imbalance (Ferrando & Freyberg, 2008; Foreman & Zane, 1996; Foreman, Mion, Tryostad, Fletcher & the NICHE Faculty, 1999; Ignatavicious, 1999; Panharipande et al., 2008). As well, many effective preventative measures and treatment interventions are also based on the biomedical/scientific model (Bagri, Rico & Ruiz, 2008; Lemstra, Kalisvaart, Vreewijk, van Goot & Eikelenboom, 2008; Maldonado, 2008a; Maldonado, 2008b; Redelmeir, Thiruchelvam & Daneman, 2008).

The contribution of nursing to this body of knowledge continues to grow (Abdallah, Remington, Devereaux Melillo & Flanagan, 2008; Antai-Otong, 2003; Balas, et al. 2007; Beck, 2008; Burns, 2003; Dyson, 1999; Fick, Agostini & Inouye, 2002; Kratz, 2008). However there remain few studies focusing on delirium in the elderly population from a qualitative perspective (Brajtman, Higuchi & McPherson, 2006; Namba, Morita, Imura, Kiyohara, Ishikawa & Hirai, 2007; Neville, 2006; Sorensen Duppils & Wikblad, 2007) and a significant criticism has been that the limitations of positivist approaches to nursing research

fails to acknowledge the social and cultural context of the research question (Crowe, 2005). The following literature review focuses on the discursively constituted object of POD, current nursing practice related to POD, and discourse analysis relating to both.

2.2.1 Delirium

Delirium is a common, costly, and dangerous condition, especially among older adults (Anti-Otang, 2003; Balas, et al., 2007 Inouye, 2003, Kiely et al., 2009). Delirium is a medical emergency, which requires early recognition and immediate evaluation and treatment of the underlying cause/s to prevent negative outcomes (Inouye, 1999; Britton, Hogan-Doran, & Siddiqi, 2007; Cole, et al. 2002). Delirium has been defined as “a transient organic brain syndrome characterized by the acute onset of disordered attention and cognition, accompanied by disturbance of psychomotor behavior and perception (Lipowski, 1990, p. 41). It is a mental disorder characterized by a cluster of fluctuating symptoms (Cole, et al. 2002, Dyson, 1999); it has multiple mechanisms and is a potentially reversible impairment of cerebral oxidative metabolism and multiple neurotransmitter abnormalities cause by acute medical illness (Foreman, 1992; Inouye, 1999; Litton, 2003). It is not a disease. It is a syndrome represented as a set of *symptoms* of a pathophysiological response (Marcantonio, Flacker, Wright, & Resnick, 2001) much like a fever is symptom of an infection. It is the brain’s way of demonstrating acute organ dysfunction (Cole, et al. 2002); anything that hurts the brain or impairs its proper functioning can provoke a delirium. Delirium is also a medical emergency. If the cause of the delirium is not identified, and immediate interventions are not initiated, the patient is at great risk for irreversible neurological deficits and even death (Pompei et al., 1994; Inouye, Rushing, Foreman, Palmer

& Pompei, 1998; Inouye, 1999; Inouye, 2006; Schuurmans, Duursma & Shortridge-Baggett, 2001).

2.2.1.1 Delirium in Hospital Patients

Delirium has been described as a *consequence* of hospitalization (Caplan, Coconis, Board, Syers & Woods, 2006; Lipowski, 1990). Certainly, precipitating factors including relocation, sensory overload, sleep deprivation and invasive procedures such as urinary catheterization and intravenous insertion may contribute to delirium (Rogers and Gibson, 2002). Delirium occurs in diverse settings in the hospital, for instance, not only medical and surgical areas, but also rehabilitation and emergency wards. There have even been documented cases of delirium in older adults immediately following cataract surgery (Milstein, Barak, Kleinman & Pollack, 2000). New studies are investigating delirium in the pediatric population (de Carvalho, 2008; Turkel & Tavaré, 2003) and maternal/child nurses are beginning to question whether delirium, precipitated in part by sleep deprivation, may be a contributing factor to post partum depression (M. Ryder Howell, personal communication, September 22, 2008).

The incidence of delirium in the hospital setting is highest in the ICU (Bourne, 2008; Devlin, et al., 2008; Pandharipande, et al., 2008; Webb, Carlton & Geehan, 2000) “estimated incidence rates are approximately 30-73%” (Chang, Tsai, Lin, Chen & Liu, 2008, p. 568). Postoperative patients are at particular risk because factors such as anaesthesia, hypothermia, hypotension, hypoxia, electrolyte and/or fluid imbalance contribute to delirium.

The type of surgery affects the delirium rates. The incidence is highest after orthopedic procedures, with a range of 16% to 62% after femoral neck fracture repairs. Estimates for delirium after vascular surgery are 29.1% to 42.3%. The incidence of postoperative

delirium after cardiac surgery is 8.4% to 41.7%. After general surgery, delirium occurs 7% of the time, but estimates increase to 26% after major abdominal surgery for cancer (mainly colectomy). Emergency surgery, as opposed to elective surgery, may also increase delirium risk. (Bagri, Rico & Ruiz, 2008, p.670)

Of the patients who experience surgery, orthopedic patients who experience emergency surgery (for example patients who require surgery for a fractured hip) are “nearly twice as likely to experience [delirium] as patients undergoing planned, orthopedic surgery (Rogers & Gibson, 2002, p. 10).

2.2.1.2 Delirium in Older Adults

Although confusion is not *normal* in the older adult, this patient population is at increased risk for delirium. Numerous cohort and randomized studies consistently demonstrate the relationship of older age to increasing incidence of delirium (Bowman, 1997; Eriksson, Samuelsson, Gustafson, Aberg & Engstrom, 2002; Galanakis, Bickel, Gradinger, Von Gumpfenberg & Forstl, 2001; Kalisvaart, Vreeswijk, de Jonghe, van der Ploeg, van Gool & Eikelenboom, 2006; Leung, Sands & Wang, 2006; Litaker, Locala, Franco, Bronson & Tannous, 2001; Norkiene et al. 2007; Rudolph, Jones, Rasmussen, Silverstein, Inouye & Marcantonio, 2007; Vaurio, Sands, Wang, Mullen & Leung, 2006; Yildizeli, Ozyurtkan, Batirel, Kuscu, Bekiriglu & Yuksel, 2005). Reasons for this include reduction in physiologic reserves, immobility and poor functional status, vision and hearing impairment and increased frailty (Bagri, Rico & Ruiz; Inouye, Studenski, Tinetti & Kuchel, 2007). Delirium has been labeled as a frequent form of *psychopathology* occurring in hospitalized elderly patients (Inouye, Rushing, Foreman, Palmer, & Pompei, 1998; Marcantonio, Simon, Bergman, Jones, Murphy & Morris, 2003; McCurren & Cronin, 2003;

McLafferty & Farley, 2007; Sties & Fick, 2008) with a prevalence of 10-31% (Lipowski, 1987) at the time of admission. The post admission (during the period of hospitalization) incidence of delirium ranges from 5 to 86% depending on the population studied, the criteria used for diagnosis and the methodology used to guide the study. (Brauer & Siberzweig, 2000; Francis, Martin & Kapoor, 1990; Francis, 1992; Irving, Fick & Foreman, 2006, Wang & Menten, 2006). For example, delirium incidence in intensive care patients has been documented as high as 80% (Ely et al., 2001) and delirium incidence in older adults patients with hip fracture remains significant, averaging 40% (Galanakis, Bickel, Gradinger, Von Gumpfenberg & Forstl, 2001).

In cognitively impaired hospital patients (MMSE score < 24), 45% have been shown to develop delirium (Rockwood, et al. 1994). These patients have longer lengths of stay and a higher rate of complications, which together contribute to an increase in cost of care for these groups of patients (Cole & Primeau, 1994; Franco, Litaker, Locala & Bronson, 2001). The combination of being elderly and chronically cognitively impaired leads to high risk of delirium with the associated increased risk of prolonged hospital stay, complications and poor outcomes (Law, 2008; Lyons, Grimley & Sydor, 2008). Postoperative delirium in older people predicts a poor outcome in cognitive and functional status (Bagri, Rico & Ruiz, 2008; Lemstra, Kalisvaart, Vreeswijk, van Goot & Eikelenboom, 2008; Redelmeier, Thiruchelvan & Daneman, 2008; Rudolph et al., 2008; Wong, Wong & Brooks, 2002)

Although delirium is classified as a medical emergency, it is often not treated as such by health care providers. Perhaps because of the prevailing myth that confusion is a normal change that occurs in aging adults, recognition and prognostic significance of delirium is often overlooked (Bradley, Webster, Baker and Inouye, 2004). Nurses are in an ideal position

to recognize and therefore intervene with delirium because generally they spend more time with the patient than other health care providers (Foreman, 1986; Linck & Phillips, 2004; Litton, 2003).

2.2.1.3 Delirium as an Under-Recognized Symptom

A thorough review of the nursing literature revealed a multitude of articles about how nurses *should* assess and care for older adults with delirium (Brajtman, Higuchi & McPherson, 2006; Cole et al., 2002; Hewitt, 2002; Kane & Kurlowicz, 1994; Kratz, 2008; Linck & Phillips, 2004; Litton, 2003; McCurren & Cronin, 2003; McLafferty & Farley, 2007; Naughton, Saltzman, Ramadan, Chadha, Priore & Mylotte, 2005; Pitkala, Laurila, Strandberg, Kautiainen, Sintonen & Tilvis, 2008; Schuurmans, Duursma & Shorridge-Baggett, 2001; Voyer, Cole, McCusker, St-Jacques & Laplante, 2008; Wasznski & Petrovic, 2008). The key principles guiding care of the patient with POD reflect the centrality of the nursing process (which generally has not changed over the last few decades) and includes recognition, assessment, nursing diagnosis, planning, implementation, and finally, evaluation of the outcomes (Kozier, Erb & Blais, 1992). Specific to delirium this includes recognizing the symptom presented as a change in behavior, assessing with a validated assessment tool such as the Confusion Assessment Method (CAM) (Inouye, van Dyck, Alessi, Balkin, Segal & Horwitz, 1990; Inouye, 1999), investigating the cause of the change of behavior, intervening to correct those causes, managing the behavior in order to keep the patient safe, and evaluating outcomes of interventions. This general process of recognition, assessment, diagnosis, planning, implementation and evaluation is no different than the process a nurse would use to identify and treat other symptoms indicating an acute onset in the patient, including chest pain.

However, just as patients who experience cardiac related issues can expect a consult to a specialist group of care-providers, patients who experience geriatric related issues should receive a consult to a geriatric group of care-providers. “Gerontological nursing is a distinct nursing specialty with a specific set of knowledge and skills required in order to provide a nursing service that meets the needs of the older adult in a timely manner” (Neville, 2006, p. 116), yet the consult to gerontology does not often follow. Reasons for this include the invisibility of geriatrics; either there is no one to consult, or staff are unaware of who to consult.

A recurring theme in the literature is that delirium continues to go unrecognized by health care professionals including nurses (Dunn, Adams and Adams, 2008; Fernandez & Likourezos, 2008; Fick, Hodo, Lawrence & Inouye, 2007; Inouye, Foreman, Mion, Katz & Cooney, 2001; Irving, Fick & Foreman, 2006; Inouye, Studenski, Tinetti & Kuchel, 2007; Irving & Foreman, 2006). Reasons for nurses’ lack of recognition of delirium vary although inadequate education and challenging workloads have been suggested as two possibilities. As well, “shorter hospital stays mean less opportunity for nurses to get to know older people who are delirious” (Neville, 2006). Neville argues that due to a decrease in days spent in the hospital, nurses should acknowledge the personal expertise of the patient in knowing him or herself; in other words, shifting the emphasis from the expertise of the health care provider onto the older person knowing what they need.

Fick and Foreman’s (2000) study revealed that despite nurses having received education about delirium, 75% reported they did not know the difference between delirium and dementia. This finding suggests that factors other than education influence nurses’ lack of recognition of delirium. Other studies have implied that shorter hospital stays combined with

managing the often challenging behaviors of older adults with delirium contribute to increased nursing workloads (Brannstrom, Gustafson, Norberg & Winblad, 1989; Neville, 2006). The increased workloads nurses experienced limited their opportunities to spend time assessing and caring for the older adults with delirium, thus perpetuating a cycle in which delirium is not recognized and nurses' workloads are increased (Rogers & Gibson, 2002).

The practice of not recognizing, not intervening with, and not documenting about delirium is not unique to nurses; physicians and other clinicians also fail to respond to delirium, which compounds the problem and contributes to poor management (Fricchione et al., 2008; Lang, Clark, Gustafson, Brannstrom, Norberg, Bucht & Winblad, 1991; Medina-Walpole & McCann, 2008; Milisen et al., 2002; Potter & George, 2006; Ski & O'Connell, 2006; Tropea, Slee, Brand, Gray & Snell, 2008). One study reported:

The physician's documentation in the medical records of these participants was devoid of any mention of delirium. No formal diagnosis of delirium was made, nor were any of the common synonyms of delirium (e.g., confusion) found in the physicians' documentation. Moreover, none of the clinical indicators of delirium were used as a means for describing the behavior of these patients. (Milisen et al, 2002, p. 24)

These findings have prompted medical associations and colleges to deliver strong language and policy to physicians in order to promote practice change (Potter & George, 2006; Tropea, Gray & Snell, 2008).

Although there has been demonstrated effectiveness of interdisciplinary programs, such as the Hospital Elder Life Program (Inouye, 1999; Inouye, Bogardus, Baker, Leo-Summers & Cooney, 2000) these programs face significant challenges during initial implementation. These challenges include gaining internal support despite differing goals of administration

and clinical staff, ensuring clinical leadership, integrating with existing geriatric programs (coordination vs. competition), balancing program fidelity with local resources (reduce duplication), documenting positive outcomes despite limited resources for research, and maintaining momentum despite unrealistic timeframes, limited resources and staff turnover (Inouye, Studenski, Tinetti & Kuchel, 2007).

Once these programs are in place challenges to sustainability include “presence of clinical leadership, adaptation to local circumstances and obtaining long term funding” (Inouye, Studenski, Tinetti & Kuchel, 2007, p.786). Therefore it is clear that in order for nursing practice to change, nurses must be supported, and an interdisciplinary approach (including administrative support and funding) must be adopted to share in management of these acutely ill patients (Bradley, 2006; Brajtman, Hall, Weaver, Higuchi, Allard & Mullins, 2008; Day, Higgins & Koch, 2008; Lang, Clark, Medina-Walpole & McCann, 2008).

2.2.2 Current Nursing Practice in Response to POD

Few studies have explored how nurses actually care for patients with delirium, possible reasons for under-identification of delirium in older adults, and nurses’ perceptions about delivering care for this patient population (Dahlke & Phinney, 2008). This smaller body of literature provides some evidence that nurses rely on orientation in their assessment, even though this is one of the least sensitive markers of delirium (Budd & Brown, 1974; Fick & Foreman, 2000; Rogers & Gibson, 2002). In a proposed mixed-method study (Rice, 2008) provided “additional support and confirmed the significance of the problem of nurses’ under-recognition of delirium” (p. iv) through completion of phase I (quantitative portion) of the study. Phase II (qualitative portion) was intended to further enhance understanding of staff

nurses' recognition of delirium in the hospitalized older adult (the *how* and *why* of nursing practice). "Phase II was not completed because nurses refused to participate" (p. iv).

Other studies have identified strategies nurses use to promote safety, such as constant care providers and sitters (either family members, friends or unlicensed care providers) who provide surveillance by watching over the patients, moving the patient closer to the nursing station or into the hallway, and pharmacological and/or physical restraints (Lou & Dai, 2002; Neville, 2006; Rogers & Gibson, 2002; Williams et al., 1979). Rogers and Gibson (2002) describe some of the approaches nurses use to manage confusion in their study.

The nurses in the study described five major strategies to manage confusion: Constant surveillance, elimination of underlying causes, human caring, reorientation strategies and strategies for disruptive patients. The nurses' primary focus was the safety of the patient. If the patient was quiet, nurses tended to observe him from the periphery.

Nurses emphasized the trial and error nature of interventions, need for consistency of approach, and warned that what works for one patient may not work for another. (p. 12-13)

Nurses' practice of managing delirium has been linked to nurses' perceptions of caring for older adults in general, as well as specifically caring for older adults with delirium (Neville, 2005; Neville, 2006; Rogers & Gibson, 2002).

2.2.2.1 Nurses' Perceptions of Caring for Older Adults with Delirium

Only a small number of studies explored nurses' perceptions of caring for older adults with delirium. In many of these studies, nurses' experiences of moral distress were reported as secondary factors to the main focus of the study (Andersson, Hallberg & Edberg, 2003; Brajtman, Higuchi & McPherson, 2006; Breitbart, Gibson & Tremblay, 2002; Neville, 2006).

In other studies, the instruments were inadequate (Milisen, et al., 2004), or the sample lacked sufficient numbers to be confident in the rigor of the findings (Lou & Dai, 2002). A noted exception is Rogers & Gibson's (2002) rigorous study that found moral distress was evident in self-reports of nurses' decreased self-esteem and threatened personal safety when caring for older adults with delirium. In this study the authors identified that nurses used innovative strategies to cope with what they often identified as the "time-consuming, frustrating, challenging and exhausting" (p. 14) task of caring for delirious patients. These strategies included creative staffing and using male nurses to communicate to the female confused patient; interestingly, the female delirious patient "may settle down when they hear a male voice" (p. 13).

2.2.3 Discourse Analysis

While discourse analysis as a research method has been described in many research methods texts (Denzin & Lincoln, 2005; Cheek, 2000; Glesne, 1999; Green & Thorogood, 2005; Palys, 2003; Parker, 1992; Patton, 1990; Silverman, 2002; Wood & Kroeger, 2000; Wodak & Meyer, 2006) and is being used increasingly in nursing research (Browne & Smye, 2002; Cheek, 2004; Cheek & Gibson, 1996; Cheek & Porter, 1997; Crowe, 2005; Fox, 1993; Grant, Giddings & Beale, 2004; White, 2004; Wicks, 1995), there remains a gap in the literature in terms of discourse analysis and POD. In fact, after an extensive literature search, only one article was obtained which used a postmodern discourse analytic approach to investigate delirium (Neville, 2006).

Neville's work was informed by critical gerontology which serves as a methodology to critique and challenge positivism (Neville 2005; Neville 2006; Neville & Wilson, 2008). "By problematizing positivism, critical gerontology questions the basis for knowing about ageing

being measured solely through objective means” (Neville, 2006). Neville sharply critiqued the process of naming the behavioral aspects associated with delirium using diagnostic tools such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the Confusion Assessment Method (CAM), which he argued extended the authority and expertise of the medical discourse controlling these unusual behaviors:

The positioning of delirium within a respected and highly influential classification system such as the DSM, has resulted in a proliferation of delirium screening tools to aid with the diagnosis that have been specifically designed for use by doctors and nurses. These tools have both a diagnostic and prognostic function and therefore can serve a disciplinary function through the use of the clinical gaze as a means of social control (Foucault, 1994). The meanings that arise out of diagnostic tools specifically related to delirium say something about the older person’s past, present and future. The medical discourse can therefore determine the ‘truth’ about delirium through the use of these tools. (2005, p. 78-79)

Neville went on to assert:

by supporting screening tools like the CAM in respected refereed journals The American Psychiatric Association, who publish the DSM, cement their authority on what constitutes the ‘truth’ about delirium in older people. This ‘truth’ is constructed through the setting of research agendas, establishing research priorities, the political lobbying for research, the production of lay knowledge, the structure and function of health professions and hospitals (2005).

Neville explained that Inouye (1999, 2000, 2001, 2003 & 2006) as well as other expert clinicians and researchers:

[have] eloquently linked the incidence of delirium in older people with increased hospital stay and therefore cost. The reduction of the costs associated with health care is a major focus of health care institutions. Consequently, health professionals working in hospitals become preoccupied with treating the physical problem, for example delirium, at the expense of addressing the social and cultural needs associated with being a consumer of a health service. Hospitals, which are sites associated with medical and nursing practice, allow the emergence and maintenance of specific clinical practices associated with older people who are delirious. These clinical practices frequently focus on the disease while largely ignoring the person. (2005, p. 82)

Neville's (2006) findings included identification of a nursing discourse of delirium, which consistently provided "detailed descriptions of the pathological changes and current biomedical research findings" (p. 115). He also identified a smaller body of work, which explored "the experience of delirium from the perspective of the older person" (p. 115). He affirmed that "biomedical discourses underpin medicine's understanding of ageing and consequently the personal aspects of being delirious are not given primacy" (P. 118).

Neville attributed the changing health care environment to the challenges that gerontological nurses face in their ability to remain patient centered. "These changes include shortened hospital stays, increased patient complexities, the use of sophisticated biomedical technologies and the increasing utilization of untrained caregivers" (2006, p. 118). His study resisted a biomedically focused health service and instead promoted a hospital setting specifically focused on the older population that espouses "the essence of gerontological nursing practice, holism and patient centered care through the deployment of a personal discourse of delirium" (p. 118).

Although this may seem like a dream, especially in today's health care climate, Parke and Brand (2004) document not only the possibility, but the actuality of turning this dream into reality. The Vancouver Island Health Authority (VIHA) has implemented a new approach by moving towards an Elder-Friendly Hospital, which takes into account not only the acute healthcare crisis but the unique issues of elders in the health care system (Parke & Brand, 2004). Part of this philosophy includes a "Delirium Watch" program, which serves to heighten awareness and therefore intervention for patients at risk for, and patients presenting with delirium. "Delirium Watch is a surveillance process representing a customized strategy that was developed for a clinical problem" (p. 70).

Neville (2005) presented the argument that biomedical/scientific discourses served to objectify the body in relation to health and illness, often to the exclusion of the personal discourse of delirium. His work also produced findings that although biomedical discourses (in the form of evidenced based practice) produced 'truth' regarding what nurses should do to manage delirium, nurses were not taking up these discourses, nor were they taking up the personal discourse of delirium according to the patient. From a poststructural lens it is not the intent to identify one discourse as 'good' and the other as 'bad'; rather the intent is to focus on the usefulness these discourses have for nursing practice. The intent of my study was to illuminate and examine how these discourses produce realms of thought around 'truth' and how they are at work in nursing practice. My study served to unveil the reasons why nurses practice in a certain way, specifically, how discourses serve to shape and discipline nurses' response to caring for patients who experience POD.

2.3 Summary

This chapter began by exposing EBP as a discourse in itself and problematized the assumptions that EPB is the favored path to the sound development of nursing knowledge. Although the literature identifies effective assessment, prevention and management strategies for the care of hospitalized adults at risk for, or experiencing delirium, there is limited evidence of how nurses actually care for this population, and what factors are at work shaping their practice of caring for these patients.

There is great deal of quantitative delirium research, which describes what health care professional *should* do to investigate and treat this syndrome. There is a smaller amount of qualitative research including studies on what nurses are actually doing. Many of these studies reveal that nurses are not responding to this symptom appropriately, yet there remains a gap in the literature regarding the reasons for nurses' lack of response.

Neville's work (2005) is the only qualitative study (to date) that has looked at delirium through a poststructuralist lens using discourse analysis to investigate delirium. He presented a sharp criticism of the biomedical discourses at work in the discursively constituted object of delirium and asserted that these biomedical discourses override the patients' personal discourse. My work builds on Neville's findings, not to argue that one discourse is better than the other, but to discuss through a poststructuralist deconstruction that *both* discourses can be useful to contribute to improved patient outcomes.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents my research methodology, beginning with the theoretical traditions that informed my research. Rather than stating definitions of these traditions, I provide meanings, which from a poststructural perspective are not foundations, rather they are in flux, evolving and changing over time. I describe my understanding of discourse and discourse analysis which is informed by Foucauldian theory. I list the methods of my study including site and population selection, participant inclusion and exclusion criteria, ethical and political considerations, data gathering methods, data analysis procedures and lastly issues relating to legitimacy of the findings.

3.2 Theoretical Traditions

Using a poststructural/postmodern, feminist, critical discourse analysis methodology, I investigated how discourses were at work in nursing practice, and how these discourses shaped nursing practice in the care of patients with POD. The theoretical tradition included a Foucauldian genealogical approach (Foucault, 1972) which has particular relevance to nursing (Cheek & Gibson, 1996; Cheek & Porter, 1997; Crowe, 2005) and which “investigates complex and shifting networks of relations between power, knowledge and the body which produce historically-specific forms of subjectivity” (Crowe, 2005, p. 57).

3.2.1 Poststructuralism/Postmodernism

Poststructuralism, as postmodernism, has remained difficult to define. Denzin and Lincoln link the two by explaining that poststructuralism is a “particular kind of postmodernist thinking” (2005, p. 961). Poststructuralism has been described as “not [having] one fixed meaning but generally applied to a range of different theoretical

positions” (Weedon, 1987, p. 19). What is generally agreed upon is that poststructural perspectives interrogate language, meaning, subjectivity, social organization and power (Cheek, 2000; Denzin & Lincoln, 2000; Weedon, 1987). Poststructural perspectives challenge the notion that language is a neutral, objective, value-free conveyer of aspects of reality, and expose it as being “constituted by and constitutive of, the social reality that it seeks to represent” (Cheek, 2000, p. 40). In other words, “language does not ‘reflect’ social reality but rather produces meaning and creates social reality” (Denzin & Lincoln, 2005, p. 961).

Language is how social organization and power are defined and contested and the place where one’s sense of self (one’s subjectivity) is constructed. Understanding language as competing discourses (competing ways of giving meaning and of organizing the world) makes language a site of exploration and struggle (Cheek, 2004a; Denzin & Lincoln, 2005; White, 2004).

Poststructural perspectives challenge unwritten rules and assumptions. In the health care arena the challenge is on “correct or accepted ways of acting and thinking” (Cheek, 2004a, p. 41). Questions that might be asked from a poststructuralist research approach include the way that health care is represented, and “why this representation is the one accepted as ‘normal’ or ‘given’; what are the alternate ways of representing the same reality; and why these ways are absent and/or marginalized and suppressed” (p. 41). Cheek goes on to explain how such questioning “calls into question claims to autonomy, objectivity, and political neutrality of medicine” (p. 41).

3.2.2 Feminism

Additionally this work is also informed by critical feminist theory (Barrs, 1991; Fine, 1992; hooks, 1984; hooks, 1994; hooks 2000; Ray, 1999). Fine (1992) calls for action: “If there is no other task that feminist activist researchers can accomplish, we must provoke a deep curiosity about, indeed an intolerance for, that which is described as inevitable, immutable and natural” (p. 26) while Ray (1999) argues for a specific kind of gerontology informed by feminism and postmodern theories which direct us to connections between language, self and social action. From a feminist perspective it is the responsibility of scholars to transgress, to break bonds and overcome restrictive limits and boundaries around what we say, how we speak and how we act (Ray, 1999; hooks, 2000). In other words it is important to understand, question, challenge, contest, resist and reframe the status quo in order to extend current thinking about how nursing practice is produced and disseminated.

Feminist theory focuses analysis on discursive and material formations, and patriarchy, in order to foreground the taken-for-granted assumptions that structure it and enable it to continue to control and oppress. In this way participants of research begin to discover who they are and who they have been socialized to be (Adams St. Pierre, 2000; Farganis, 1994). hooks (2000) explains that radical feminism is working for the eradication of domination and elitism in all human relationships. She focuses her analysis on informed understanding of the politics of domination and recognition of the interconnections among various systems of domination. This system of domination remains operational in the medical model as the scientific, positivist paradigm. In fact, feminist scholars have asserted that the scientific paradigm is, by definition, antithetical to the politics of feminism (Ray, 1999; Hooyman, Browne, Ray & Richardson, 2002). In our culture, women who step out on the edge,

courageously resisting conventional norms for female behavior are portrayed as crazy, out of control and mad (hooks, 2000). In this sense POD is gendered. Set apart, captured in a circus of raging representations, POD is often mocked, belittled and trivialized.

3.3 Design and Methodology

The type of study conducted was a qualitative research design utilizing a poststructural/post modern, feminist, critical discourse analysis methodology, to investigate postoperative delirium (POD) as a discursively constituted object, drawing on a Foucauldian perspective of nursing practice and discipline.

3.3.1 Critical Discourse Analysis

There are numerous definitions of discourse in the literature, and just as often it is either undefined or poorly defined (Cheek, 2004a; Parker, 1992; Wood & Kroger, 2000; Wodak & Meyer, 2006). The understanding of discourse for this study is informed by Foucauldian theory.

3.3.1.1 Foucauldian Discourse Analysis

Cheek explains that “for Foucault, discourse refers to ways of thinking and speaking about aspects of reality” (2004, p. 1142) and that discourses consist of common assumptions that are “so taken for granted as to invisible or assumed” (p. 1142). As well, they “both enable and constrain the production of knowledge, in that they allow for certain ways of thinking about reality while excluding others” (p. 1142). Foucault described discourse as the assumptions, the ideas, the talk, the text, and the images that produce understanding and meaning (Hole, March 10, 2008, personal communication). These discourses are at work in multiple layers, as Fox (1993) and Wicks (1995) describe as a hierarchy of discourses, or what Foucault (1972) identifies as regimes of truth, which are the dominate ways of

knowing, represented as those hegemonic discourses that prevail over other discourses. In other words, there are overriding discourses at work which shape, direct and govern all other discourses. These overriding discourses maintain their power by remaining invisible, so much so that they are taken for granted and accepted as 'common sense'.

The assumption is that by troubling and exposing this hegemonic thought it is possible to raise consciousness toward social justice. In doing so, is it also assumed that social justice is not an end product but a process of change? In addition, a Foucauldian analytic lens examines the relationship between language practices and power, and how power is productive (Foucault, 1980)

3.3.2 Site and Population Selection

Selection of research participants included consideration of the purpose of the research (Lopetrone, 2006). Selecting a sample that was closely related to the research question, deciding what information was necessary and discovering who has access to that information was an important component of identifying participants (Palys, 2003). I used purposeful sampling to identify the participants for this study in order to ensure individuals with a specific set of characteristics were selected (Berg, 2004).

“When developing a purposive sample, researchers use their special knowledge or expertise about some group to select subjects who represent this population” (Berg, 2004, p. 32). Glesne (1999) concurs that qualitative researchers tend to select their participants in a purposive manner to ensure that the information generated is rich in depth. Selecting participants that meet specific criterion will ensure quality assurance (Patton, 1990, Silverman, 2002). Orthopedic surgical patients have a high incidence of delirium, in part due to the fractured hip population (Marcantonio, Flacker, Wright, & Resnick, 2001); therefore

sampling nurses working on a postoperative orthopedic patient care unit was relevant for this study.

Once ethic approval was obtained, a letter (Appendix A) was sent to the Unit Manager of '2A' (orthopedic, urology and neurology surgical unit) to introduce the study and request permission to distribute information packages to the nursing staff (Registered Nurses and Licensed Practical Nurses). This letter also included a request for the Clinical Nurse Educator designated to '2A' to introduce the study at a ward staff meeting and explain the purpose and methods of the study. I asked this individual to read a prepared statement (Appendix B) and place information brochures (Appendix C: Recruitment Brochure) on the ward, which listed my contact numbers should any of the nurses be interested in participating in this study. The recruitment package also contained an information and consent form (Appendix D). A follow up phone call was made to the unit manager to answer any questions regarding the study; there were no questions identified.

Inclusion criteria incorporated all nurses (Registered Nurses and Licensed Practical Nurses) who spoke English and were working (either full time, part time or casual) on one unit (orthopedic, urology and neurology surgical unit) who had cared for a patient with POD within the last six months (leading up to the study). Since the aim of the study was to critically examine the language practices and discourses that shaped and disciplined nurses' care of older adults with POD, it was prudent to select nurses who have an understanding and recent experience of what it is like to care for a patient presenting with POD.

Exclusion criteria consisted of staff members who were not nurses, did not speak English and who had not cared for a patient experiencing POD in the last six months. None

of the participants who contact me were excluded from the study; all respondents were nurses and all of these nurses were included in, and completed the study.

3.3.3 Ethics and Political Considerations

Ethics approval was obtained from the University Of British Columbia Clinical Ethics Board (Appendix G: Approval Certificate) as well as the Interior Research Ethics Board (Appendix H: Approval Certificate). I adhered to the Canadian Nurses' Code of Ethics and the College of Registered Nurses of British Columbia Standards of Practice.

Recruitment packages including the *Recruitment Brochure* (Appendix C) and the *Information and Consent Form* (Appendix D) were placed on the ward to provide information to the nurses regarding the study. This form explains what I would be asking the participant to do in my study, which included answering questions about his/her experiences of caring for patients that presented with an acute onset, including delirium. Information in the form directed interested individuals to contact the researcher directly at which time the researcher would discuss the purpose of the project, ethical issues and answer any questions that the individual may have. If the individual agreed to participate in the research study, the interview was scheduled for at a date and time that was convenient for the participant. Participants had at least 48 hours to consider the consent form after they agreed to participate, before the interview took place. This provided the participants the opportunity to reflect upon their potential participation in the study. Recruitment was open for a two month period. As such, participants had two months to consider whether they would like to participate in the research study.

I conducted all interviews alone with the participant in various private offices in the hospital. Interviews were conducted during both the participants and my personal time.

Prior to commencement of any interviews (including follow up interviews) and prior to asking participants to sign the consent form, participants were asked if they had read the *Information and Consent Form* and if they had any questions. Participants were informed that they had the right to withdraw from the study at any time during the study, and consent was obtained to digitally record the interview. The participants were also provided a copy of this information and consent form. This form outlined the background, purpose, procedure, benefits and risks of the study. As well, the form confirmed the voluntary nature of participating in addition to information regarding the maintenance of participant confidentiality. Additionally, it explained possible future uses of data and dissemination of results. After consent was signed, the participants were asked to complete the *Demographic Form* (Appendix F). All participants received a beverage card as an honorarium up to a value of ten dollars.

Information from participants was held private. I did not identify any issues with the information that was disclosed to me from the participants where professional codes of ethics or the law required reporting. Digital recordings and written material from the study were secured in a locked filing cabinet in my home office and were stripped of all identifying information. Participants' names were not disclosed to others. To maintain confidentiality, the names of participants have not been included in any of the documents arising from this study, nor will be included in any further documentation or published accounts of this study. I assigned pseudonyms to the participants and obtained permission from each participant to use the pseudonym I had chosen. Participants were requested not to use names of persons during the recorded interviews. When names of persons were inadvertently mentioned during the interviews, the names were not entered onto the written transcripts, or data

analysis, to preserve confidentiality. The name of the hospital, patient care ward and all names of individuals (except my own) were changed in an effort to address confidentiality.

Electronic data (e.g. transcript files) were stored on my password protected computer. Only my research committee reviewed the data. All digital recordings of the interviews were deleted immediately after they were transcribed. Typed transcriptions of the digital recordings will be securely locked in my home office for the expected standard time of seven years after data collection at which time in September 2015 they will be erased and destroyed by myself. The electronic data which has been transcribed has been stored in a password protected format and backed up by a flash drive. Once seven years has passed, shredding the paper data, double deleting data from electronic databases and burning the flash drive will permanently destroy the data.

All participants were made aware that they will be provided a copy of the findings; every participant but one provided a mailing address for this purpose. The one participant who did not provide an address stated she was not interested in receiving a written report of the findings.

Minimal risk is defined as “those risks that would be encountered in normal, everyday life” (Interior Health Research Ethics Board, 2007). As nurses are likely to discuss these topics with colleagues, and reflect daily on their practice regarding similar issues, it is anticipated that the risk is minimal and no potential harm may come to participants as a result in participation in this study.

3.3.4 Data-gathering Methods

The research methods used to collect data for this study included face-to-face, in-depth, personal interviews with the participants. The longest interview lasted 43 minutes, the

shortest was 19 minutes and the average was 28 minutes. All interviews were digitally recorded with the permission of the participants. The interview questions were developed in consultation with the members of my research committee, including one member who is an expert in the clinical field of POD. A pilot interview was conducted with this individual to establish appropriate questions and optimal flow of the narrative.

I began each interview by asking the participant to tell me about the patient that he/she cared for within the last six months who presented with POD. I then asked the participant to tell me about another patient that he/she cared for within the last six months who presented with an acute onset, for example chest pain or respiratory distress. The prompts for each question were the same and are included in Appendix E (interview questions). Finally I asked the participant how his/her care of these two patients differed. (The assumption is that care differs between all patients, due to individualized care practices).

A follow-up interview was arranged and conducted with each of the six participants to review the narratives. Other data included field notes from my observations in nursing practice, including nursing research.

3.3.5 Data Analysis Procedures

I analyzed the data manually. The main principle of data analysis was that it related back to the research question, which was: With a focus on the orthopedic patients on '2A' at 'Canora Jubilee Hospital, what are the key discourses that shape and discipline nurses' response to POD? In other words, how do these discourses implicate practice in terms of how nurses respond to POD?

I personally transcribed the interviews verbatim to become immersed in the data. Based on the interpretive process described by Hole (2007) I conducted five analytic readings of the

data. The first reading read for content, and served as a checking process to ensure that the transcription best reflected the participant interview. The second reading read to identify current nursing practice. The third reading read for the position of the narrator for example, does the participant position him/her self as a novice, expert, and/or change agent? The fourth reading read for the research question identifying the discourses in the narratives. The fifth reading read for how those discourses were at work in the narratives: how they shaped and disciplined nursing practice, influenced the evolution and dissemination of nursing practice, and impacted national, international and global levels of society.

I formatted the transcripts onto landscape format 11 X 17 inch paper, numbered each line, set a three-inch margin on the left side and a set a six-inch margin on the right side. I then divided the six-inch margin into four columns to represent reading two, three, four and five. I assigned different colored pens to each reading. For example, reading two was documented with a yellow pen, reading three with green, reading five with purple and reading six with orange. As well, I assigned each participant another, different color. I recorded each color assignment in a codebook.

As I read through the transcripts I wrote notes to myself in the margin on the left hand side of the formatted sheets. I completed multiple readings of each reading on each participant. The initial readings were relatively basic. For example, the first readings stayed very close to the language used by the participant. I recorded words that were used a number of times in the narrative such as “safety”, “disruption” and “work”. As the sheets became filled and cluttered I transferred my analysis onto new, clean sheets. In the process the analysis also moved in depth; as I transcribed the data, I moved into secondary and tertiary analysis.

When each reading of each participant was complete I transferred recurring themes from the data onto larger flip chart paper. I compiled the analysis of the readings for each participant onto two pieces of flip chart paper; one reflected the position of the participant and the other reflected the discourses identified in the participant's narrative. I pasted verbatim quotes from the transcripts onto these papers as well as my notes linking themes. I also wrote a narrative summary for each participant, and attached these summaries to each participant's flip chart sheet.

From these individual sheets, I read across the narratives and identified three prominent discourses at work in the narratives. I began new flip charts which listed these discourses, and I transferred the information from individual participants onto the new sheets to produce a representation of the collective narratives of discourse.

3.3.6 Legitimacy of Findings

Topics of legitimacy and validity become problematic from a poststructural/postmodern lens because of the connection the topics have to the positivist paradigm (Hole, 2004). I propose a concept of *Reflexive, Crystalline Validity*. Cheek (2003) explains:

Postmodern thought is enabling in that it encourages us to think about reality in a reflexive way. Such reflexivity unmask "complex political/ideological agendas hidden in our writing [and practice]. Truth claims are less easily validated now; desires to speak 'for' others are suspect" (Richardson, 1994, p. 523). Thus, as much as postmodern thought is "undetermined" it is also "undetermining" in that it serves to "weaken...the constraining impact of the past and effectively prevent...colonization of the future" (Bauman, 1992, p. 190). (p. 20)

Richardson (1997) eloquently describes the difference between ‘triangulation’ which is valorized by traditional research and crystallization, which fits excellently with postmodern thought:

I propose that the central imaginary for ‘validity’ for postmodern texts is not the triangle – a rigid, fixed, two-dimensional object. Rather the central imaginary is the crystal, which combines symmetry and substance with infinite variety of shapes, substances, transmutations, multidimensionalities, and angles of approach. Crystals grow, change, alter but are not amorphous. Crystals are prisms that reflect externalities *and* refract within themselves, creating different colors, patterns, arrays, casting off in different directions. What we see depends on our angle of repose. Not triangulation, crystallization. (p. 92)

This issue of legitimacy in critical, poststructural research has been identified by many (Cheek, 2003; Cheek & Porter, 1997; Denzin & Lincoln, 2005; Hole, 2006; Lather, 1993). However, “a postmodern, poststructural consciousness does not release social scientists [including nurses] from confronting validity” (Hole, 2006, p. 55). I chose two concepts, verisimilitude and pragmatic value, adapted from Hole (2006), to form my framework for reflexive, crystalline validity.

3.3.6.1 Verisimilitude

Postmodern thought emphasizes that reality is plural and there are multiple positions from which it is possible to view any aspect of reality (Cheek, 2003). In addition, theorists drawing on postmodern thought argue that, “every knowledge is contextualized by its historical and cultural nature” (Agger, 1991, 0. 117). Therefore, the researcher is situated in the act and process of research attempting to “produce a likeness or similitude to the truth, as

close as possible” (Hole, 2006, p. 55), with the assumption that reality is continually under construction. To capture, as close as possible what was “real”, once data was analyzed and preliminary findings documented, a follow up session with each participant was arranged to seek validation from the participants.

Each member of my committee reviewed at least one transcription (verbatim) of the interviews. In addition, a member of my committee, who is an expert on POD, reviewed the narrative summaries to determine if they resonated with the stories of nursing experiences that circulate in nursing cultures around POD. She validated that they were true to her experiences in practice. In addition, I provided quotes from the participant’s transcripts to provide ‘evidence’ for my interpretations.

I conducted follow up interviews with every one of the participants in order to strengthen validity and legitimacy. One of the outcomes of this process was that one participant highlighted a piece of analysis that I had originally overlooked. By illuminating this data through a different angle, and bringing it to the forefront, this process served to enhance the analytic quality, and thereby the validity of my work.

3.3.6.2 Pragmatic Value

“Pragmatic value refers to the usefulness of the findings” (Hole, 2006, p. 56). As a Clinical Educator with an interest in the field of POD, there is value in adding to the body of nursing knowledge not only specific to POD, but around discourses that guide and discipline nursing practice. I plan to disseminate this knowledge in seminars and workshops, with a focus on the discursive object of POD as well as the historical and contextual practice of nursing. I also plan to publish my findings. The findings will be made publicly available as the completed thesis through UMI/Proquest and the Theses Canada portal.

I have presented this research experience, including my methodology, at the 9th Annual International Interdisciplinary Advances in Qualitative Methods held in Banff, Alberta (October 2009). The title of the presentation was *Research Positioning Turned Inside-Out: A Poststructural Approach to Researching as an "Insider"*. I am preparing an article for publication, based on the presentation, to the International Journal of Qualitative Methods. I have had a number of national and international inquiries from other registrants at this conference for further information regarding the topic of delirium.

In addition I will present my findings for this study to the Fifth International Congress of Qualitative Inquiry (QI2009), held at the University of Illinois in May 2009. The theme of this congress is "Advancing Human Rights Through Qualitative Research".

3.4 Summary

In this chapter I presented my research methodology beginning with the theoretical traditions that informed my work including poststructuralism/postmodernism and feminism. I provided a detailed account of my research design and methodology. This framework included critical discourse analysis informed through a Foucauldian lens. I presented a comprehensive explanation of my site and population selection, ethics and political issues, data gathering methods and data analysis procedures pertaining to my study. In addition, I provided examples of how my study addresses validity through a process of reflective validity which incorporates both verisimilitude and pragmatic value.

CHAPTER 4: FINDINGS

4.1 Introduction

This chapter is divided into two parts. Part one presents the findings of my research. These findings are introduced by a short demographic description of the six nurses who participated in my study (a table illustrating these demographics is presented in Appendix G). The responses of the participants are presented in six vignettes, representing a narrative summary of each of their interviews. Each participant's summary is divided into three subsections. The first subsection reflects his/her responses to the questions regarding POD. The second subsection reflects responses to the questions regarding another acute onset (for example chest pain or respiratory distress). The third subsection reflects responses to the questions regarding differences between the two.

Part two of this chapter presents my analysis of the vignettes, specific to the research question which is: With a focus on the orthopedic patients on '2A' at 'Canora Jubilee Hospital' what are the key discourses that shape and discipline nurses' response to POD? Applying a poststructural, postmodern Foucauldian critical discourse analysis lens, I focus my discussion on the identification of two prominent discourses at work in the narratives. These prominent discourses were identified as discourses of legitimacy/illegitimacy and discourses of nursing work.

4.2 Part One: Demographic Data Representing the Nurse Participants

Six nurses participated in the research study. One nurse was male; five nurses were female. The ages of the nurses were 23, 27, 37, 41, 48, and 52 years of age; the average age of the nurses was 38. Four nurses listed their ethnic background as Caucasian, one as Asian/Pacific Islander and one as Métis. The education level of the nurses was divided

evenly between LPN, RN and BN. Total years of experience in nursing was reported as one with less than two years experience, two with two – five years experience, one with six – ten years experience, and two with greater than 20 years of experience. Responses to the question of years of experience in orthopedic nursing included two with less than two years of experience, one with two – five years experience, one with six – ten years experience, one 16 -20 years experience and one with greater than 20 years experience. Three nurses disclosed that they cared for patients with POD once a week. Two nurses reported caring for patients with POD two times a week. One nurse indicated caring for patients with POD one – three times per month.

4.3 Six Vignettes

The following section presents the narrative summaries of the six nurses who participated in my study: Tanya, Donna, Ivan, Kirsten, Lindsay and Kathy. The names of the participants have been changed in an effort to address issues of confidentiality.

4.3.1 “Tanya”

Tanya’s narrative summary includes examples of a patient who presented with POD, another patient who presented with respiratory distress and a narrative of difference.

4.3.1.1 POD

This patient was an elderly lady who had fallen and broken her hip, had surgery and was confused. I had her on a night shift and this was the first time I had seen her, so I didn’t have any idea of how she presented before she went to surgery. She came to us from PAR [postoperative anesthetic recovery] about 8:00 pm. I am always concerned about their safety when I go in and they are confused and not directable. I did her assessment in the room and then we ended up pulling her into the hall. She ripped off her dressing, she pulled out her

catheter, she did everything. I made the decision to pull her into the hall for her safety. I didn't feel comfortable leaving her in her room thinking she was going to climb out and bonk her head. I was concerned about her safety so I moved her out into the hall right beside the nursing station so that we could see her and kind of have an eye on her, except for when we went into other patient's rooms. So what happens is we try to keep an eye on her, but then we go into another patient's room, and 5 seconds later she's got everything out. So, it's not the greatest solution, but I just feel that it's safer for them, if we are kind of trying to keep an eye on them.

I think about the other people in her room as well. It's tough for them when she is calling out and disruptive and disturbing them. I feel bad because I'm spending more time with the confused patient than my other patients. Sometimes I have eight or nine or even ten other patients. At the same time I know I should be thinking of her, and maybe not bringing her out into the hall, but its tough for the other patients in that room. I feel sometimes I neglect my other patients because I spend so much time redoing and redoing things for my patient that is confused. She just kept pulling everything apart. The other patients don't get as much attention because the confused patient takes all my time. I wish I had the time to sit with the confused patient. I know it is best to have family there with them. That is the best way to deal with them, especially at night, because I think they are just scared.

So this particular night at least she didn't end up on the floor, but I felt bad because I wish we had more resources to be able to sit with her. I really feel bad for these people because we don't have the resources to spend time with them. Even to sit with them, or maybe talk with them or even get them up to a different area, to sit them up and maybe push them through the hall a couple of times. Of course that could just make them more confused,

but sometimes just a change of scenery helps. A bit more resources to fill the one-to-one assignments would be really helpful.

I didn't learn much about delirium in my nursing education. I learned most about how to manage confused patients by watching what worked for other nurses. I observed other nurses managing their pts with delirium by pulling them into the hall. I think that's the safest. I don't like to use physical restraints. I'd rather bring them into the hall and keep a closer eye on them than restrain them. We always use chemicals like loxapine, but I don't find it works that well. It's really helpful if a family member can come and sit and watch them.

With this particular patient there was no one. There was no one there. There was no other staff that could come and help. I didn't know who to call, what to do, or who my resources were. All I knew was to try and contact the family and I tried them, but they weren't able to come in.

As far as charting goes, it was definitely one of those "pink page nights". The pink page is an extra page that we use to chart when the regular "24 hour record" narrative section is full. When you have to add the pink page, it means you have had to do a lot of extra work, extra charting. I charted the basic data of how things happened, and I always chart "patient confused, unpredictable, moved to the hall" and then whatever happened, like "catheter pulled out, dressing dressed and redressed." It is helpful to have completed charting for the next shift that is coming on, so that they have a better idea of where she is at. That night I was charting about the outcomes of what was happening, not what I was doing, because I didn't know what to do. The only thing I did was move her out into the hall.

I'm probably not as good about charting how the mental status is changing; I definitely could improve on that. I learned about the CAMI [Confusion Assessment Method Instrument] in orientation, but then I forgot about it, because orientation is extremely overwhelming, especially for the new graduate nurses because there is a lot of content covered in just one week. So, I don't think it really set in, in orientation. But when you begin to work with these patients it's a bit easier to understand. Nurses are using the CAMI assessment; even the students are good about using it.

4.3.1.2 Respiratory Distress

This patient was a gentleman who was pretty much in respiratory distress. I knew because he was blue, his respirations were really increased, I put the sat (oxygen saturation) monitor on him and I just knew he looked bad. I got way more support with him. Nursing staff were more willing to come and help me. This particular incident happened on a day shift, so there is generally more support available than on nights, but I just noticed that there was way more people around to help me. I had more support to start out with and also I knew how to contact people. We knew we needed RT (respiratory technician team) and so we called them and they came up. We called the resident; she knew what was going on and she came in. People are more willing to respond to a patient experiencing respiratory distress than they are a patient with delirium. I said to my colleagues, "This guy's not doing very well" and I got help. We just knew what to do. I've been involved in a situation like that before and I just kind of did the same thing as I did last time, because it worked last time. We were doing things; we knew what to do, we were doing something. We knew who to call, who would write orders and who would intervene. We were trained and educated about respiratory distress. It wasn't like I had to make more decisions; it was just so much more

supportive in this situation than in the other. The only barrier I can think of was that we had to ask the wife to step back so that we could assess the patient.

4.3.1.3 Narrative of Difference

I don't know why there is such a difference between the two. Maybe it's me too. For example, with the lady with the delirium, I didn't know who to call, what to do, who were my resources. All I knew was to call the family; I tried them, but they weren't able to come in. Maybe it's also a mind set sort of thing; maybe that's another barrier. Maybe it's attitude. For example, people are more willing to respond to respiratory distress than they are to confusion. Like with the lady who was confused and not re-directable, they are telling me to just bring her out into the hall, like it's not emergent. But with the gentleman with respiratory distress I said I needed help and I got it.

I guess that's because of the way we were trained, the way we were educated. We really didn't talk a lot about postoperative delirium in school, so maybe that's an area where we need to receive more education. I know there is a lot about regular stuff like pain control and post op nausea and vomiting, but confusion happens a lot on the postoperative floors too, so in nursing school it could be touched on a lot more.

I felt good about my practice with the patient who was in respiratory distress, because even though he wasn't perfect by the time I left my shift, at least I did something. And I can go home and sleep at night knowing that I did *something*.

It's sad, because the respiratory distress was solved in an hour, while the confusion was still going on hours later.

4.3.2“Donna”

Donna’s narrative summary includes examples of two patients who presented with POD, one patient who presented with chest pain and a narrative of difference.

4.3.2.1 POD

After Donna had finished discussing one patient whom she had cared for with POD she asked if she could mention another one. I chose to include both examples in her vignette.

4.3.2.1.1 Example #1

I was taking care of this gentleman, Mr. ‘Jones’. He was alert, but totally confused. He didn’t know where he was. He was shouting out people’s names, not names of the nurses, but other people’s names, and he was trying to crawl out of bed. He was pretty much a pain in the ass. What I did was “number 1” try to orientate him that he was in the hospital. This was pretty well every time I went in there. I would say, “Mr. ‘Jones’, you are in “Canora Jubilee Hospital, you had an accident and you broke your femur, and this is what is happening”. That didn’t work, and he is still confused. So then I check his medications, for example, what medications he is taking that may be causing it, or if he is on any medications that may help his confusion. For instance, I checked his pain medication to see when he was getting it and how much he was getting, because narcotics can cause delirium. He needs to have adequate analgesia but not too much. Also, he may have been on some type of medication before he came in, and when he had surgery it wasn’t reordered. A lot of people are on certain meds that accumulate in their system, and if those medications are stopped suddenly and not weaned gradually it can cause confusion.

We ended up having to restrain him because he was pulling at everything. He had a very bad leg from the accident and when he moved it was very painful. So we ended up

having to give him more narcotics for the pain, which caused more delirium. I looked after him for 4 or 5 days and when I left he was still confused.

If you have an elderly person with confusion the first thing you do is look at the narcotics because they are susceptible to narcotics, especially epidurals and PCAs (patient controlled analgesia). Anesthetic can be a cause too. This pt had his surgery a while ago; in fact he was transferred from the surgical floor to where I was working that day on a medical floor. We thought the cause of the confusion was the *whole* part and parcel of the accident, the accident, surgery, pain, everything. You need to look at the whole and get to what is causing the delirium. You need to get to the source. If you can't identify the source you need to make sure they don't hurt themselves.

You are still trying to orientate him no matter what and explain to him what is going on. You need to talk to the doctor and if the two of you can't figure it out with a change in narcotics, then you need to look for other causes, for example a UTI (urinary tract infection). You also need to go back and see what he was like prior to the surgery; you need to get a baseline. For example, he might have dementia, and this might be the way he is. He may not ever be orientated. For example, if he came from a nursing home you need to go back and see what he was like there; if he was in the nursing home with dementia, chances are you are not ever going to orientate this fella.

You have to deal with it and find out what is going on. In a period of time you need to make a decision. For example, if they are in a four bed-room and if they need to be moved. So in that period of time you need to decide if you need a one-to-one to keep the patient safe. You need to decide if you should approach your charge nurse and say that you think your patient is unsafe, because the bottom line, before anything is safety of the patient.

I guess I learned this practice from experience. I worked a lot on a medical floor and there we get lots and lots of confused patients. Especially the chronic medical patients, a good many of them were quite confused. So you had to deal with them and find out what was going on. It was so busy that you had to deal with the situation, the delirium, in some way. You can't just let it continue on, because you had other patients to deal with too and the confused patients were disruptive. So you had to make sure that that sort of disruption somehow was addressed. It's just a frustrating situation and it's hard to deal with because your patient becomes disruptive, and disruptive not only to himself and to you, but the other patients around him.

I can't remember any formal education to do with delirium, I probably had some when I went to school, but that is so long ago. Basically it's just trial and error, watching, years of experience and talking to the doctors and other nurses.

In this case I felt supported pretty well. Sometimes I am frustrated by the doctors that don't pay attention and don't take our opinions to heart. Some of them are good of course; it helps if they know the patient from their family practice, and they can say that this behavior is not normal for that patient. Or sometimes they have been dealing with the patient's dementia, and family issues like placement already. It just helps to have a doctor who knows the patient and will listen to you and trust your judgment.

4.3.2.1.2 Example #2

This was a postoperative orthopedic pt; she had knee surgery, and she wanted to get up. She was a few days post op and she wanted to use the commode. Now, in hindsight I blame myself, because I should have known better and I didn't. But on the other hand, I was not supported in any way either.

I got her up on the commode and she did fine. She was heavy, but not bad. But when I went to take her back to bed she wouldn't stand and put any weight on her knees. So I pulled out the emergency bell because she was kind of collapsing; her knees were ready to buckle, and I waited and waited and waited and no one came. So then I was all alone, and I kind of heaved/shoved her into bed. So, I got her into bed and then I went to the desk and said, "Well how come nobody showed up?" They said, "Oh, it didn't ring emergency." Then I said "Well, that lady was collapsing on me and I barely got her into bed and I could have really hurt myself, and there was no emergency bell".

The charge nurse said that she would look into it, and I said I was going to fill in an incident report because it was number one the patient's safety but also my safety too. Surely to God somebody knew before hand that this bell was not working and never got it fixed. I didn't feel that was handled very well. So I called the UCMN (Utilization and Care Management Nurse) and told her that I would fill out the incident report. I don't feel that the charge nurse took the matter seriously, or that she did a whole lot for me, or my patient.

The rest of the patients in that room went home and now I have this confused patient who wants to go home and I am worried that she will try and get up and damage her knee. As it was, trying to get her safely into bed the first time caused her postoperative knee to bleed. So I went to the charge nurse and asked that she be moved into another room because she was delirious. She kept saying that she wanted to go home and I was scared that she was going to climb out of bed. I was told by the charge nurse that this team already had a confused pt and she didn't want to give them another one. Also the ward clerk says, "Ya, and if you are going to move her it will just make more paperwork for me". And I thought, (and then had to say to the ward clerk) "You know that's what we you are here for." That's

what we are all here for is to *work*. We all have workload, but that wasn't good enough. The patient is the one that is ultimately going to suffer, not the other nursing team on the other side of the hall. They might have one more patient, but that doesn't make any difference. That's what we are here for.

And I was very disappointed that my word was not taken seriously, that no one listened to the fact that I was seriously worried about the safety of my patient, myself and other staff. So then I asked the charge nurse to assign the first admission, the very next person to be admitted to the ward, into that room, so at least there was someone who could watch her, even if that someone is another patient. So when we got that admission I went over and chatted with that new patient and explained to her that her room mate was a little confused, and if she saw her trying to climb out of bed to ring the bell. That lady (the new patient) was wonderful. A while later I went into that room, and this lady said, "You know I'm watching her. I'm watching her, and she hasn't tried to climb out of bed yet, but she is talking about going home, and if she does try to climb out, I'll ring the bell". So I think, at that point you have to take an alternative. You have to find a different direction, because this direction wasn't going anywhere, and it wasn't going to be resolved. I think this is just the epitome of what nursing is today: it is the attitude of "Oh they are already heavy; they already have a confused one, and they don't want any more work".

4.3.2.2 Chest Pain

This one is easy. I had a patient with chest pain yesterday. The student came to me and said that this gentleman was having chest pain. I asked what she meant, for example, where was the pain? The student said the pain was down his left arm. So I went in there right away and asked the patient where he was having the chest pain. He said "It's down my right arm".

He said “I am having some pain right about here”, and he gestured to his lower sternal area. He also said that it was not like any pain he had experienced before. I asked the student to put oxygen on him and start taking his vitals. I asked him if he had experienced any heart problems before. He said “Never”. I asked him if he had taken nitro before. He said “Never”. I asked him if the pain radiated to his neck. He said “No”. He had presented to the hospital with a history of jaundice and he had an ERCP, and I knew by experience that he might have pancreatitis which presents a lot like chest pain. But no matter what, you have to treat chest pain as cardiac until it is ruled out. You assume cardiac related until proven otherwise. So, once the vitals were done I went to my team leader, my RN (Registered Nurse) and told her. I mean better safe than sorry! And then we told the charge nurse and an EKG (electrocardiogram) was ordered and a TROP (bloodwork which indicates an enzyme specific to cardiac damage). And the cardiologist came up too. Within minutes the EKG was done and the TROP was drawn. The conclusion was that it was pancreatitis caused by the ERCP, which we kind of felt was the case, because after a period of time the patient kind of said that the pain was more epigastric.

It was such a big difference with this gentleman than the lady who was confused. People listen to you; like I say, with chest pain you can't rule out a heart attack until the tests are done. You have to take that as a consideration and then get the doctor to rule it out. It's not my position to do that. I'm in the position to complete all the steps that follow up to that, to make sure that the patient is as comfortable and stable as I can make him. You just have to approach chest pain as heart related. You have no choice.

4.3.2.3 Narrative of Difference

I don't know why there is such a difference between the two. Maybe it's me too. For example, in the case of the patient that presented with chest pain, we figured it out pretty quick. I think the difference between the two is that one is a medical condition that can be treated. You can treat chest pain. You get the nitro, (medication used for relief of cardiac related chest pain) you do this and you do that. There are steps to follow, and those steps are tangible. There are reasons for following those steps. With delirium it's very difficult, because how do you deal with it? You need some sort of guidance.

Maybe that guidance could be from a psychiatrist; we would need a consult. The problem is if they are consulted, they don't show up for days. It is not their fault, it is just that there are only two of them and they are so busy. We don't even have one geriatrician; we had one, but she left. The geriatric psychiatrists are good, when they finally get there, they definitely are a help, but they usually don't show up for two or three days or even longer. So you are left to deal with it, you and the GP (family physician). And a lot of the time the GP doesn't know what to do with it. So I think that basically you are the front line. You are the one that is going to have to deal with it. I think that with delirium we don't have the resources to deal with it, and when it gets out of hand, we call a Code White (team which responds in an emergency to an aggressive patient). So that is another action that can be taken, we call in security, the Code White team. Then all the drugs are ordered. I think it's a part of our nursing care that is not really well done; we could prevent a lot of these events if we only knew what to do and had some supports to do that.

If you have a patient that is delirious it is a lot of work; so it is a manpower issue too. At least with the patient that has chest pain, at least I know they are going to stay in bed. But

the delirious patient with the fractured tibia/fibula is a lot more complicated and takes a lot more of your time. I hate to say this, but I think as nurses we don't deal with it very well because it is annoying. It is repetitive. It is a huge amount of workload. People are realizing how much work this is taking up. You have six or seven other very sick patients and you get one with delirium and he takes up all of your time. It's like: "Damn it! I've got a confused patient today. Oh Jesus, he's out in the hall".

We don't feel like that with a patient with chest pain because you know that will be resolved. The confusion is going to be longer, it is not just a short-term thing, and you know it is going to take up more of your time. The problem is that there just doesn't seem to be a tangible thing to say about what you do with delirium, like you do with a patient that has chest pain. With chest pain there are things that you do. You give him oxygen, you do this, and you do that. And with delirium what do you do? What do you do with delirium? I can't tell you how many times I have said, "This guy is confused, and I filled in all the assessment data. Yet, the patient gets put out in the hall or tied into a chair. That's our answer to delirium.

And, the other thing is we are getting more and more elderly patients all the time, and they are older and older. We do huge surgeries on these old people. It's going to get far worse because we are an ageing population, and nobody thinks it's important. Gerontology is not important.

I don't think there's anybody that addresses the situation. There's nobody that addresses delirium. Who do you go to? There's nobody that knows what to do or what they are doing. The GP's don't even know. They don't know how to deal with it, so you are left to deal with it.

4.3.3 “Ivan”

Ivan’s narrative summary includes examples of a patient who presented with POD, another patient who presented with chest pain and a narrative of difference.

4.3.3.1 POD

Right away when you see the patient you can tell that something isn’t right. This patient was very pale and there was a certain look in his eyes. I know that look. I don’t know whether it’s fear or something else, but confused patients have this certain look that you can see. I’ve learned to recognize that look, and then I start asking the patient a few questions to see if they are orientated. This person was fairly orientated but he was vague. I know to pick up on those subtle things that alert you that something is a bit off. There is so much in the hospital that you learn through experience and time. It [experience] is not recognized enough. I have been here a long time and I see things; you can tell when other people don’t see things. When you stand there and look you can see a lot that goes unseen.

When I recognize that look I tend to try and orientate the patient. I explain to them what has happened, where they are, and what surgery they had. I like to see if they know that, and if they can recall this if I ask them later. I find that usually helps to bring the patient back; it depends how severe the confusion is. If this doesn’t work I will often see the patient become agitated, and then I step back a bit, it depends on how delirious they are. Sometimes the questioning can make the delirium worse. I just try to see how they respond.

I usually chart if they are alert and orientated and whether they were able to tell me the date and where they are, or if they were unaware of what time it was. I will try to show how they were vague.

I basically learned to deal with these patients from trail and error. You learn what works with certain patients. You are here all day, so you have all day to try things. I remember taking a little bit about confusion in my nursing program, for example with diabetes. But I don't think that really stuck with me. My first aide training has helped a bit; they go over confusion in patients that are hypoglycemic.

I kind of feel helpless in the sense that there just doesn't seem to be anything that helps them. I used to think that it was always due to drinking and that they were withdrawing from something. Why else would this be happening? It wasn't until my father-in-law was in the hospital that I saw it so clearly that drinking was not necessarily the cause at all. My father-in-law wasn't a drinker, and yet he got so mixed up, so confused. He was a very normal, independent person before that. I never expected that to happen to him.

I had a patient who I was very concerned about yesterday. I brought my concerns forward and let my teammate know about that person. I also make sure that the next shift is aware of the person because I am worried about the safety of the patient. For example, this patient would get up often and start heading to the bathroom. It didn't matter what side of the bed the IV was on and it didn't matter if you had reminded him to call you if he needed to get up. He just didn't seem to retain even the simple instructions that I gave him, which was to call me using the call bell. Often these patients will say, "Yes, I'll call", and I will believe them too! I believe them because, they seem quite rational and they are very convincing. Then you talk to the family and find out there is a little, only a little bit of dementia that was going on at home, before they came in, but it is heightened here.

The problem is that the system is so overloaded that there isn't the manpower to handle the problem. The person needs closer watching; someone needs to watch them more closely,

but there are no resources to do that. So, because we need to keep these patients safe, and because we don't have the manpower to watch them with a one-to-one, sometimes we use the Geri chair. Sometimes there doesn't seem to be anything else to do but restrain them for safety. Yesterday we had nine patients and we couldn't do our job properly. We even had help, but patients got left in the Geri chair too long; they didn't get a walk because you couldn't get to it. We were just putting out fires all day long. It was so busy, so hectic, because of the workload. It's mentally stressful. We were both experienced nurses and I think good nurses, and we couldn't do our job properly. It was hopeless. Also, many of the nurses are hurt already with back injuries. A lot of times you can't get the help when you need it from your colleagues because they don't want to hurt their backs even more, and you don't want them getting hurt either. I can't ask them to put themselves in that situation.

I've kind of let go of it a bit, because it got to the point where it really bothered me. It's not that I don't care. I do care. It's just that I think the system is falling apart. But, then again I still like what I do, so until I see something, something really bad, I will keep doing what I am doing, but definitely if I see something I will get out.

4.3.3.2 Chest Pain

I tend to take chest pain as a more serious situation. What really changed my outlook is my first aide training and working on the ski patrol. You learn things like shock for example, and then you see it, and that's what solidified it for me. Every year you have to take a new test and the training is very comprehensive. That training has helped so much in my understanding shock. You end up seeing shock out on the ski hill, after all that specific training about it, and it's like a way deeper understanding of it. It's like "Oh wow look at

that! That's definitely a clear case of shock". So that's what really changed my outlook; I view that type of patient differently now.

When I have a patient that presents with chest pain, I would definitely get some support from the RN. First thing I would ask the patient about the pain, where it is and where it is going. For example, I would ask if it is radiating to the back, going down the arm or the jaw. Then I would immediately contact the person in charge, do vitals right away and put oxygen on him. I would think about giving him some nitro spray. This could be life or death, so you need to jump on this as soon as possible. I think we usually deal with it very well, really effectively. You have great support. You get respiratory involved, and they come right away.

I would chart the time it happened, explain the pain, write down the vitals, document that I contacted the RN and generally make sure that it is well charted. If I don't see the RN I would definitely let the charge nurse know. Then I would stay in the loop, watching, listening and talking as they contact the Doctor.

4.3.3.3 Narrative of Difference

I've noticed a difference between new staff and older staff. It doesn't matter how much education you have had, it is different what you see. I don't know how you can teach something like that. For example, I can see a patient and see a problem. Years ago it wasn't that bad of a pace, and you could look at your patient more. You had more time to assess your patient and now we've lost the ability to get to know the patient. Everybody talks about it. You don't even have the time to get to know who you are working with. You have to run to get it done.

I see the two situations (POD and chest pain) treated totally differently. They are not classed the same. Delirium is not seen to be as serious. It is not seen to be life or death. We look at delirium more as a risk of a personal injury, like a fall, not that they are going to die. I think delirium is misunderstood. It's like, "Well, they are just confused". Because without my experience from my father-in-law, without the knowledge I had about that, to see how he was so confused, and I couldn't find the reason, I would have believed the same thing. Post op delirium and chest pain are definitely not in the same ballpark as far as how we respond to them.

4.3.4 "Kirsten"

Kirsten's narrative summary includes examples of three patients who presented with POD, a general discussion of patient presentation of chest pain/respiratory distress and a narrative of difference.

4.3.4.1 POD

Kirsten could not decide which patient to discuss between two patients that she had cared for who presented with delirium. During the course of the interview she mentioned three separate examples; I chose to include each one.

4.3.4.1.1 Example #1

This gentleman had a TUPR (transurethral prostate resection) and he lived alone. I took care of him one evening. The LPN had done his assessment and charted that he was alert and orientated. He slept through the night and there were no concerns. The next night when I came in he was still orientated. He knew who and where he was, and he knew the date, but he started asking questions that didn't really make sense. For example, he said that I needed to get him into bed when he was already in bed. He wasn't certain that he was staying in the

hospital that night, and he was concerned about what he called his “water bag”. I explained what the water bag (urinary catheter) was, the reasons why it was in place and what we were monitoring for (blood clots, bladder spasms, pain or feeling of fullness in his bladder). He seemed OK with that and when I asked him about pain he said he didn’t have any. I was concerned about him so I checked on him closely over night.

At about midnight I found him standing at the side of his bed. He had no regard to his catheter, and he was unsteady on his feet. He didn’t know what time it was and he couldn’t tell me what he wanted to do, or where he was thinking of going. I settled him back to bed. I let the LPN know that we needed to watch him closely overnight. She (the LPN) removed his catheter at 0600. At that time he was up getting dressed and wanting to go home right away. I explained to him that he still needed to void a sufficient amount before he would be discharged, because sometimes there were complications and we needed to monitor his urination for a short period of time after the catheter was out.

I charted what he specifically said to me, and what happened. For example I would chart what he would say to me and how I responded. Sometimes I will chart “blank stare”, when they can’t maintain attention. I don’t think I charted about his inattention though. I don’t think I did the CAMI.

When I left that morning I told the charge nurse that he couldn’t go home that day. He wasn’t aggressive, he didn’t need loxapine, he just wasn’t right. He wasn’t aggressive; he didn’t try to pull any tubing. I’ve had other situations where they come back from surgery and they just pull everything out. That’s when we usually give loxapine, when they are trying to crawl out of bed or they are pulling at things. In this situation I didn’t see that loxapine was appropriate. He wasn’t aggressive; he just wasn’t right.

4.3.4.1.2 Example #2

The other pt was a lady who had a fractured hip and she was waiting for surgery. The first day she was my patient and nothing seemed out of the ordinary. She was known to one of the other staff members who said she was very sweet, and nothing was mentioned about confusion. The next day, she seemed a bit off. I knew something was wrong, so I called [the educator]. Then she ended up going for surgery before I could investigate further. When she came back, I didn't notice anything too unusual; normally in the first couple of hours patients can be in and out, but as my shift went on I knew something was wrong. I did the CAMI and it was positive. I let the surgeon know.

I wasn't sure if it was the morphine that she had been getting prior to surgery, and I didn't know her history. We had no history on her chart. We tried changing her analgesic but she was getting worse not better. So I started investigating, and I asked her husband if she ever seemed like she couldn't remember things. It came out with my conversations with him that she was a bit forgetful, so then we did a mini mental.

The result of the mini mental was that she was in the preliminary stages of dementia. We had stopped the analgesic that was previously ordered and we tried something else, but she wasn't getting better, she was getting worse. Then we were really scrambling. It was a good three days before she started getting better, and I had her the whole time.

Because she was an orthopedic patient she had loxapine ordered; it is included on the pre-printed orders. She didn't necessarily need it, but she was having a hard time, because she was reacting to the morphine that she had been given the past two to three days before the surgery. I had her on days and then I switched to nights and no one caught it in between. There was no record of any follow up in that time.

It was actually the resident that responded to our call. Residents are fantastic! I told her that something was wrong. I didn't know if we were exacerbating things with the narcotics, but she was clearly agitated and not doing well. She would cry, and I just felt awful for her. The resident called the family doctor to get a complete history because there was no history in the chart.

4.3.4.1.3 Example #3

I had another time where we had a lady who was orientated but confused on admission. She was another fractured hip waiting for surgery, and she started becoming quite agitated. Usually we don't get the extremes; usually they are confused but they are pleasant. They aren't fidgety, agitated and pulling at things. But then you get the other extremes where they are doing all of that plus, crawling out of bed, grabbing, pulling everything out and screaming. We get both ends.

I haven't experienced POD in my other surgical experiences, at least not as frequently. Here I see it very frequently. Sometimes it's once a week, sometimes it's two or three times a week, and we end up with five patients in the hallway because they are all confused. Because our population in this city is older, and because the older population is more at risk, we get it a lot, and it's a lot of work. Two to three times a week is a lot, because you are on the floor working nights, and often you are working short staffed. So to be dealing with this is time consuming and you really have to manage the risks that they present to you and to themselves.

I think I learned about POD from my experience working on this floor and also from the education we had about it in orientation. I find a lot of times that it (POD) is missed. It isn't seen as a critical situation. Often nurses won't call the Dr. They don't want to *bother* the Dr.

with *that*. Sometimes we have these pts for an extra week because of it. I think staff are just used to seeing it. The charting is usually “Patient confused”. It’s never specifically charted that “Patient has postoperative delirium”. It is never picked up. Why are they confused? Were they previously confused before? It’s just not seen as a critical situation; it’s not the top of their priority list. I don’t think it is safe. I don’t feel secure. It’s disconcerting. The general feeling is that “Well, they will wear it off”. We are such a busy unit that it’s not seen as something critical; it’s not seen as life threatening. To many people, as long as they are not crawling out of bed, as long as they are not falling, then it’s OK; it’s not a big deal.

There are a few of us that do the CAMI, and I think we are really good about reminding each other to do it when we get a confused patient. We try to encourage each other. There are just so many of them, all these elderly patients presenting with delirium, more than I’ve ever seen.

4.3.4.2 Chest Pain/Respiratory Distress

We don’t see chest pain as much, but when we do it’s dealt with like *a snap of the fingers*, like that! It’s seen as a critical situation and there is an emergency response to it. I would assess ABCs, the pts’ respirations, how many, what quality. I would assess the O2 sat, and vital signs, and identify if this was an acute change. For example, what were they like prior to this? I would assess their need for oxygen, call the Dr. and get an EKG if needed. I feel confident that I would definitely reach the doctor and get orders if this was an acute cardiac or respiratory event. The RT team is fantastic; they always respond right away, and in an emergent situation like this they come up right away.

I learned this assessment, this way to assess emergencies, in my education. From the “get go” we learn to assess the ABC’s (Airway, Breathing, Circulation); this is the basis of

patient assessment. When I notice confusion I think of ABCs too, because it could be that the patient is not perfusing his brain, but I don't know if the staff think that way. For example it could be lack of oxygen, or lack of hemoglobin molecules to carry the oxygen to the brain. I just don't think those connections are made with confusion like they are with chest pain or respiratory distress.

4.3.4.3 Narrative of Difference

Unfortunately when you work as a team (team nursing, rather than primary care) it's hard to catch everything. You assume that your team member will come to you when there is a problem, for example, when there is an abnormal finding in the patient's assessment, but often they don't. So it is really frustrating when two to three hours into your shift you find out that this patient's sat is 86% on room air, and you were not told. Neither was oxygen applied to that patient. So when the patient presents as confused, it is the same thing. There is no action; there are no investigations or questions that maybe the low oxygen is causing the confusion. I try to catch it as much as I can.

I've become a bit more diligent just working in orthopedics now, because you see it all the time. I just continue to see a lack of attention to POD and a lack of education. It is more a lack of wanting, or realizing that we need more education. I love to investigate; but I don't see that in everyone. I guess that's why I'm not too keen on the nursing team, because I don't have the control to say "No. This is what is going on with my patients. This is what is going on, this is what is happening and these are the outcomes that I assume would happen". When I am not made aware it's hard, especially if we are short staffed, and we are running, running, running all the time. But if we treated POD correctly, we wouldn't have five patients out in the hallway in the first place.

It seems that some of the younger RNs are more investigative than the older ones who have been nursing along time. I think the younger ones are still hearing that instructor behind them, looking over their shoulder and asking for information on what is happening with the patient. I remember my first shift as an RN after I graduated, when I first got my license; I remember thinking that now I was the one responsible. The younger ones just seem to be keener. I don't know why the older ones are like that, and I hope I never get like that! I worked hard to get here, and I want to make a difference.

We had a patient the other night who was confused and crawling out of bed and the staff lost him twice. They put him in a Geri chair, he got out of it, and he wandered off the unit. We finally found him and they wanted to give him ativan. I asked them to try loxapine first. We needed to calm this patient down because he had an abdominal aortic aneurysm and he was waiting for surgery. It is crazy here sometimes.

Patient's safety is very important to me. I don't want to be sending people home when something is amiss, when I have that gut feeling that you know something is wrong. I guess that feeling comes from experience, and from my need to know, to always learn why something is happening the way it does.

With the emergent conditions there is always support. You know whom to call and they come. They investigate the cause right away, while with POD, they seem to feel it will just work it's way out, they don't bother to investigate. Chest pain is seen as critical; the patient could potentially die. Whereas with POD, it's like there's no big deal; we always have confused patients. Even when I go to the charge nurse and tell her that someone is confused I don't think she understands what to do. POD is just dismissed. I get very frustrated with that, because it seems to me because we deal with such an older population that they just

assume people are going to be confused, and they are not worried why. They are not worried about how to treat it, because that's just the way it is.

4.3.5 “Lindsay”

It is interesting that although I asked Lindsay a number of times to tell me about specific patients who she had cared for, she continued to talk in generalities. This was the case both with the example of POD and the example of a different acute onset.

4.3.5.1 POD

There are a lot of these patients; it's hard to pick one. They range, for example there are the mild ones, who are more or less slightly confused, but they easily orientate and they don't try to climb out of bed. Then there are the ones that are very confused and they need closer monitoring. For example, at nighttime bringing them closer to the nursing station or getting a one-to-one. They can pick at their gown or their IV, they don't know they are in the hospital; they are very agitated or combative. Most often they are just pleasantly confused; they seem a bit more anxious, sometimes they think they are at home. You can easily tell them that they are in the hospital, even though they don't remember the conversation, but at least they are easily directable.

I would chart “Patient confused”, and what they say, what they believe. For example, that they believe they are at home, and whatever else they believe. I would chart if they are easily directable and redirected that they were in the hospital. I would chart if they for instance, are picking at their clothes, or at the air. I would chart if I did anything, like brought them closer to the nursing station, or arranged a one-to-one for closer monitoring.

Depending on how delirious they are, sometimes we will give loxapine, for example if they are trying to climb out of bed. But half the time it doesn't do anything. If you can, you

try to talk to them and reorientate them continuously. It helps to just spend that extra time with them to make sure they understand they are in the hospital. That's difficult because workload is so heavy you don't often have extra time. A lot of times I leave the bedside light on so it's not completely dark, and they remember they are not at home. Because most of the time I find that if you turn all the lights off in a room then they are going to climb out of bed. Usually we will pin the call bell to them so that if they do try to climb out it will alarm.

I learned to practice this way from other nurses here, not in school. In nursing school you didn't have a lot of patients, so you were sitting there a lot more. I probably learned the medication part of it in school. I've seen nurses respond to patients with delirium by giving them drugs. I think they do that because it's easier. They give them drugs and they keep an eye on them as well.

I haven't seen the nurses use the CAMI, although I have heard about it. I don't think they use it because it's not readily available. Even me, I think I know it's there, but I think if it was placed in the charts they would probably be more inclined to fill it out. We didn't learn about the CAMI in nursing school.

It's frustrating dealing with patients with delirium, but it's nice to know when you come back after the next couple of days and they are normal. It tests you, but that is rewarding. It tests you because they are quite agitated and confused. You bring them to the nursing station and talk with them and you get to know them because they talk about their pasts a lot. So that part is rewarding.

4.3.5.2 Chest Pain

With a patient who presented with chest pain, I would finish off their assessment, take vital signs, put on some oxygen and let the doctor know. I would always put oxygen on

them, whether it is heart related or not, because you never know. You always want to assume the worst. When you talk to the doctor you need to know the vitals for a baseline. Potentially something can go wrong, so you want to do the right thing. With chest pain once you get the diagnostic tests, you can feel better if they show that it is not a heart attack. Charting is so simple. "Patient complained of chest pain", the type of chest pain they were having, vital signs, what you did, for example, put oxygen on them, put the head of the bed up, called the Dr, and whether he called you back. Then you would chart if anything was done, for example any orders that you carried out.

4.3.5.3 Narrative of Difference

We don't think along the same lines with confusion as we do with chest pain. I think that's because we see a lot of delirium; I think with postoperative delirium you think it'll eventually go away. I guess chest pain will eventually go away too, but you always just link the delirium to the surgery that the patient had and it just eventually goes away. With chest pain you get more adrenalin going, because potentially something could go wrong and you want to do the right thing, you want to make sure. I think POD is easily overlooked, where chest pain is not. Because with POD it can range; you can have somebody that is completely confused and trying to climb out of bed, but you can also have somebody that is just a little bit confused and all it takes is for you to redirect them. Some patients only have a slight change in their behavior. A lot of people don't pick that up. Then the next nurse comes on and says "There's something not right with this person'. So it's hard, because every nurse sees things differently.

I don't think nurses recognize delirium as an emergent symptom. I think they see the potential for something to go wrong. For example, if they have a fresh postop orthopedic

patient and they are trying to get out of bed, and then they fall, they can easily hurt themselves. I don't think nurses even see the other part.

4.3.6 “Kathy”

Kathy's narrative summary includes examples of a patient who presented with POD, another patient who presented with respiratory distress and a narrative of difference.

4.3.6.1 POD

This patient was an elderly lady; I've had so many. They come up all the time that it's hard to pick just one. This lady was an older lady in her seventies or eighties. She had her hip done and she was quite confused. She was pulling at her IV (intravenous line) and calling for her son. We gave her loxapine and I tried to sit with her to calm her down. She started yelling and she was upsetting her neighbor. When her family came in and she saw them she seemed to settle better.

I did my assessment on her in the morning. The night staff told me that she had been quite confused at night, but she had moments where she was with it, and she knew where she was. After lunchtime she started getting more confused. I asked her a few questions and she knew where she was; she knew she was in the hospital. But then she started off again. Her family was worried about her feeding. I explained to them that she was calling out for someone and they told me this person she was calling out for was not coming in. She wanted me to call this person to have him come in. They were worried about her, but I explained it to them.

I did her morning care, her feeds and turned her. I gave her Tylenol, which she spit out. It was hard to keep her pain under control because she didn't want to take the Tylenol and I

didn't want to give her anything stronger. She was just getting more confused and eventually she became a total.

I certainly didn't learn how to care for these patients in nursing school. I learned it from experience, from the other nurses that I was working with and from being on this ward so long. Just from seeing it over and over and over, from experience and from talking to other nurses. I also know what narcotics like morphine do to the elderly.

It's frustrating dealing with these patients because it takes up a lot of time, it's a lot of work and because we are so busy. I feel like I don't have time because we are running, and sometimes I have more than one. I can have other confused patients. This ward is an extremely harsh floor. So it's frustrating. I go with it, when I don't have enough time with them.

I felt frustrated because the other lady in that room had gone through a bad experience with cancer and she was upset with this confused lady yelling and screaming, and the family on top of it. So then I had to think of bed moves, to try to please this other lady, and then the confused lady's family was upset about the confused lady being moved. So I really feel like I don't have the time I need to handle all this. They take up so much time when they are confused, especially at night. Because then they become hallway patients and they are unsafe; they may crawl.

I don't feel supported in my practice. Supported by other colleagues, yes. Supported by management, no. It's frustrating because we don't have enough staff and because we are getting sicker and sicker patients. I feel like I am just exhausted, running around. And you try to tell them (management). You draw up these forms, these stupid forms that we draw up every time it becomes unsafe. And nobody really does anything. It just becomes paperwork.

So the only support I get is from my girlfriends and my colleagues. We talk about it in the staff room; we talk after work. I don't talk with my family because they wouldn't understand anyway.

So I just sort of deal with it. We talk about the frustration, about leaving the floor, but where are you going to go? Sometimes you get angry too. I wish I didn't have to show up to work and feel angry. We have staff meetings, but they do nothing. You sit and talk, and then you go home and nothing's been done, so you feel frustrated with that. We are saying that it is unsafe, but management doesn't respond or anything. So it's frustrating, because on top of that family members are also upset with us.

The family members are upset with us, but that is probably because they feel frustrated and upset too. They are worried about their father, or mother (the patient) and then they see us tie the patient down; we have to tie them down. Then we have to bring them into the hallway, and the family feels the stress. They don't like to see their family member lying in a bed in the hallway.

Sometimes the doctors don't get it either. They really don't get it. They don't get it as far as the orders, what we want for them, and what they are ordering. Sometimes it is the narcotics. I don't think they understand, because they don't have to deal with it. We are the ones that see it. The doctors don't seem to want to know about it. They don't want to be bothered; they won't listen or let you explain it to them. Even some of the nurses don't call the doctors about it because they know the doctors don't want to be bothered with that.

The elderly population is such a big field now. I used to work in extended care. I have taken classes about delirium, but I don't think there is enough education about it. We don't have enough education about the elderly population because it is such a specialty. When we

had a Geriatrician I learned a lot from her. I learned about the medications, and how they work differently in the elderly. We just don't have enough education about the elderly.

I have heard about the CAMI, but I never really got taught it. I haven't seen other nurses doing it. I've heard about it, that's all.

4.3.6.2 Respiratory Distress

This was an older man too. There was another nurse caring for him and I just kind of helped her out. I tried to keep him calm and held his hand. The other nurse was assisting him with his oxygen. We positioned him and adjusted the bed. The doctor had already been in, he knew what was going on and he had ordered the nebulizers, which we gave. We also gave him a very small dose of morphine, which settled him a bit. I learned to practice this way both from schooling and from being with my colleagues. You watch the way other, more experienced nurses talk to the doctors and what they ask for.

As far as how I feel about my practice with these types of incidents [patients presenting with other acute onsets], at first you get a bit of a rush out of it. You feel the stress, but you always know you will get support from the staff. You will always get someone to come; I always get someone to help me. When I phone a doctor about something like this, I usually have no trouble. I chart my assessment, when I was in the room, when I called the doctor, and what I did. This can be stressful too, but it's not the same stress as with a confused patient. Delirium is a lot of work, a lot more. It's different; it's heavy work. It gets scary. I feel like I might miss something because we get so busy.

4.3.6.3 Narrative of Difference

There is a big difference between what happens with confusion and other acute onsets. You get way more, or at least you feel like there is way more support, from the doctors

anyway. For example, when a patient is in respiratory distress, we call respiratory (RT) because you know when you phone them they're there! With delirium it's like pulling teeth to get anybody.

I don't know why that is. People even fail to write anything in the chart about the delirium. I don't know why that is either. For example, when I come in and I'm going to take over this patient assignment, and I don't know what's been going on because nothing's been charted. It's frustrating. The family members are wondering what is happening, and there is no way to track when it started, or what has been going on. With another acute onset it's all right there. When you have a patient like that, with an acute onset like a respiratory event, people always chart. I've worked in geriatrics for a while before, and it just seems like it doesn't get the same attention.

4.4 Part Two: Discourses at Work in the Narratives

In this section I discuss the findings of discourses at work within the narratives. It is important to note that these discourses were not discreet entities; they overlapped and coexisted. As a result it was difficult to categorize these discourses in a linear presentation for this text. Therefore although they are listed separately they were interdependent (not static), integrally related, interwoven, and mutually informing one another. In congruence with other poststructural health research focusing on discourse (Copnell, 2006; Hole, 2004; Neville, 2005), I have incorporated some theoretical discussion within this section in order to provide a foundation and explanation for these findings.

I begin this section with an illustration of the context of where these discourses were at play, which was the postoperative patient care unit. I proceed to a discussion of the two most prominent discourses at work in the vignettes, discourses of legitimacy/illegitimacy and

discourses of nursing work. Within and between these two discourses were other discourses, which I will discuss briefly as they relate to the interplay between the major discourses, and to nursing practice. I have not attempted to give an overview of each and every discourse operating in the narratives; rather I focus the discussion on the discourses that are most salient to my research question which was: With a focus on the orthopedic patients on '2A' at 'Canora Jubilee Hospital', what are the key discourses that shape and discipline nurses' response to POD? In other words, how do these discourses implicate practice in terms of how nurses respond to POD?

4.4.1 Context

The discourses identified in the narratives were at work within the context of a postoperative patient care unit located in a 450-bed tertiary care centre. This is a 37 bed surgical unit where staff mainly provide care for acute postoperative orthopedic, urology and neurology patients. The nursing team consists of RNs and LPNs. Ideally, one RN and one LPN are assigned to a team of seven to eight patients; there are five of these teams. In reality, most days the ward is over census, leaving those patients waiting for beds being accommodated on stretchers in alcoves and hallways sometimes for days at a time. Lack of privacy as well as safety issues such as access to emergency equipment (suction and oxygen) make it difficult for nurses to provide safe and competent care for these patients.

In addition, the nursing shortage complicates matters. Without the regular compliment of staff combined with increasing numbers of patients, nurse-to-patient ratios are larger. Therefore nursing staff are responsible (often on short notice) to reconfigure the nursing teams. This is not a straightforward task and it causes disruption in the routines and norms of the ward.

Increasing retirement of experienced nursing staff leave a demographic of fewer nurse leaders and more new graduate/novice nurses. Therefore the *redelegation* of assignment must include careful consideration of the knowledge and skill level of the RN and LPN as well as the acuity of the patients. Experienced staff members carry a greater burden of work responsibilities in not only assuming full patient loads, but also intervening, teaching and solving problems for the other nursing teams. As well, nurses are often asked to work overtime; this contributes to increased sick time and perpetuates the problems.

The majority of nurses on this ward work 12-hour shifts, with rotation patterns characterized by two days and two nights on, then five days off. Nursing leadership includes an RN who attends to the day-to-day operation of the ward. Other experienced RNs on the unit rotate through this position on the night shift. This individual is responsible to coordinate communication between all the other members of the health care team as well as bed utilization, which means creating a balance between discharging patients and accepting newly admitted postoperative patients. There is daily pressure to discharge patients in order to accommodate the *surgical slate*, the number of patients who are scheduled for surgery that day and require a postoperative bed on the ward. Repeatedly, surgical patients have their scheduled surgery cancelled because there is no available bed in which to recover them. Reasons for this vary, one reason is that there are a number of older adult patients in hospital beds who are no longer acute, yet are unable to go back to where they were living and require placement in long-term care beds. There is a critical shortage of these beds in the community (CBCNews.ca, March 18, 2008) therefore the problem is compounded.

In part because this ward is located in a tertiary-care hospital there are number of support teams available to the nursing teams, including (but not limited to) managers,

educators, pharmacists, respiratory therapists, cardiologists, nephrologists, intravenous specialists, and psychiatrists. Geriatric support includes one of two geriatric psychiatrists and a geriatric assessment team (REACH team) consisting of a geriatric nurse specialist, an occupational therapist and physiotherapist who specialize in geriatrics (REACH stands for Referral for Elderly Assessment in the Community and Hospital). All of these support staff are not available in the evening or through the night except for the respiratory therapist (RT) and on-call physicians. As well, the RT staff numbers are decreased at night and the on-call physicians are fewer at night and generally not acquainted with the patients on whom they are asked to intervene. Many of the participants indicated that from their experience, POD (and the problems associated with caring for these patients experiencing POD) occurred more often at night.

It was within this context that each of the participants in my study navigated and performed discursive practices that competed, overlapped and coexisted with other discourses. From their narratives, which described their practice of caring for patients (including patients with POD) within this environment, I identified two prominent discourses that shaped and disciplined nurses' practice: discourses of legitimacy/illegitimacy and discourses of nursing work. I will begin my discussion with discourses of legitimacy/illegitimacy.

4.4.1.2 Discourses of Legitimacy/Illegitimacy

Discourses of legitimacy/illegitimacy represent the binary between what is accepted and assumed, and what is rendered invisible, silenced or reduced to the margins of nursing practice. For example, these discourses produce power and powerlessness, in so far as positioning phenomena in one way or another or one category or another. In terms of one

discourse or another, the binary is that one is powerful because it can be spoken about (legitimate) and one is powerless because it cannot be spoken (illegitimate).

At the same time, discourses of legitimacy/illegitimacy were not explicitly named in the narratives. These discourses were revealed repeatedly in the narratives in conjunction with differences in attitude and responses of health care providers to other acute onsets (such as chest pain) compared to POD. This revelation of attitudes and actions unveiled the legitimacy of chest pain and the illegitimacy of POD. One means through which POD was constituted as illegitimate was through the practices of absence.

4.4.1.2.1 Discourses of Absence

Those practices that would have constituted POD as legitimate were simply absent in nursing practice. Examples of absence included absence in naming delirium, absence of being taken seriously, absence of being listened to, and absence of taking action. These practices of absence were perpetuated and reinforced at all levels of care from LPN to physician. Nurse participants emphasized repeatedly not being listened to or taken seriously when discussing a POD patient situation with nurse colleagues or other health care professionals, particularly physicians. LPNs reported not being listened to by RNs, who in turn described other RNs and nurse managers/charge nurses who were inattentive to their expressed concerns. To show this chain I will start with an LPN example, follow with an RN to RN, then an RN to charge nurse, and then proceed to the physician level.

The first example is from Donna, an LPN with over 30 years experience and excellent clinical skills. Donna expressed disappointment in the actions of the charge nurse (RN, with less work experience) who did not take seriously her concern for a patient with POD:

That was one thing I don't think was very well done...I thought the charge nurse was lackadaisical about the whole thing...and I really don't think she did a lot for me or the patient (Donna, lines 162-166).

Donna further explained her disappointment in the response to her concerns about her patient with POD, "I was very disappointed in the fact that my word was not taken seriously, that I was seriously worried about this patient. [It] wasn't good enough. The patient is the one that is going to ultimately suffer" (Donna, lines 179-187). The reason that Donna was not taken *seriously* was because her concern was not recognized as a legitimate one.

Kathy and Kirsten (both RNs) described their frustration with the absence of charting and communication on POD compared to the charting on other acute incidents (chest pain):

It bugs me sometimes when I come in and I'm going to take over and I don't know what's...or family members wonder...you try to see where or when it [POD] all started. Cause with the acute [incident] you have it right there. People always, like when I come in, what I've seen anyways, when you have somebody like that, [chest pain, respiratory distress] they chart. (Kathy lines 238-241)

In addition, discourses of illegitimacy were performed by nurses based on physician responses to POD. Nurses described their reluctance to call physicians who referred to POD as "*that*". They recalled having been told, by both the physician as well as other nurses (often nurses in *charge*) not to bother the physicians with *that*. POD is so *illegitimate* they don't even *name* it. Kirsten reinforced this when she explained: "It's just, OK, patient's confused. Um, it's never, ever specifically said 'patient has post op delirium'" (line 213). Kirsten further reinforced how nursing practice reflects and takes up this discourse of legitimacy/illegitimacy through lack of communication. She explained nurses' tendency to

avoid communicating with physicians based on their previous negative responses from physicians to receiving calls about patients with POD. This is another expression of absence in the case of POD: the absence of communication, which further reinforced the illegitimate status of POD. “It’s just, it’s *dismissed*...it’s dismissed a lot” (Kirsten, line 576, italics added for emphasis). “And a lot of nurses are scared to call the doctors because we’ve called doctors before [and heard] ‘Well, why are you calling me for that?’” (Kirsten, lines 452-453, italics added for emphasis).

Kathy expressed another way that POD was unsanctioned and illegitimized by doctors when she explained the difference between what nurses see or have to deal with and what doctors don’t see and *don’t* have to deal with: “Well, sometimes the doctors don’t really get it either I guess. They really don’t get it...they don’t listen I guess when you call them about it, or explain to them. They don’t...cause we see it...but they don’t” (Kathy lines 122-130).

Kirsten described the illegitimacy of POD in moralistic terms with POD clearly positioned as the “wrong thing” because it did not fit the legitimacy of a critical, life and death condition. She described how POD fails to fit into the priority category and therefore is unsanctioned as a class of symptom and unable to be spoken about:

They’re just seeing it...this isn’t a critical situation. I find sometimes it’s like well, lets not bother the doctor with *that*. They have, you know, loxapine is ordered, they don’t need to know about that kind of thing...they don’t need to know about it...it’s the wrong kind of thing...it’s not top of their priority list (Kirsten, lines 281-287, italics added for emphasis).

4.4.1.2.2 Discourses of Classification

Ivan captured legitimacy as residing or emerging from the seriousness of symptoms, and suggested a hierarchy in the classification of symptom severity. Compared with other symptoms such as acute onset chest pain, POD was classified as non life-and-death, rendering it less important, and therefore illegitimate.

[Post op delirium and chest pain are] totally different. It [POD] is not classed the same.

I guess it's seen not to be as serious, not to be as life and death. Delirium [is] more...it's a risk of personal injury from a fall or something like that, rather than they're going to die...or could die (Ivan lines 433-445)

Ivan continued this discussion affirming “Well, post op delirium and chest pain or respiratory distress are definitely not in the same ballpark (line 492). Tanya elaborated on the differences in nurses’ attitude between the two symptoms and suggested that this attitude existed in her basic nursing education/training:

OK...here's another barrier. Maybe it's a *mind set*, like and *attitude* sort of thing. Like people are more willing to respond to...respiratory distress than they are to confusion. I guess [because] we were trained...we were educated [that way]. It's sad because ...this respiratory distress was solved in an hour really, and the confusion was going on hours later. (Tanya, lines 177-182)

Ivan unveiled further evidence of the legitimacy discourse when he spoke about how he received *continuing* education on the topic of shock during first aide training, and how this helped him to understand shock as a serious situation, a legitimate situation. As he was speaking about shock during the interview it was evident that the condition of shock incited excitement and a sense of urgency:

Well I tend to take [chest pain, or shock] as a more serious situation. [I learned that] in first aide [and] ski patrol. You know, every year you have to take a new test and the training is...it's huge and it's helped so much in understanding shock. And you know, you'd see it out in the ski hill or even in the course and you'd see shock and you'd learn about shock, and then you'd come here and see shock and [it's like] "Oh! That's shock! Oh wow look at that! That's definitely a clear case of shock!" And so for me that's what really changed my outlook to [shock], like I view the patient different (Ivan, lines 285-305).

Ivan's next responses made it clear that he did not equate POD with the same sense of emergency as chest pain or shock. He also disclosed that he was unaware of the causes of delirium. Until his father-in-law experienced delirium he thought delirium was only caused by withdrawal from alcohol:

When there was a more severe case, um, like I, I always thought it was something like, ah, maybe someone drinks at home...I would kind of go into my brain, well they must drink, and maybe they're withdrawing, and why else would this be happening? And then especially when my father-in-law was in the hospital I saw it so *clearly* because he wasn't a drinker. Yet he got so mixed up. *So confused*, and he was a very *normal* independent person that I would *never* expect that [to] happen to. (Ivan lines 84-100, italics added for emphasis)

Towards the end of the interview Ivan asked me "Why are we not treating it [POD] like it's an emergency situation?" (lines 460-462). I replied by asking him if he had any ideas why, and he answered "I think it's misunderstood" (lines 464-466). Later he told me "I had no idea. I had no idea they would die, or they *could* die". This statement illustrates yet another

way POD is positioned as illegitimate. Ivan has practiced as an LPN for over 15 years in this facility, yet in that time he had received no education on POD. On the other hand, working as a first aide instructor he was required to write a yearly test that evaluated his skill and knowledge of shock.

While POD was constituted as illegitimate and unsanctioned, nurses' responses in the study indicated that other acute onsets such as chest pain and/or respiratory distress received immediate attention. For example, Kirsten reacted with a snap of her fingers when I asked her how chest pain was dealt with, "like *that* [snap]" (line 102). She then explained that this is because it is seen as a critical situation. Donna provided a verbal, comprehensive example of a focused acute nursing assessment and resulting interventions when asked to describe how she would care for a patient who presented with chest pain. She added, "You can't rule it out" (line 273). "You have to approach it as chest pain [indicating a heart attack]" (line 280).

These findings illustrated how chest pain is constituted differently than POD: it is assumed that nurses and other health care providers *have* a responsibility to respond to chest pain because it is a legitimate symptom. What makes chest pain legitimate is that it can be measured.

4.4.1.2.3 Discourses of Evidence

Measures are intricately tied to evidence, and in the case of chest pain these measures are tied to the *right kind* of evidence or legitimate evidence: represented as Randomized Controlled Trials (RCTs). POD cannot be objectively measured and verified as a symptom signaling an attack on brain. On the other hand, chest pain has been verified as a legitimate symptom through objective technological determinates such as an EKG and lab tests, which

scientifically and definitively indicate an attack on the heart. In the case of chest pain, diagnostic tests evaluate stages of abnormalities. Lab values compare the patient's results to normal values, dictated by scientific, positivist determinates. Abnormalities to these levels often reveal the cause of the insult. When I asked the nurses how they would respond to a patient who presented with another acute onset (for example, chest pain) they included the diagnostic tests (EKG and a troponin level) which would either confirm or rule out a heart attack.

Lab values may also indicate an attack on the brain. For example, low sodium levels may present as the symptom of hypoactive delirium. A positive urine culture may indicate the cause (infection) which may present as the symptom of hyperactive delirium. The key word is *may*. The causes of POD are multifocal and complex; interventions cannot be *proven* to be effective to the same extent as cardiac issues. Therefore, the same type of diagnostic tests (lab values) used to identify POD in patients do not equate to the same degree of legitimacy as lab values used to identify cardiac issues in patients. As well, while the nurses were quick to identify that investigations and interventions occur emergently for chest pain, they also recognized that the opposite characterizes POD, as Kirsten described:

You know whereas...you know chest pain they need to investigate the cause...whereas they don't, with delirium, they don't seem to *investigate*...you know when I go to the charge nurse and you know [tell her the] patient's confused [I don't think] they know what to do (lines 541-551, italics added for emphasis)

Donna's responses further emphasized this attitude. When I asked Donna how she would care for a patient experiencing POD, she provided a list of tests that should occur when investigating the cause of the behavior. These investigations included medication review

(including narcotics), consideration of a urinary tract infection, and identification of the patient's baseline cognitive status. She even identified the need to investigate that the patient may have delirium superimposed on dementia, and provided a sophisticated clinical description of the need to identify between the two. Yet, even with her experience and her sound clinical skills she was not listened to. I could feel her immense frustration as she expressed concern that no one took her seriously.

Donna goes on to explain how the body is constructed as a machine that can be fixed:

I think the difference between the two is that one's a medical condition that [is] *treatable*. You can treat that medical condition...you get the nitro, you do this; you do that. There are steps to follow...and those steps are tangible. They're there for a reason and you follow those steps. Where with delirium, you know it's very difficult to find that. Because how do you deal with it? (lines 317-323).

Legitimacy was linked not only to having evidence to validate the condition but having supports available for nurses who are caring for patients experiencing delirium.

4.4.1.2.4 Discourses of Support

The illegitimacy of POD was apparent in nurses' lack of awareness of specific supports for POD, or how to access them. Yet, each nurse identified the supports available for other acute onsets, such as chest pain or respiratory distress. For example, nurses understood chest pain as reflecting something broken with the heart, and the need for intervention to fix the affected part to prevent cell/muscle death and pump failure. However, most of the participants in this study did not connect POD as a symptom that indicated an attack on the brain that could ultimately result in brain death. Every nurse except Tanya talked primarily about orientation in relation to the assessment of a patient who is *confused*, even though

orientation is one of the least sensitive markers for delirium. All of the participants admitted to hearing about the CAM (Confusion Assessment Method) in some capacity, including hearing other nurses talk about it, hearing about it in education sessions, observing other nurses using it, or having personally used it in the past. None of the nurses spoke about using it in their narratives of caring for a patient with POD prior to me prompting them about it. Reasons mentioned from the participants for not using it included that the nurses do not know it is there, or do not know it is “readily available” (Lindsay, line 98). Other reasons included lack of education, lack of support from physicians, and attitude toward the syndrome and older people in general.

Not one participant (when asked about existing supports for their practice) mentioned the REACH team (geriatric resource team) in their narratives, yet each nurse identified the resources available for other acute onset emergencies. It was if the REACH team did not exist. All of these examples contribute to the way that POD is constituted as illegitimate. Legitimacy was linked not only to having adequate supports available to validate acute onsets in patients, but also having explicit time-limited protocols to treat and resolve these conditions.

4.4.1.2.5 Discourses of Resolution

Nurses talked about the difficulty of resolving POD compared to what they identified as swift resolution of other acute onsets. Without standardized protocols or pathways to fix/treat the problem, and undeserving of more than “hallway” approaches, POD remained elusive and reduced to illegitimate status. Donna elaborated:

We don't feel like that [frustrated] with a patient with chest pain because you know that will be resolved. The confusion is going to be longer, it is not just a short-term thing,

and you know it is going to take up more of your time. The problem is that there just doesn't seem to be a tangible thing to say about what you do with delirium, like you do with a patient that has chest pain. With chest pain there are things that you do. You give him oxygen, you do this, and you do that. And with delirium what do you do? What do you do with delirium? I can't tell you how many times I have said, "This guy is confused, and I filled in all the assessment data. Yet, the patient gets put out in the hall or tied into a chair. That's our answer to delirium (Donna, lines 398-415).

A measure of legitimacy came only when the untreated and largely ignored patients with POD became highly aggressive and completely out-of-control. In the facility where this study occurred, this extreme situation activated a Code White, which brought an emergent response from a team consisting of security personnel, staff members trained in physical management of aggressive patients, and a psychiatric nurse. Donna spoke about how calling a Code White mobilized action in the same way that action was mobilized in patients presenting with chest pain:

I think with the...I think with delirium...we don't have enough resources to deal with it. The resources [are] when [the patient] gets out of hand, we call a Code White, because we don't know what to do. So...I mean that is an action too that can be taken. You know sometimes you have to do it. It just depends. By that time the whole situation [is] out of hand. So then you sort of put the cart before the horse at this point because this person [is] *completely* delirious and antagonistic and everything else that goes with that. And that's when the Code White [is] called because you can't deal with the situation and *then* everything comes into place. All the stuff comes, the drugs and stuff. (Donna, lines 355-365, italics added for emphasis)

4.4.1.2.6 Discourses of Normalization

There was a complex relationship between discourses of illegitimacy and discourses of normalization. For example, where it could be assumed normalization connects to discourses of *legitimacy*, what was revealed in the findings related to nurses' care of patients with POD was the converse. For instance, participants stated that other acute onsets that signaled medical emergencies (for example chest pain or respiratory distress) did not happen often, where *confusion* was a regular occurrence. This is another example of how POD was constituted as a symptom not valued as legitimate, or worthy of an emergent response because it was *seen all the time*. Rather than being recognized as an emergent situation it became accepted as a "pain in the ass" (Donna, line 29). Ivan also illustrated this phenomenon when he talked about getting "to the point where you're banging your head against a wall" (line 171-172). What he was explaining was his reluctant admittance that one can only keep the diligence up for so long, and if no one listens, eventually your voice becomes weaker and finally silent. If there is no one left to question, it becomes assumed the situation is normal, and it is accepted.

Parallel to this, often the behaviour is seen as *normal* for these patients because they are elderly. Generally, nurses are not educated in the specialty of geriatrics; therefore they do not have the skills and knowledge to confidently question whether the behavior [confusion] is normal. The result is that one symptom is seen as illuminating a life and death situation, and the other is seen as normal, because these individuals are old and demented. Therefore, it is reinforced that POD does not need to be fixed because it is assumed *normal*.

4.4.1.2.6.1 Agism is Normal

Agism is normal is a sub-discourse of the normalcy discourse, which in turn, is a sub-discourse of the legitimacy discourse. These discourses are intricately connected and woven within a complex matrix. While POD should have been treated as a legitimate symptom, and therefore an abnormal condition, it was not. POD was did not receive adequate attention because it was considered just a normal part of what happens on the unit. If POD was recognized as a legitimate symptom health care providers would have treated it in the same way they did other legitimate symptoms such as chest pain or respiratory distress. The participants revealed that most health care providers did not recognize delirium separate from aging, as a phenomenon in its own right. Therefore they did not single out delirium as a medical condition that required a medical or nursing response. Because POD is not recognized as a legitimate symptom, health care providers did not differentiate between what constitutes a normal change occurring in aging and what constitutes an abnormal change in aging (POD). For example, if nurses saw the signs of infection in a wound of an older adult, they would not necessarily equate that symptom with aging. They would likely respond to that symptom as they would in any other patient population. But because *confusion* is often linked to *normal* behavior in the elderly, participants revealed that the behavior is treated as normal. It is assumed that the symptom of delirium is just ‘what old age looks like’.

While participants identified that the patients presenting with POD were not “right” and not “normal”, they also spoke about POD “happening all the time”. Therein lies the complex negotiation matrix between discourses of normalcy and discourses of difference, where the abnormal became normal. When difference becomes repetitive, it becomes attributed to normal; because POD was seen so often on the ward, it eventually became expected and

commonplace. Donna spoke about the general acceptance of ageism as older adults make up more of our patient population:

And, the other thing is we are getting more and more elderly patients all the time, and they are older and older. We do huge surgeries on these old people. It's [POD is] going to get far worse because we are an ageing population, and nobody thinks it's important (lines 487-488).

Kirsten reinforced the realization that the aging population is a *problem*. 'I've never experienced postop delirium in my other surgical experiences...not as frequently, because here I find it very frequently. I'm finding having it in the older population that we get *a lot*' (Kirsten, lines 86-91, italics added for emphasis). She then goes on to describe "all these elderly patients and them presenting [with delirium] more often than I've ever seen" (Kirsten, lines 265-266). In this way the agism discourse contributes to the construction of the illegitimacy of POD. Donna emphasized this point when she expressed the permeating general belief that "Gerontology's not that important" (Donna, line 488) and by inference POD is rendered unimportant and illegitimate by its association and high incidence within the older population. Kirsten elaborated further on this discourse of agism:

It seems to me that because we deal with such an older population, they just *assume* people are going to be confused. And they're not worried why. And they're not worried to treat it. Because *that's just the way it is* (Kirsten, lines 578-582, italics added for emphasis).

Further investigation of these discourses of legitimacy/illegitimacy revealed that there were two usages of illegitimacy present in the narratives of the participants: first, where nurses themselves (and the knowledge of nurses) did not feel like they were being

legitimated and, second, where POD was not legitimized. These two usages of illegitimacy will be further discussed in the discussion chapter of this thesis related to nursing practice. Discourses of legitimacy and illegitimacy were closely tied to discourses of nurses' work.

The unit where this study took place had a high incidence of delirium not only because of the older adult population but also because orthopedic patients have a higher incidence of POD due to the fractured hip population (Marcantonio, Bergmann, Jones, Murphy & Morris, 2003). These factors also greatly impact nursing work.

4.4.1.3 Discourses of Nursing Work

The second group of prominent discourses identified in the participants' narratives was discourses of nursing work. Discourses of nursing work are integrally related to discourses of support and discourses of illegitimacy; rather than acting discreetly, this interrelation of discourses worked to produce an interwoven cohesive network where each discourse informed and was informed by the other. For example, lack of legitimacy of POD resulted in nurses not perceiving their supports for POD; therefore because they did not perceive these supports, their work was increased.

Emphasis on the word *work* was most often used in negative terms and was particularly significant in every participant's narrative when they spoke about POD. The participants spoke about increased nurse to patient ratios, staff shortages, and in particular, the already increased workload intensified by adding patients presenting with POD to the 'regular' patient population on the ward. Ivan expressed his frustration with the workload in general:

Yesterday we had nine patients and we couldn't do our job properly. We even had help, but patients got left in the Geri chair too long; they didn't get a walk because you couldn't get to it. We were just putting out fires all day long. It was so busy, so hectic,

because of the workload. It's mentally stressful. We were both experienced nurses and I think good nurses, and we couldn't do our job properly. It was hopeless (Ivan, lines 179-182).

Donna expressed her frustration as she captured the local culture and ideology of work specific to caring for patients with POD in this conversation:

I said to the charge nurse, "I would like to move Mrs. So and So into [room] three because she's delirious...she wants to go home and I'm scared she's going to climb out of bed. I was told by the charge nurse, "Oh, they've already got one that's confused already and so I don't want to give them another one". And the ward [clerk] says, "Ya, and if you are going to move her you just make more paperwork for myself". And I thought, and I had to say to the word clerk, "*You know that's what we're here for. That's what you're here for is to work*" (Donna, lines 175-179 italics added for emphasis).

I'm sorry but that wasn't good enough. The patient is the one that's ultimately going to suffer...not the people on the other side of the hall. Ya, they might have one more. But it still doesn't make any difference. *That's what we are here for* (Donna, lines 185-191 italics added for emphasis).

Donna went on to clarify, "I think it's the epitome of what nursing is today is, oh well they're already heavy. They already have a confused one" (Donna, line 200).

Nurses perceived a lack of support even though supports were available. Their problem was a lack of knowledge about specific supports available to them in caring for patients with POD. Because POD was not legitimate it increased the work of nurses. Yet the use of such resources might serve to decrease their work. Kirsten provides evidence for this:

Like it's *hard*, um, especially when we're *short*. And I think that's another thing, is because we're really running; we're running all the time on that unit. Like constantly. But if we treated postop delirium *correctly* we wouldn't have five patients out in the hallway. (Kirsten lines 627-632 italics added for emphasis)

Tanya's conversation about extra charting for her patient experiencing POD was symbolic of the amount of *work* she felt.

Well it was definitely one of those *pink page* nights. [The pink page] is like ah, *extra, extra, extra* charting. So the full narrative that we have to chart was all filled therefore I had to use an extra page. (Tanya, lines 97-102, italics added for emphasis)

Contributing to an increase in nursing work was the disruption created by patients experiencing POD. Nurses talked about the disruption created by a disorganized, chaotic environment that in turn created more stress on nurses. Ivan put it simply "You're just putting out fires all day long and that's stressful. I just want to say that. That it is mentally stressful" (lines 226-230). Anything that disrupts, whether it is patients' disruptive behavior or disruption of normal routines, most often causes distress for nurses. The extent of this disruption is captured by Donna's comments "It's a frustrating situation and it's hard to deal with because like I say again your patient becomes disruptive and disruptive not only to himself, to you, but the patients around him" (lines 108-110). She also admits to 'it' being annoying. "I think because number one it's annoying. It can be very annoying. And I mean I'll...I'm...I'm the first to admit it, you know repetitive. You know repetitive, repetitive. Umm again...*huge* amount of work load" (lines 381-385, italics added for emphasis).

In the case of POD, the problem includes increased work. Donna states it plainly "You know, like you get somebody that's delirious it's *a lot* of work (lines 368-369 italics added

for emphasis). POD, represented by the patient's behavior, is a disruption; it interferes with nurses' work and getting the work done.

4.4.1.3.1 Characteristics of the Disrupted Work

What made POD work so disruptive was i) its repetitive nature (all-consuming nature); ii) its extended unresolved timeframe; iii) managing behaviour not cause, and, iv) trial and error in which nothing worked. Tanya talked about having to redo, redo and redo tasks such as dressings for her patient with POD. The goal then was to *manage* the disruption. The nurses talked repeatedly about attempting to "settle" (Lindsay, line 257; Kathy, line 24 & Kirsten line 59) these patients, the problem of "dealing" (Kirsten, line 92; Kathy, line 104 & Donna lines 76-79) with these patients, and how to "handle the *problem*" (Ivan, lines 158-159, italics added for emphasis). However, the process of managing, or what the nurses described as *dealing* with the problem of POD, caused new problems. This is evident in Tanya's description of how she tried to manage her confused patient and the distress it caused her:

I think about the other people in her room as well. It's tough for them when she is calling out and disruptive and disturbing them. I feel bad because I'm spending more time with the confused patient than my other patients. Sometimes I have eight or nine or even ten other patients. At the same time I know I should be thinking of her, and maybe not bringing her out into the hall, but its tough for the other patients in that room. I feel sometimes I neglect my other patients because I spend so much time redoing and redoing things for my patient that is confused. She just kept pulling everything apart. The other patients don't get as much attention because the confused patient takes all my time. I wish I had the time to sit with the confused patient. I know it is best to have

family there with them. That is the best way to deal with them, especially at night, because I think they are just scared (Tanya, lines 34-76).

The reality expressed in the vignettes around the context of work was explicit in the talk and text about the significance of work produced by patients with POD. Increased work causes a disruption in routines. The images of delirium produced by the nurses were that the patient *becomes* a “Hallway Patient” (Karen, line 84), a “Total” (Karen, line 61), even a “Pain in the Ass” as described by Donna:

He was alert, but totally confused. He didn't know where he was. He was shouting out people's names, not names of the nurses, but other people's names, and he was trying to crawl out of bed. He was pretty much a pain in the ass (Donna, lines 27-29).

Donna's frustration with this patient who is confused is further emphasized in her reflection about how this patient is different from her *other very sick patients*:

I hate to say this, but I think as nurses we don't deal with it very well because it is annoying. It is repetitive. It is a huge amount of workload. People are realizing how much work this is taking up. You have six or seven other very sick patients and you get one with delirium and he takes up all of your time. It's like: “Damn it! I've got a confused patient today. Oh Jesus, he's out in the hall” (Donna, lines 385-388).

This illustrates another example of how POD is disruptive to nurses' work. Nurses' routines and organization are disrupted as they are forced to further separate the patient presenting with delirium from the other patient population, in order to maintain the status quo of the other patients. Therefore the patient presenting with POD is moved into the hallway. Donna revealed that she was not satisfied with the nursing care of these patients: “I think it's a part of our nursing that's not really well done; we could prevent a lot of these events if we

only knew what to do and had some supports to do that.” (line 366). Intricately tied to discourses of nursing work and discourses of legitimacy/illegitimacy are discourses of competency.

4.4.1.3.2 Discourses of Competency

A sub discourse of competency appeared within the dominate discourse of nursing work. The word competency was not mentioned in any of the narratives, yet an unspoken and unnamed discourse of competency exercised power in directing the actors in this discourse. Nurses performed the competency discourse in their work even though they did not speak it, and even though it was not explicitly present in their talk and texts. For example, there was much talk in the participant narratives about ‘knowing’ and ‘doing’. Tanya talks about not knowing what to do as illustrated in this example:

Because maybe it’s me too, like I didn’t know who to...in the confusion...in the lady with delirium, like I didn’t know who to call, what to do, who were my resources. Like I knew about the family and I tried them and they weren’t able to come in (Tanya, lines 173-175).

Donna disclosed that she doesn’t believe *anyone knows*:

But I don’t think there’s anybody that addresses the situation. There’s nobody that addresses delirium. Who do you go to? There’s nobody that knows what to do...what they’re doing, and the [doctors] don’t even know. They don’t know how to deal with it, so it’s left to us to figure it out (Donna, lines 510-512).

‘Knowing’ and ‘doing’ are intricately related, yet separate in terms of nursing practice. For example, the act of ‘doing’ does not always indicate that the doer *knows what they are*

doing. In order to be competent in doing, one must first know. Tanya talks about ‘doing’ in this conversation:

I felt good [about my practice with the patient who had chest pain] even though he wasn’t...like by the time I left he wasn’t ...you know...really perfect. But I just...as long as I feel like I am doing *something*...that’s what I always say...at least I am doing something, then I can go home and go to sleep at night. But I feel if I am not doing anything then it doesn’t sit well with me, it doesn’t feel...sit well with me with the post op delirium patients when I don’t feel like I am doing anything for them (Tanya lines 232-236, italics added for emphasis).

On the other hand, all but one of the participants indicated in their narratives that they knew exactly what to do with a patient experiencing chest pain or respiratory distress; they laid out all the steps for caring for this type of patient. Even though the incidences of these other acute onsets were relatively rare occurrences on the ward, much less than occurrences of POD, these other acute incidences took precedence over POD. Therefore nurses in this study clearly indicated they lacked competency to effectively manage patients presenting with POD. This lack of competency negatively impacted their workload, which in turn, lead to revelations of discourses of safety.

4.4.1.3.3 Discourses of Safety

Working intimately within the discourses of competency and the discourses of nursing work are discourses of safety. To be good nurses, nurses must practice competently and *safely*. This value is reflected from the implicit gaze imposed on nurses from their regulated body based on professional standards. Nurses have long held the moral imperative to keep patients safe. Similarly, safety issues have become the hot topic with many hospitals’ quality

improvement departments. The body of research supporting many specific activities devoted to safeguarding patients continues to grow (Cronenwett, Sherwood, Barnsteiner, Disch, Johnson, Mitchell, et al., 2007). Yet, “the literature is replete with data suggesting that patient safety continues to be a problem in practice settings across the United States” (Ironside, 2008, p. 92). Safety (both of the patients and themselves) were recurrent themes in the narratives of the participants as evident in Tanya’s conversation: “I’m always concerned about their safety when I go in and they are confused, not directable” (line 12). “[It’s] mostly about safety...just that...like I don’t...I don’t feel comfortable like leaving her in the room thinking that she is going to climb out, fall and bonk her head” (lines 27-28). “I’m concerned about her safety and so to bring her out into the hall, like right by the nursing station, so we can see her” (lines 30-31). Donna elaborated on the responsibility she felt to keep the patient safe:

So in that period of time you’ve got to find out whether you might need a one-to-one so that at that period if he starts climbing out, unsafe to himself, then you...basically have to go to your charge nurse and say, “I think this patient’s unsafe, and I think he needs more observation than what I can give him with the rest of my patients. And I think the bottom line, before *anything* it’s the safety of the patient. (Donna, lines 117-120 italics added for emphasis)

Kirsten further reinforced this sense of responsibility: “Patient’s safety is just very important to me...I don’t want to be sending people home when I don’t think...when something’s amiss and you know like I said I get that gut feeling” (Kirsten, lines 495-498). Donna added that both the safety of the patient and the nurse must be taken into account: “Because

number one it was the safety of the patient and my safety *both*” (Donna, lines 160-161 italics added for emphasis).

And finally Ivan expressed the dilemma nurses face in ensuring safety:

Well, I just feel that the system is so overloaded that there, there isn't the manpower to handle the problem. The person needs closer watching...someone needs to watch them more closely...or what I did today was put this person in a Gerichair and left him in it with the table, and he tolerated that quite well. They don't always though, but there's nothing, there doesn't seem to be anything else to do except to restrain them somehow for safety. (Ivan, lines 158-169)

Like Ivan, Kirsten related the immense workload as a significant factor to patient safety issues. “You know when you're on the floor and you're working nights and you're short staffed to be dealing with this is...very time consuming and you really have to manage the risks that they present to you and themselves” (Kirsten, lines 92-94). Studies on nurse staffing and patient outcomes have continued to show the relationship between appropriate numbers of nursing staff and lower mortality rates (Storch, 2005). Yet, participants in my study reported working on a unit constantly over census, stated they could not provide the nursing care needed by their patients, and often went home feeling morally distressed because they had been unable to accomplish the requirements of good, safe and ethical care. These feelings are reflected in Kathy's statements:

No [I don't feel supported]. Supported by my other colleagues yes. Supported by management no. It's frustrating because we don't have enough staff, because we're getting sicker and sicker patients, because I feel I'm just exhausted running around. And you try to tell them, and you draw up these forms, these stupid forms that we draw up

every time it becomes unsafe or whatever. And nobody really does anything it just becomes paperwork. (Kathy, lines 88-94)

We have staff meetings but they do nothing! We sort of sit there and “Blah, blah, blah”, and then you go home and nothing’s been done, so a lot of people feel frustrated with that. And I think it’s because we’re saying we feel unsafe and then it just becomes like a block. Like the management, they don’t respond. (Kathy lines 111-113)

These feelings of responsibility, frustration and hopelessness were a common thread in each of the narratives as nurses demonstrated how they navigated the discourses at work in their practice. Navigation of these discourses also involved practices of surveillance. This surveillance is not a one-way gaze. Rather, this type of surveillance is complex; it reflects at different angles and deflects back and forth within, between and throughout nursing practice.

4.4.1.4 Surveillance

Discourses of surveillance were both implicitly and explicitly evident in the nurses’ talk and text. Although listed in categories, these implicit and explicit discourses of surveillance remain integrally related, mutually informing and being informed of one another. Implicit surveillance was directly related to regulation of the professional nursing body.

4.4.1.4.1 Implicit Surveillance: The Regulating Professional Body

A discourse of surveillance emerged in nurses' talk and text that was both implicit and explicit. On the one hand surveillance was implicitly related to nursing as a self regulated profession embedded in the language that the nurses' used in their narratives. This language reflected the 'doctrine' of the Professional Standards for Registered Nurses (CRNBC, 2008) and the Standards of Practice and Competencies for Licensed Practical Nurses (CLPNBC, 2001) under which nurses are licensed to practice. The nurses talked about communicating "client status, [and] using verifiable information, in terminology used in the practice setting" (CRNBC, 2008, p. 10). For example, Kirsten talked about documenting vital signs, heart rate and quality, as well as the color of the patient as part of her communication regarding her patient who presented with chest pain. In addition, every participant mentioned safety of the patient as a priority in their care. This language is congruent with the Canadian Nurses' Association Code of Ethics for Registered Nurses (CRNBC, 2008, p. 18).

4.4.1.4.2 Explicit Surveillance

Explicit surveillance was evidenced in a multiple of ways including surveillance from personal and professional reflection, surveillance from one nurse to another nurse, surveillance from experts, and finally surveillance directed to patients.

4.4.1.4.2.1 Personal and Professional Reflection

The nurses in my study directed surveillance on themselves, in a combination of ways as evidenced in their talk, when reflecting *on* as well as *in* practice. Reflection *on* practice was demonstrated by Donna's comments about what she *should* have done in a situation that did not go well with a patient who presented with POD:

Well, now in hindsight I blame myself because, ah, I should have known better and I didn't, and I could have foreseen the circumstances where this wouldn't have occurred.

So in a way I did blame myself on this one. (Donna, lines 136-137)

Such practices of self-surveillance led to Donna's naming of self-blame. This issue of blame was reflected in other narratives: both Tanya and Kirsten began reflections about their practice with the words *maybe it's me too*, indicating that they were applying surveillance to themselves and their practice. These words imply responsibility and accountability for their practice, which reflects back on the implicit surveillance of the professional standards of Registered Nurses: Standard Number One is listed as Responsibility and Accountability (CRNBC, 2008, p. 4).

Tanya expressed "feeling bad" about her practice in caring for these patients with POD in a number of ways. First she felt bad because she wished she had more resources to care for her delirious patient. Second, she felt she neglected her other patients because she spent so much time caring for the delirious patient. Third, she felt it was unfair to pull the patient experiencing POD into the hall. These situations illustrate surveillance as reflection *in* practice. When referring to her care of patients with POD, Tanya stated "I *always* feel bad" (line 34). This expression of feeling during practice is an indication of reflection *in* practice. An example of how she reflected *on* her practice was when she stated that she believed (in retrospect) that she could have done better on an assessment of a delirious patient. In addition to this complex matrix of personal reflection, it was clear that the nurses were also involved in surveillance of each *other's* practice.

4.4.1.4.2.2 Between Us Nurses

As well as focusing surveillance on him/herself, nurses in my study talked about nurse-to-nurse surveillance. There was much talk about how they learned to deal with patients with delirium from watching how other nurses dealt with it. I asked each of the participants where they had learned to practice the way they did both with patients who presented with delirium as well as patients who presented with another acute onset. Whether novice or experienced, nurse participants stated that they learned how to care for patients with delirium by watching other nurses in their practice. They stated they had not learned, or could not remember learning much about delirium in their formal education. Tanya talked about how she learned to bring the patient out into the hall:

Ya, like we had this one, and I don't think he was post op delirium, he was just dementia, and when I first [graduated], and like we had him perpetually out in the hall at night because he would not stay in bed [he would] end up on the floor night after night and so yes, that's a learned behavior because that's how we think they're the safest. And I also feel that...like...I *don't* like using physical restraints. That's just, like, that's a learned behavior too. But I really *do not* like it. (lines 46-55, italics added for emphasis)

When I asked Lindsay where she learned to care for patients with POD, she replied:

No, not in school. More through watching the nurses here...um, I've seen a lot of them give them drugs. I don't know if it's because it's just easier or what not? But they do that and obviously keeping an eye on them as well. (Lindsay, lines 75-92)

Kathy put it bluntly:

Well, I didn't learn it in school, I'll tell ya. I learned it by experience and by being on '2A' so long. And the older nurses that I was working with, and just experience and seeing it. Basically just, you know, with experience and talking with the other [nurses].

(Kathy, lines 65-67)

Donna included learning from physicians as well as nurses in her dialogue about where she learned to care for these patients:

...no formal education as far as I can remember. I mean I probably did, when I went to school, with that sort of thing, but no, it was *definitely* from just watching...um years of experience, taking to the doctors, talking to other nurses. (Donna, line 87-93)

There was also talk that reflected there are different qualities to 'seeing' and different strategies to surveillance. Donna and Ivan spoke about learning about delirium from trial and error. For example, Ivan talked about learning what works with "certain patients with trial and error because you've got all day to try things right?" (lines 44-50).

As well, there was a component of watching and evaluating as evidenced by Ivan talking about the practice of *seeing*:

I think there's so *much* in that hospital that [is not] recognized enough. Because I see so much that...well you can tell when people don't see things. When you stand there and look you can see a lot that goes unseen. (Ivan, lines 24-28)

Lindsay suggested that perhaps she had experienced the focus of surveillance on her own practice or had observed how surveillance was focused on the practice of another nurse as she described how "a lot of people don't pick it up, and then the next nurse comes on and says 'There's something not right with this person!', and it's hard because every nurse sees

something differently” (line 35). Kirsten expressed disappointment in her colleagues that don’t *see*, or don’t *pick it up* and don’t perform to her standards. She talked about the younger nurses being keener than some of the older ones, and expressed frustration with nurses who have lost their interest in inquiry. Rather than a source of expert wisdom and an ideal to aspire to, she conveyed dissatisfaction in the practice of some of the nurses with the statement “I hope I never get like that” (Kirsten, line 679).

4.4.1.4.2.3 Learning From the “Experts”

There was some talk about learning from individuals who were recognized for their expertise in geriatrics, including specialized knowledge in delirium. Kathy spoke about learning about the older adult population when she worked on a geriatric ward during the time that the hospital had a geriatrician on staff:

I guess I realized it even more when I met Dr. ‘Smith’ that I was working with on [another ward]. And I found that she, you know [I learned] how different it is, you know with them? Ah, you know like I said with the [medications] and the whole care. You know with the medications and how everything works with them. It’s not just like with anybody coming in right? (lines 137-140)

Kathy also mentioned her experience of working in extended care, as well as special training in the field of delirium “Like I worked in extended care for a while and I took classes with that, you know, with delirium” (lines 132-133). Kirsten remembered that during nursing orientation at the time she was first hired to work at the hospital someone came to talk about POD: “Also, when we had orientation to this hospital they introduced post op delirium in their orientation, [but] that was a year ago” (lines 96-97).

None of the nurses mentioned learning about delirium through the patient's experience, or the patient's retrospective analysis of experiencing POD.

4.4.1.4.2.4 Focus on the Patient

The concept of health care providers focusing an expert gaze on the body of the patient is one that Foucault explored (1994) and which nursing literature continues to revisit (Gastaldo & Holmes, 1999; Gilbert, 2005; Heartfield, 1999; Horsfall & Cleary, 2000; Irving, 2002). For Foucault the clinical gaze represented the power of medicine; "the body is an object of inquiry and the individual a case" (Henderson, 1994). Rather than a 'gaze' (which implies a unidirectional focus) my research revealed a process of surveillance that was quite different than the typical medical gaze. In a few lines Ivan talked about focusing the 'nursing gaze' on a patient with POD; he identified the difference between an experienced gaze and a non-experienced one, and he objectified the patient as a problem.

Right away you could tell, well just looking at him you could see that they're very pale and there's this certain look in the eyes that I know...that I tend to look for. Whether [the look] is fear or there's a real confusion look that you can see. I've noticed too, that the knowledge between new staff and old staff, it doesn't matter how much education you had, it is different what you see. I can see a patient and see a problem. (Ivan, lines 525-532)

Ivan's dialogue is an excellent example of the experienced gaze as observation that is penetrating. Ivan looked through the patient's skin to the fear inside.

While Ivan recognized the problem, he did not understand what to do with the problem. While Foucault talks about the power of the gaze (Henderson, 1994), it was evident that the nurses in my study felt quite powerless. They didn't know what to do, they didn't know who

to call and they didn't know who (or what) their supports were. They could not exercise their power in this situation because they didn't *know*. Rather than exemplifying a powerful gaze, theirs' was an uninformed, incompetent gaze and thereby an illegitimate, powerless gaze.

In the case of POD this observation of the patient is often *assumed* to be heightened, with the application of what is called a *close* or *constant* care provider. The intent of close or constant observation is that patients remain restricted, assessed, checked, discussed and documented: their mental state is recorded and detailed to a higher level than the general patient population. In practice, this is often not what happens; deconstruction analysis revealed this level of care to be the *opposite* of what is assumed to be happening and the opposite of what was intended.

This level of care is reflected in the interviews as the nurses spoke about a "one-to-one". The nurses in my study were not the providers of the one-to-one care; rather this care was provided by either a sitter or a nursing aide (unregulated care provider). While the duties of the individuals providing this care include watching the patient, often appropriate assessment, documentation and interventions do not follow as they are intended, because the acuity of the patient is not recognized. The eyes of the experienced nurses are diverted to other patients as less qualified eyes take over the focus of the patient experiencing POD. In other words, where the intent is to heighten the gaze, it was actually lowered further to an *uninformed* and thereby an *illegitimate* gaze.

The observation method is only understood in so far as to provide physical safety for the patient. This is evidenced in Ivan's comments when he stated that delirium is seen "more as a risk of personal injury, not something like they are going to die, or *could die*" (lines 439, 445, italics added for emphasis). Kirsten's comments reinforced this belief:

I think the main thing is that they don't see it as life threatening. I think they assume that the patient will come out of it. It will work its way out. Whereas with chest pain, they need to find the cause, with delirium they don't seem to investigate. The chest pain is seen as something critical. The patient can potentially die and so they see that as a critical situation. Whereas they don't see a patient that's confused as a big deal, we always get confused patients. (Kirsten lines 538-548)

In nursing practice, a "one-to one" provides continual and constant care to one or two patients who exhibit behaviour problems. This practice of care was rationalized primarily by the risk that the patient posed to him/herself and others, and was justified by keeping the patient safe. Tanya spoke about being concerned for the patient's safety and therefore making the decision to bring the patient out into the hallway, right beside the nursing station, so that she could keep an *eye* on her. Lindsay talked about bringing the patient *into* the nursing station so that the nurses could *watch* her while they completed documentation and filing duties.

Nurses spoke routinely about the problem of watching these patients. Because surveillance is such an important part of caring for these patients, nurses are forced to use unconventional means to do so. Donna purposely attempted to get another patient situated in a room with a confused patient in order for this patient to do the surveillance that the nurses were unable to do. Because nurses are unable to be all eyes and all ears to these patients they extend the surveillance to others, beyond themselves:

So anyways, so I said to the charge nurse "Whatever you do, the first admission that comes, put her in that room. At least the lady can watch her, and ring the bell." So we had a transfer, the lady went in that room, and I said to the lady, "This lady over here's a

bit confused, so if you see her climbing out of bed, will you please ring her bell. So after about an hour or so...I went over and chatted with her, she says, "You know I'm watching her, I'm watching her and she hasn't climbed out of bed yet, but she is talking about going home, but if she does I'll ring the bell". So I think at [some] point you have to take an alternative. You know, you have to find a different direction because [the last] direction wasn't going anywhere and still it wasn't resolved (Donna, lines 191-197).

Therefore, the practice of surveillance is much more than a one-way course from nurse to patient. Observation penetrates through all levels within the hospital. "Acknowledging the power of the 'gaze' permits cognizance of how knowledge is generated by practices within the hospital" (Henderson, 1994, p. 936). The practices of surveillance were implicitly and explicitly at work within and between the discourses of legitimacy/illegitimacy and discourses of nursing work which in turn influenced the nursing practice of caring for patients with POD.

4.5 Summary

In this chapter I illustrated current nursing practices specific to caring for patients experiencing POD (specific to the time and place where my study took place), and how this practice is passed on. I did this by presenting six vignettes, representing each participant's narrative in response to the interview questions. I discussed how the two most prominent discourses of legitimacy/illegitimacy and nursing work are at work in the narratives of the participants. I demonstrated how these discourses coexist, overlap, and compete to shape and govern nursing practice in response to patients experiencing POD as well as how they discipline the dissemination of this nursing practice. I illuminated how these discourses are

at work in multiple layers, how they produce meanings, and how they come to be assumed and understood as common sense. I revealed the persistence of these regimes of truth that prevail over other discourses to form the status quo and dictate a reality that is recognized as legitimate and thereby normal. Lastly I uncovered the power of surveillance, which operates throughout all levels of health care and illuminates and unveils discourses of meaning in terms of how nurses care for patients with POD.

CHAPTER 5: DISCUSSION OF FINDINGS, IMPLICATIONS AND CONCLUSIONS

5.1 Introduction

This chapter presents a discussion of the findings of my study related to the research question which was: With a focus on the orthopedic patients on '2A' at 'Canora Jubilee Hospital', what are the key discourses that shape and discipline nurses' response to POD? In other words, how do these discourses implicate practice in terms of how nurses respond to POD?

I begin this chapter with a discussion of the theoretical implications of poststructural theory, including how poststructural theory provides the opportunity to question 'correct' or 'accepted' ways of acting and thinking in nursing practice. By means of this poststructural lens I present the revelation of how biomedical/scientific discourses were unveiled as the most dominant discourses in the participant's narratives. I proceed to reveal how all other discourses (previously identified in the findings section of this thesis) relate to these overriding biomedical discourses.

Congruent with discourses of biomedicine/science I relate my findings to current literature (EBP) regarding the topic of POD and discuss the relevance and value of adding my findings to this body of knowledge. I move on to a discussion of the implications of my methodology, specifically the implications of researching as an insider in my facility of practice. I proceed to reflect this discussion of methodology through a poststructural lens, identifying the value in unveiling and questioning 'correct' or 'accepted' ways of acting and thinking in nursing research, specifically assumptions regarding researching as an insider. I continue with the implications of this study for nursing practice specific to the care of patients presenting with POD and identify needs for further research. I reveal how

biomedical discourses not only influence the evolution of nursing practice but how they impact the overall development of society. Finally I end with a conclusion of this thesis work.

5.2 Discussion of Findings

A discussion and analysis of my findings is outlined below, beginning with an explanation of the implications of poststructural theory.

5.2.1 Theoretical Implications of Poststructural Readings

Poststructural views allow one to see what is otherwise unnamed and unmarked. The *unnamed* discourse is powerful because it remains *purposefully positioned as unnamed* in order to operate, direct and govern while continuing to be hidden. Poststructural theories provide a method of uncovering reality (taken for granted assumptions) in that “rather than accepting the reality of a clinical or health care setting as a given, the very reality itself is made the focus of the research” (Cheek, 2000, p. 41). Discourses on medicine, health, illness, disease, and nursing construct realities in ways that are often taken for granted and invisible (Lupton, 1994). Poststructural analysis uncovers

representations of health care, [including the way that nurses practice] and enables the questions to be asked whether this is the only way that practice can be represented; why this representation is accepted as ‘normal’ or ‘given’; what are alternate ways of representing the same reality; and why these ways are absent and/or marginalized and suppressed. Such questioning calls into question claims to the autonomy, objectivity and political neutrality of medicine [and nursing] as language [and practice] is exposed as an important site of political struggle. (Cheek, 2000, p.41).

5.2.1.1 Revelation of Biomedical/Scientific Discourses

Biomedical/scientific discourses went unnamed and unmarked by the participants in the narratives. Yet, the pervasiveness of these discourses in hospital settings is well documented in the literature (Brown & Seddon, 1996; Frank, 1991; Grant, Giddings & Beale, 2005; Neville, 2005; Neville, 2006). Through the process of *comparison* between nurses' response to patients presenting with POD and nurses' response to patients presenting with another acute onset (chest pain and/or respiratory distress), it became evident that although biomedical discourses went unnamed and unmarked in the narrative transcripts, all of the other discourses *pointed to* discourses of biomedicine/science. In this sense all the other discourses, implicitly and explicitly present in the narratives, unveiled the power of the *absent presence* of the biomedical/scientific discourses specifically in cases of nursing response to patients experiencing an acute onset such as chest pain and/or respiratory distress. The question remains, why was nursing response different to patients experiencing POD?

The notion of absent presence is offered by Derrida who asserted that at the presupposed 'center' of any system is "a point from which everything comes and to which everything returns" (Klages, September, 11, 2008), Derrida also asserted that this 'center' is in actuality an absence. More precisely, this absence is a nonabsent absence. It is not missing; it is a purposeful and intentional absent presence. Derrida further posited that this absent presence is more than a static or binary relationship. For example, the center of absent presence is under infinite slippage (from competing and intersecting discourses) and can only maintain its definition and position by the negotiation and opposition of other positions. These other positions are represented as binary pairs or oppositions that create the system or structure,

and simultaneously serve to maintain or dismantle the center. Derrida explained that the binary opposition or pair (light/dark, good/evil, right/left) which are at play positioning the center, are 'marked' according to one term represented as positive and the other as negative (Derrida, 1978; Klages, 2008; Storey, 2001).

In my study, poststructural analysis served to unveil these binary positions, including discourses of legitimacy/illegitimacy; competency/incompetency; normalcy/difference; and, safe/unsafe. Further deconstruction revealed how these binaries were purposefully 'marked' by the absent presence:

In other words if binary positions are not natural but rather are constructed for particular [situations] in particular contexts "then we need to look at who has an interest in maintaining them. For instance, in the practice setting whose interests does it serve to maintain the mind/body or the medical/nursing oppositions? Such analysis enables us to be critical of the way in which ideas are 'ordinarily' expressed in patterns of meaning. (Cheek & Rudge, 1994, p. 19)

Thereby the relationship between discourses is more complex than a unilateral sequence. While the absent presence of the biomedical discourses (centre) direct and govern other discourses, these other discourses are actively at play constructing and deconstructing that centre even as they compete with and support each other.

Whereas biomedical discourses were identified as powerful overriding discourses operating in a position of absent presence in the case of acute onsets such as chest pain or respiratory distress, further deconstruction revealed that in the case of POD, biomedical/scientific discourses were operating in an *equally powerful* position of *present absence*. For example, biomedical discourses clearly directed nurses' care of patients

experiencing other acute onsets; yet, biomedical discourses were just as clearly absent from nurses care of patients experiencing POD. This present absence remained intentional and purposeful.

From these two strategic positions of absent presence and present absence, biomedical discourses influenced and constituted all other discourses with meaning. In this sense this invisible 'freeplay' (Derrida, 1978) of positioning (where biomedical discourses were centre and other discourses maintained that center) worked to privilege the biomedical discourses in such a way that they could remain powerful in the operation of nursing practice: invisible, yet assumed *normal*.

5.2.2 Description of Biomedical/Scientific Discourses

The biomedical/scientific discourse has its origins in the nursing profession's close relationship with Western medical practice in which scientific knowledge and practices have been most privileged. "In this discourse, the patient represents a *passive object body*, a "collection of parts and systems manifesting a set of symptoms" (Brown & Seddon, 1996). The patient experiencing POD did not fit this description of passive. Instead these patients were constituted as disruptive, agitated and combative: "Pretty much a pain in the ass" (Donna, line 29). In other words, they were not *normal*.

Foucault explains that in Western industrial society, the scientific/medical discourse dominates, often to the exclusion of other types of knowledge that are dismissed as non-objective, irrational and unable to be verified by measurement of some kind (Foucault, 1994). Features of the biomedical/scientific discourse include the comparison of this object body to a scientifically agreed upon (most often through RCT research studies) *norm*. In other words, the body is examined, classified, and compared according to scientifically established

norms. The examinations that health care professionals perform, the documentation that is developed from those examinations, the proliferation of diagnostic tests and procedures resulting in the production of the docile body, “are symptomatic of the process designed to restore normalization” (Cheek & Rudge, 1993, p.20). In addition, these observations are hierarchical; truth is defined by what can be measured. This description fits the clinical expectations on the patient care unit where the participants in my study practice.

Initially it appeared that nurses in this study took up the biomedical discourse when caring for patients with other acute events but did not take up the biomedical discourse when caring for patients with POD. Further deconstruction of this practice revealed that they took up the absent presence of the biomedical discourses in caring for patients with chest pain *and* they took up the present absence of the biomedical discourses in caring for patients with POD. This difference in position of biomedical discourses in nursing practice relates to the body; the body was absent in patients experiencing POD. Instead, *behavior* rather than the body dominated the nurses’ assessment and, therefore, what was decided (diagnosed) as normal or abnormal. Congruent with other studies where nurses stated “We consider delirium more of a patient’s personality rather than we do an acute illness” (Dahlke & Phinney, 2008, p. 43), nurses in this study disclosed that delirium continues to go unrecognized as a serious insult to the brain that must be investigated immediately.

Reasons for this include that POD was not subjected to measurement and correction; therefore, POD did not fit the biomedical model; therefore POD was not identified as an acute illness but rather as a *problem*. POD was a problem because it was not designated (by biomedical discourses) as legitimate.

5.2.3 Biomedical Discourse Production of Discourses of Illegitimacy/Legitimacy

Rather than a unilateral position where biomedical discourses would *imbue* discourses of illegitimacy/legitimacy with meaning, findings in my study revealed this relationship as multifaceted and interrelated. While biomedical discourses created the notions of illegitimacy/legitimacy, illegitimacy reflected back on biomedical discourses to reinforce the notion that POD was illegitimate. Concomitantly, because biomedical discourses shaped illegitimacy, illegitimacy then shaped nursing practice of caring for patients with POD. One of the ways that it shaped this practice was in the assumption that POD is normal.

It was clear from my findings that POD was constructed as an *illegitimate* set of symptoms (syndrome), unsanctioned by biomedical discourses and therefore not drawing the same degree of attention as other acute onsets such as chest pain or respiratory distress. In other words, POD was constituted as illegitimate because biomedical discourses were absent; because it was illegitimate, POD could not even be discussed. By taking up this assumption and not even naming it (rather maintaining the vague description of confusion) the absence became assumed as *normal*. In terms of access and/or use of power imbued from biomedical discourses, POD was relegated to a position of present absence. The biomedical discourses were removed from nursing practice of caring for patients with POD; therefore power was removed.

Discourses are “mechanisms through which power is exercised” (Heslop, 1997, p. 88). For example, the power of discourse lies in its ability to prescribe and affect socially accepted behaviour, or what can be said and what can be thought. In other words, what gets the stamp of approval and what is suppressed? From this perspective, biomedical discourses worked to *produce* discourses of illegitimacy and legitimacy in nurses’ practice of caring for

patients with POD. In turn, these discourses worked (cross fertilization so to speak) to mutually inform one another while simultaneously constructing, maintaining and deconstructing the centre. From a poststructural perspective these discourses of illegitimacy and legitimacy highlighted questions such as ‘what is legitimate knowledge?’ and ‘under whose authority can legitimate knowledge be constructed (produced)’? Thus, power, as understood in Foucauldian theory, is exercised by determining whether something can be spoken about and if so, by the way it can be discussed (Heslop, 1997).

5.2.3.1 Revelation of Two Usages of Illegitimacy

Not only did study findings reveal the illegitimacy of POD, but also nursing knowledge associated with the care of the patient with POD. Direct care nurses spoke of being dismissed when they sought to advocate for patients with POD, rendering illegitimate their clinical assessments and clinical judgments – their practice. Immersed in a system that constantly reinforced the illegitimacy of POD, nurses took up illegitimate practices, failing to perform the specialized assessments required in the care of patients with POD and neglecting the documentation and communication of relevant information to maximize care. Use of the vague title of ‘*confusion*’, or worse still, no title or the descriptor ‘that’ perpetuated the illegitimacy.

5.2.3.2 Rationale for Illegitimacy

Some of the possibilities suggested in the literature for nurses’ lack of recognition of delirium in older adults were inadequate education, negative attitudes to the elderly population in general and insufficient support from management and administration (Rogers & Gibson, 2002). Lack of recognition is a result of lack of legitimacy; lack of legitimacy is a result of lack of recognition. One explanation for lack of legitimacy, which was revealed in

my study, was lack of educational preparation in the area of geriatrics in general as well as basic and continuing education specific to POD.

Despite the fact that most of the hospital patient population is over the age of 65, and a significant portion of this population consists of frail elderly individuals at risk for delirium, the nurses in this study reported having little to no formal education about delirium in their basic nursing programs. These findings were consistent with the research reports that nurses learned about caring for patients with delirium by watching others, through personal clinical experiences over time (Dahlke & Phinney, 2008) and by trial and error. Yet, participants identified that their basic nursing program did not dismiss biomedical discourses when presenting education regarding other emergent syndromes such as chest pain or respiratory distress.

It is evidenced that this ideology of what constitutes emergent responses begins in the culture of basic nurses' education. Absence of appropriate and specific education about POD contributes to certain preconceived ideas about what constitutes the presentation of normal in this patient population. Because POD is positioned as a common occurrence, and because confusion is believed to be normal in the elderly, the symptom that *should* elicit an emergent response from health care providers results in complacency because POD is constructed as illegitimate. The general ideology is reflected as: "These patients are 'old and demented', so of course they will be confused. What do you expect? Don't bother me with 'that'". What *is* expected, as evidenced by the participant narratives, is that health care providers *will* be bothered with *chest pain*. Even if the patient is elderly, chest pain is a legitimate symptom, and therefore one worth being bothered about.

There lies another example of the complex matrix of negotiation in the relationship between discourses of legitimacy/illegitimacy:

- Biomedical discourses constitute chest pain as legitimate
- Agism constitutes POD as illegitimate
- The present absence of biomedical discourses in POD allows agism to have more prominence in the case of a patient experiencing POD
- Biomedical discourses trump agism in the case of chest pain

This ideological hierarchy follows from basic education programs into the facilities where nurses work. “It has been well documented that choosing to work as a nurse with the older population is not an attractive career option and is sometimes referred to as the ‘Cinderella’ of nursing” (Neville, 2005, p. 177). These ageist discourses suggest that if you are elderly you have no worth, and by association if you choose to work with this population you are not recognized to be as credible as the nurse who works in a highly specialized technological environment such as cardiology, respirology, or the ultimately respected field: ICU (McCormick, 1997; Neville, 2005).

The point must be made that it is not *nursing's lack* of making POD legitimate that is the issue; because the biomedical model has not endorsed POD, POD remains largely invisible. By positioning POD as invisible, and by remaining presently absent in the discourses of care around POD, the biomedical discourses contribute to the increased work of nurses who are attempting to care for these patients. By association nurses' work in caring for patients with POD becomes illegitimate.

5.2.4 Biomedical/Scientific Discourse Production of Nursing Work

The discourses of nursing work were taking place within the context of the nursing shortage where nurses are working overtime and managing more patients with greater acuity with increasingly less staff (Lynn & Redman, 2006; Ulrich; Buerhaus & Donelan, 2005). Within this context nurses are placed in positions where they have to work even harder to manage patients with POD. The discourse of nursing work taken up by nurses in this study emerged out of the illegitimacy of POD accorded by the system and filtered down to the care they gave patients who experienced POD. The “so much work” that nurses talked about was the legitimate work of appropriate assessments, communication, intervention, documentation and evaluation. Instead, the work was represented as illegitimate work and demonstrated as the difficulty of managing these types of patients. In a system that disregards both the patient and the nurse, the nurses’ work increased significantly.

Consistent with the literature (Dahlke & Phinney, 2008; Fick & Foreman, 2000; Rogers & Gibson, 2002; Steis & Fick, 2008), nurses in my study identified that caring for confused patients not only greatly increased their workload but took away from their other acutely ill patients. The workload associated with care of the patient with POD was at the *basic* (another value laden term) nursing care level of ensuring safety and no harm. In other words this type of care did not involve the highly sophisticated, more advanced care of other acute onset situations (chest pain). Therefore the care for patients experiencing POD is positioned at the bottom of the hierarchy of care.

Deconstruction analysis revealed examples of how the biomedical discourses were absent in nursing work of caring for patients with POD. The present absence of biomedical discourses concealed the resources that were available to the nurses and perpetuated the

status quo. Nurses wasted their time and made more work for themselves by using ineffective forms of assessment and inappropriate interventions during their care of patients with POD. In this sense, nurses contributed to increased work because they perpetuated their own increased work. Similar to findings from other studies, some nurses continued to focus their cognitive assessment of the patient exclusively on orientation, even though orientation is one of the least sensitive markers for delirium (Fick & Forman 2000; Morency, Levkoff, & Dick, 1994 & Rogers & Gibson, 2002). Although the CAM, (Inouye, van Dyck, Alessi, Siegal & Horwitz, 1990) the tool considered to be the gold standard for assessment and diagnosis of delirium (Dahlke & Phinney, 2008) is available on the patient care unit, most nurses in my study were not using it. Herein lies the power that Foucault (1980) speaks of. The irony identified in the findings was that if nurses identified and accessed the education, tools and resources available to them, there was potential for their workload to decrease. For example, not one nurse (when asked about existing supports for their practice) mentioned the REACH team (Referral for Elderly Assessment in the Community and Hospital) in their narratives, yet each nurse identified the resources available for other acute onset emergencies. In addition, the work required of caring for patients experiencing other acute onsets was described as less work than the work required of caring for patients with POD. The work of caring for patients experiencing other acute onsets was recognized as more efficient work than the work of caring for patients with POD. All of these examples contributed to the issue that nurses were not able to be purposeful in their work.

The nurses in my study experienced a significant amount of moral distress as they felt helpless to manage safety issues for themselves and their patients while attempting to juggle duties and tasks expected of them. Consistent with the literature, they also experienced guilt

(Rogers & Gibson) when using either physical or pharmacological restraints. They felt torn between the needs of the delirious patient and the needs of the other patients on their assignment. They disclosed that they often felt alone and incompetent in part because of their acknowledgement that they did not know how to care for these patients. They were attempting to legitimize POD, but because of the powerful biomedical discourse position of present absence it was hopeless.

5.2.5 Privileging the Biomedical Discourse: Surveillance

Privileging of biomedical discourses is connected to what Foucault (1994) described as the clinical gaze. The clinical gaze, which includes the nursing gaze and/or surveillance, is a manifestation of the biomedical discourse. Foucault (1979) provides the analogy of the panopticon, where surveillance becomes self-regulated. The panopticon of a prison is designed so that all prisoners' cells face the guard tower, which is located in the center. This allows for constant observation of the prisoners by the guards. The panopticon was specifically designed so that the prisoners could never be sure if they were being watched or not. In this way, this surveillance method caused the prisoners to self regulate. In other words, the *possibility* of surveillance "caused the internalization of disciplinary individuality and the docile body required of inmates" (Foucault, 1993, p. 46). This means that the individual is less likely to break the rules or laws if they *believe* they are being watched, even if they are not being watched.

Surveillance is formed and shaped by beliefs and values informed by the biomedical/scientific discourse; in other words, surveillance is the 'arm' of biomedical discourse. Foucault describes the clinical gaze as a "penetrative form of observation" (1993, p. 47). The power of medicine is in this gaze. The body is an object of inquiry and the

individual is a *case*. Medical knowledge views the human body as a pathological object, through which to clarify diagnosis (Henderson, 1994).

Foucault's concepts of power/knowledge and discipline can be used to analyze this scientific discourse which operates within nursing work and which is closely connected to the privileging of positivism in nursing science. This privileging was/is achieved by applying a set of disciplinary techniques including education and regulation (Gastaldo & Holmes, 1999, p. 234).

Foucault was concerned about modern strategies for governing populations and, in particular, the way in which knowledge and power circulate through social practices. He described a process in which government acts by regulating the 'conduct of conduct'; thus, moral discourses of obligation and self-management permeate a variety of social institutions, including hospitals. (Gilbert, 2005, p. 457)

Surveillance then is utilized as the regulatory practice of biomedical discourses.

5.2.5.1 Focusing on the Patient: A Unique Gaze

In relation to POD this gaze was unique; because this gaze was uninformed it was deemed illegitimate. Nurses revealed that in the case of POD, biomedical discourses were significantly absent. There was no naming of POD; there was no documentation and reporting about POD; there were no interventions to treat POD; and, because this practice was accepted as normal, there were no consequences to this practice. The general acceptance of this type of practice resulted in the present absence of regulation of this practice. Because no one was watching, there was no need for regulation. Because there was no regulation there was no means to define competency and therefore no method to hold health care providers accountable to competency.

Nurses were looking at POD just as far as being able to survive the problem that was labeled as a confused patient. Nurses were only attempting to survive through the problem without knowing what to do about it. They were restricted in the gaze and therefore were only able to recognize the confused patient as limiting their nursing practice. While normally the nursing gaze is considered an expert gaze, this gaze was clearly not expert. This was a completely different gaze from that directed at patients with other acute onsets. The POD gaze was not an informed gaze, it was a survival gaze, *seeing* the patients back to normal without any firm interventions to help facilitate that normalcy. The POD gaze was an unformed gaze, and therefore, an illegitimate gaze. The implications of positioning POD as illegitimate are significant, not only for patients but for the health care system in general.

5.3 Implications of This Study

This study is unique in looking at POD within the context of other conditions that nurses deal with in an acute care setting. By comparing nurses' practice of caring for patients with POD with their caring for patients with other acute onsets through a poststructural lens it is possible to highlight the discourses of illegitimacy/illegitimacy in a way that has not been illuminated before.

This is a distinct contribution to the body of knowledge regarding POD, and specifically a valuable addition to the qualitative study of delirium. This study serves to uncover how the present absence of biomedical discourses serves to hinder evolution of nursing practice in the care of patients with POD. Removing biomedical discourses from nurses' care of patients with POD (which means removing the informed gaze, removing the name, removing the body of the patient) sustains illegitimate, incompetent practice for these patients.

5.4 Usefulness of Biomedical/Scientific Discourses

While other studies are sharply critical of overriding biomedical discourses, which operate in the care of POD to marginalize and silence other discourses (Neville, 2005), findings from this study call for another look at this debate. The nursing profession has attempted to minimize the presence of biomedical discourses by developing unique nursing knowledge; perhaps one of the costs has been the constitution of POD as illegitimate, including nursing practice of caring for patients experiencing POD. Because POD did not ‘fit’ the biomedical discourses nurses did not know what to assess, how to intervene, and how to resolve POD over an extended time. The absences that nurses talked about including assessment, communication, intervention, documentation, resolution and evaluation represented nurses’ inability to approach POD within the biomedical model as they did with other acute onset situations.

This is where a Foucauldian poststructural/postmodern perspective is beneficial to deconstruct and examine the implications of discourse without discrediting “one method of knowledge development and [leaving] the other as the true method” (Holmes, Perron & O’Byrne, 2006, p. 101). Deconstruction is a strategy for displacing the hierarchy. Therefore, in a Foucauldian poststructural context it is understood that discourses are neither good nor bad; rather they are evaluated on their usefulness. While we are well aware that biomedical discourses are pervasive and privileged in health care settings, it is clear from a position of present absence that biomedical discourses hinder the care of patients with POD. Perhaps there is a *usefulness* at this time, until other mechanisms are in place, for biomedical discourses to move from this absent position in order to help shape POD as legitimate.

Because of nurses' closeness to patients they hold the key for legitimizing POD. There is very beginning evidence from my study to show that nurses were struggling to legitimize POD. This evidence includes expressions such as "we see it, they [doctors] don't" (Kathy, line 130), and talk about being seriously worried about the patient, but no one else listened (Kirsten & Donna). Nurses repeatedly expressed their frustration in reporting symptoms to physicians without receiving validation and helpful guidance in return, a dilemma well documented in the literature (Steis & Fick, 2008). The problem was that the dismissive culture suppressed any effort of attempting to reconstruct POD as legitimate. Nurses talked about not getting the support they needed to care for these patients; what nurses were not actually feeling supported in was the legitimacy of their knowledgeable practice, and the legitimacy of POD. Nursing knowledge remained unvalued, unsanctioned and therefore illegitimate,

The ability to categorize POD (Inouye, Studenski, Tinetti and Kuchel 2007), under the umbrella of the biomedical model, provides opportunities for other ways of knowing, that "demands simultaneous integration of not only medical but also the social, spiritual, environmental and economic dimensions often short shrift in more linear, ruthlessly reductionistic biomedical models" (Hazzard, 2007, p. 795). Inouye, van Dyck, Alessi, Siegal & Horwitz (1990) developed the CAM: the gold standard of delirium assessment. By borrowing from oncology (which has cemented respectability) and endowing delirium with status as a syndrome incorporated in a model based on rigorous research from respected academics in the field, it is possible to move POD toward legitimate standing. Gaining legitimate status demands the attention of the health care providers to take POD seriously and in turn has implications for clinical practice as well as research and public policy. The end

result is that health care providers finally recognize POD as a medical emergency comparable to chest pain and/or respiratory distress, and just as worthy of attention.

To appreciate the value of the practical value of validating and legitimizing POD under the umbrella of biomedical discourses, one need only to be reminded of the tragic case of Robert Dziekanski, whose case is now before the Court of British Columbia (Barschel, 2009). Because there is not a classification of ‘agitated delirium’ or ‘excited delirium’ listed in the DSM-IV lawyers argue that the condition does not exist, and that the terms are “a pop culture phenomenon and [don’t] have much currency among psychiatrists, although police, coroners and forensic pathologists use [them]” (Truscott, 2008, p. 668). Other individuals argue that “just because the vernacular is not in the DSM-IV does not mean that the symptom set is not in the DSM, because it is. We have evidence to suggest it is a brain disease” (p. 669). The deciding factor in this case will be the *evidence*, and *whose evidence*.

There lies the power of the evidence based practice (EBP) also titled evidenced based nursing (EBN) discourse, and the debate around what counts as evidence. While in Foucauldian terms EBP may amount to a ‘regime of truth’ and certain research results (especially those obtained through RCTs) may produce *truth*, it is also imperative to look at the usefulness of this truth; in other words, to look at what works (Holmes, 2006). The key is to unveil the origins of truth and how this truth affects not only the patient, but as in the case of Robert Dziekanski, the constitution of subjects and the shaping of society.

In nursing practice, this leads to possibilities where nursing aesthetics and evidence-based practice are no longer an oxymoron (Freshwater, 2004). The practice of nursing, then, does not need to justify the fact that it uses scientific evidence and therein evidence based practice any further than it needs to justify that other holistic ways of knowing (including the

experience of the patient) are incorporated into nursing knowledge and nursing work and deserve equal respect and recognition.

Just as we would not expect (or not allow) a general duty nurse to provide care for patients in a critical care setting without specialty education and skills specific to this area, we should not expect nurses to provide care to the elderly population in acute care without specialty education and skills in geriatrics. My work supports Neville's conclusions that:

It is time to recognize geriatrics for the specialty that it is and to admit that the majority of our acute care hospital population consists of geriatric patients. The focus on decreasing risk and maintaining safety for an older person who is delirious requires a specific skill set by [nurses providing care for this patient population]. Older people who have delirium require specialist nursing care by a skilled and educated nursing workforce if a positive health outcome is to be achieved. (2005, p. 180)

As evidenced in my research, the request is routinely made for unlicensed care providers to provide direct care for POD patients. The individuals providing this care most often are casual staff who are only on the ward for the night. The literature on delirium remains unchanged in the view that "one of the corner stones in non pharmacological management of [delirium] is to ensure that a skilled and consistent group of nurses are assigned to work with an older person experiencing delirium" (Neville, 2005, p. 181).

'Canora Jubilee Hospital' offers regular advanced specialty courses (Critical Care, Maternal Child, Renal, Operating Room to name a few) however up until now specific geriatric certification courses for the medical/surgical ward nursing staff are sparse.

Administrative staff have roles and responsibilities in improving hospital experiences for frail older adults (Bradley, 2006).

The acute setting is thus more than a site where services are provided to older people. It is a place that is constructed by, and in turn gives rise to, understandings of the remit and focus of acute care, the concomitant role of the health professionals that work there, and the position that older people occupy in that place. Exploring and exposing the often taken-for-granted assumptions that frame these understandings can reveal much about the way older people and the acute care system interact, and indeed collide at times.

(Cheek, 2004b, p. 53)

Just as important as initiating a heart failure disease management program (Velez, Westerfield & Rahko) opening a new cardiac care ward and recruiting cardiologists and nursing staff who are expert and competent in cardiac care, is decreasing the hazards of hospitalization for the frail elderly (Lang, Clark, Medina-Walpole & McCann, 2008). One of these hazards is POD.

5.5 Methodological Implications

5.5.1 Research Positioning as an Insider

I conducted the research for this study in the facility where I also practice as a Clinical Nurse Educator. The term “insider research” is used when a researcher “conducts studies with populations, communities and identity groups of which they are also members (Kanuha, 2000, p. 439). I fit this criteria. I have lived in this community for over 25 years, and worked at ‘Canora Jubilee Hospital’ for over 10 years. I work with many individuals who mentored me from a student into a nursing leader in education. I have formed professional and personal relationships with nursing staff as well as many other health care providers who are also employed at this facility. I am recognized as a leader in education as well as my field of study.

Much has been written about the intricacies of researching within one's own culture and how those same factors that bind a culture such as education, gender, sexual orientation, class, and race can separate the culture into a hierarchical world (Asselin, 2003; Bishop, 1998; Brayboy & Deyhle, 2000; Merriam, Johnson-Bailey, Lee, Kee, Ntseane & Muhamad, 2001; van Heugten, 2008). For example, conflictual and concordant issues arise when a nurse researcher interviews other nurses, similar to when one bears the label of "native anthropologist" (Narayan, 1993).

As I participated in data collection, I applied the same poststructural perspectives that founded my methodology, challenging the written and unwritten rules and assumptions of working as a researcher. This includes challenging the realities (rules that qualitative researchers have adopted) including Asselin's (2003) statement that "It is best for the researcher to assume he or she knows nothing about the phenomenon under study and start gathering data from a fresh perspective with his or her 'eyes open'" (p. 100). While I believe it is essential to acknowledge assumptions, I do not believe it is possible to bracket them from a study. In addition, I challenge those that proclaim they have done so to 'open their eyes'. Brayboy and Deyhle (2000) support his belief:

Suggesting that individuals seek to marginalize themselves from a group with which they identify is an enormous request. How can this be accomplished? If it could be, why is it necessary? There appears to be a sense that an individual is able to conduct a (mostly) objective ethnography. We challenge the position that researchers can be "objective" at their research site. Being objective when studying a group of which one is a member is impossible, and claiming objectivity can work against accurate understandings and lead to dishonest and unethical positions. (p. 165)

At the same time it remains important to recognize and unveil personal bias. For example, when a researcher works in the setting and is a peer of the group under study, there is often a tendency to believe one knows the culture. This was the case in my study. I believed I was aware of the innuendoes, rituals, specific behaviors and language of this group of nurses. These ‘taken for granted assumptions’ may limit the researcher’s ability to probe for deeper meaning or understanding of the phenomenon under study. The researcher may not even be aware that he or she holds assumptions about the culture of the setting but may become aware of this when reviewing research notes or transcriptions (Asselin, 2003).

This is exactly what happened in my study during the interview process. As identified in Asselin’s study (2003), many of the interviews in my study contained dialogue that included the words “you know”. These words were often used as *filler* when the speaker was thinking, rather than a pause. However, sometimes the participant stated “you know” with a greater purpose to imply that they believed I “knew”. For example, “You know Mary, what it is like on our ward”. At these times, I also believed I knew. In fact I responded: “Yes, I have *been there*”. When I transcribed my interviews it became clear that while I believed I knew implicitly what the participant meant during the interview, I realized after *reflection* that I was not as certain. This is where maintaining the lens of poststructural theory was useful during the research process; it served to unveil and illuminate research discourses that were concealed. By doing so, these assumptions were made available to be scrutinized and critiqued.

While I disagree that “Role confusion exists when the researcher perceives or responds to events or analyzes data from a perspective other than researcher” (Asselin, 2003, p. 102), and I do not believe it is possible to be objective, it is clear that the researcher’s subjectivity

must be open to intense scrutiny. There lies the value of applying a poststructural methodology to insider research. Values, beliefs and personal interests should not only be declared but also challenged on an ongoing basis. Research programs that disclose their value-base have typically been discounted as being overly subjective and thereby nonscientific (Lather, 1986, p. 259). Rather, I agree with Namenwirth, who declared that “Scientists firmly believe that as long as they are not *conscious* of any bias or political agenda, they are neutral and objective, when in fact they are only unconscious” (1986, p. 29).

The point remains that *insiders* conducting research and writing accounts of their own group have issues with which they must deal, but these issues do not mean they cannot conduct good, valid and legitimate research (Namenwirth, 1986; Swisher, 1986; Swisher, 1998). In doing so researchers must address the issues in a manner that shows integrity and an awareness of some of the complicated issues facing them. Just as Swisher (1986, 1998) suggests that the very position of being an insider in American Indian communities enhances the validity of the research process, data collection and analysis because “How can an outsider really understand life on the reservations, the struggle for recognition, sovereignty, economic development, preservation of language and culture” (1998, p. 194), I believe it is the same for nurses. It is difficult for anyone who is not a nurse or who does not work closely with nurses to understand the world in which nurses work. Nurse researchers have a unique opportunity, privilege and honour to enhance the validity of research specific to nursing practice.

This is where a Foucauldian poststructural/postmodern perspective is beneficial to deconstruct the rules and assumptions of research, and unveil the usefulness of alternate approaches without discrediting one method for another. The key is to be transparent, to

unveil realities for what they are and to expose the usefulness without discrediting the possibilities.

5.5.2 Positions of the Participants

It became evident during the course of the interviews that everyone takes up subject positions, and these positions are not static, but continually develop, change and compete. It is not only the position of the researcher, but also the way the participant positioned her/himself, (for example, novice, expert, change agent, student) that contributed to the findings. Not only did these positions change, but they also challenged the positions that I had attributed to the participants. For example, Ivan stated that he was looking forward to the interview because he wanted to “hear what I had to say about delirium”. His father-in-law had experienced delirium, and he was very interested in learning more about the topic. This was not the way I positioned myself; I positioned myself as the listener, not the teller.

Because the participants may have been anxious having their actions and decisions analyzed, particularly by someone they know, their comments may not reflect a true picture of what is happening on the ward, what they believe or how they are feeling. They may also engage in impression management and give answers that place themselves in a positive light or what they think the interviewer wants to hear (van Heugten, 2004, p. 215). Problems with self-reporting commonly arise when researchers ask questions about decision-making, in part because respondents have limited time and therefore limited ability to recall and analyze these processes. In an attempt to address this issue I conducted a follow up interview with participants once the interviews had been transcribed. The purpose of this follow up interview was to provide the opportunity for participants to review, add and/or delete any information from their narrative summary.

As well, there remains the position of those participants that chose not to take part. A few staff members approached me in the hospital to explain why they had chosen not to participate in the interviews; these were the nurses that wanted to explain their position. Others who did not choose to participate may question whether I had a “hidden agenda for asking them to participate or using their unit as a setting” (Asselin, 2003, p. 101). For example, they may question whether I would evaluate or critique their practice and report those findings to their nursing manager. Brayboy and Deyhle (2000) describe the experience of working hard to develop a balance between being a “good researcher and a good Indian simultaneously” (p. 165). In the same respect, I put great effort into being a good researcher and a good nurse. Just as Indigenous people have a distrust of anthropologists in their communities, such is the case with nurses’ distrust of researchers and academics in general. Front line nurses do not all see research as directly relating to their work. The question, *For whom?* (Fine, Weis, Weseert & Wong, 2000) remains at the ethical forefront of all research; in other words, ultimately, whose interests does the research serve?

5.6 Limitations

Poststructural theory acknowledges that discourse is subject to historical change and differs according to social institutions and social practices as well as the positions of those who speak and those whom they address. Discourses then cannot be truly representative of subjectivity and the notion of generalizability is antithetical to poststructuralist theory. As well, producing discourses, rather than just texts, involves bringing in the subjective understandings of the researcher (Heslop, 1997). I do not mean for the account represented in this study to be authoritative. Rather, as a researcher conducting research in my area of practice, I remain situated in the act and process of research attempting to “produce a

likeness or similitude to the truth, as close as possible” (Hole, 2006, p. 55), with the assumption that reality is continually under construction.

“Nursing and nursing practice both construct and are in turn constructed by the context in which they operate” (Cheek & Rudge, 1994, p. 15). The talk and text reflected in the interviews play a central part in that construction. As such, Cheek and Rudge explain that “nursing and nursing practice can be considered to represent a reality that is textually mediated” (1994, p. 15). This reality is represented in the content of the vignettes which is informed by ‘the social structures and historical conditions under which they were produced’ (p. 15).

5.7 Suggestions for Future Research

There is an unlimited scope for future research in the area of nursing practice specific to caring for older patients at risk for and experiencing POD. New research focusing on delirium is exploding in the quantitative paradigm, and growing steadily utilizing a qualitative lens of inquiry. Future research into how best to care for this special patient population in the acute care setting is essential.

5.7.1 Research in Education

Each of the participants mentioned that they did not receive significant information regarding delirium in their basic nursing program. Although geriatric content is covered in most undergraduate nursing programs it is usually introduced in the first year of the program before the students have developed an appreciation for the complexity of this patient population. New research possibilities include investigations of what is being taught in basic nursing programs, how that content is covered and how students are processing the information and transferring it into practice. It would be interesting to conduct a study with

students, investigating their experiences with these types of patients and gain a student perspective of caring for these patients. Many nursing programs are using patient simulation sessions to enhance student learning and critical thinking in order to develop clinical competency, promote teamwork, and improve care processes (Horan, 2009; Nagle, McHale, Alexander & French, 2009; Ravert, 2008). Bruce, Scherer, Curran, Urschel, Erdley and Ball explain the value of providing opportunities for students to participate in clinical crisis simulations through interaction with a “high-fidelity human patient simulator (HIPS) (2009, p. 22). “Scenarios such as cardiac arrest are programmed by the operator. A simulated patient monitor provides information related to waveforms, temperature, heart and respiratory rate, cardiac rhythm, blood pressure, arterial oxygen and carbon dioxide levels” (p. 24). There is no mention of using the HIPS to illustrate and teach students the clinical crisis simulation of delirium. It would be interesting to investigate if this is possible, and if the HIPS could contribute to legitimization of POD.

Continuing education for practicing nurses continues to be an issue. Providing education during hours that the nurses are working is not often effective because it is a less than optimal learning environment. Nurses are unable to focus on education when they are thinking about a practice assignment where they are already over worked and short staffed. Asking nurses to attend unpaid education opportunities on their days off is not effective either. Therefore, there is great need for research to direct practice regarding how to best provide this education to nurses as well as the role of management and administration in the provision of continuing education.

5.7.2 Research in Existing Resources

Information that this study provided regarding the use of the CAM/CAMI as well as the awareness and utilization of the REACH team was interesting in that neither were visible in the practice of nursing care of patients with POD. There is opportunity for an intervention study with a focus on capitalizing on the use of both of these resources. This type of study would be relative to my position as Clinical Practice Educator in this facility and would not be difficult to carry out. As well, a study of this kind would have potential to look at the impact of interventions on patient outcomes including length of patient stay, time from onset of POD to resolution of POD, cost to the health care system, etc.

5.7.3 Research in Shared Resources

In this climate of regionalization and standardization of health care it is appropriate to adopt pathways and protocols that would assist nurses to competently care for this patient population whether they are working in a tertiary care center, community or rural hospital. Intervention studies have the potential to evaluate best practice guidelines for this patient population in order to reach and maintain legitimacy status for this patient population.

It is important to lobby governing bodies to grant increased funding to provide specialty geriatric education for acute care nurses. As well, team approaches to collaborate on provision of care to this population have opportunities for continued research.

5.8 Conclusions

In this study I found that powerful discourses were at work in nursing practice of caring for patients with POD. These discourses included discourses of biomedicine/science, discourses of legitimacy/illegitimacy, discourses of nursing work, discourses of normalcy, discourses of competency, and discourses of safety. This study illustrates the value of a

poststructural methodology to expose and unveil the hegemonic influences that serve to direct nursing practice in a certain way, and how a critical process of discourse analysis can challenge and reshape powerful discourses with a purpose to inform new practice. By illuminating and exposing existing discourses, not as good or bad, but rather for how they are used to direct, legitimize and govern nursing practice, it is possible not only to imagine, but to realize new possibilities. These possibilities have great potential to create positive changes not only in improved outcomes for patients at risk for and patients presenting with POD, but also for length of patient stay and nursing practice.

5.9 Back to “Don”

There is an interesting phenomenon that occurs after delirium resolves in patients. This phenomenon is that the patient often remembers everything that happened during the episode of delirium. For example, they remember calling the nurse a “Bitch”. They remember three nurses holding them down to administer a needle. They remember thinking the nurses were going to poison them. They remember thinking they were in a concentration camp and the ‘nurses’ were plotting to kill them.

As a result of these memories, including the realization of the amount of disruption and increase in nursing work that was caused by their behavior, they are often left feeling embarrassed, guilty and ashamed. The need is great to provide opportunities to debrief with these patients and to communicate with them that what happened was not their fault. They did not do anything wrong. The nurses do not feel badly toward them as persons. And, we are doing our best to improve our care of patients like them, so that neither they nor anyone else ever need to go through an experience like this again.

I never saw Don again. He passed away about a year after I saw him that day on the street, from heart failure. When I spoke to his wife a few years later what I remember most clearly are these words: “You know, he was never the same again. When he came home from the hospital that time, he was never the same again”.

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APPENDICES

Appendix A: Letter to Unit Manager

XXX Unit Manager
XXXX
XXX

Dear XXX,

I am currently enrolled in the University of British Columbia Okanagan Master in Nursing program, and preparing to complete the thesis component of this postgraduate degree. As you know, postoperative delirium (POD) has been an area of study of mine for quite some time. I have prepared a qualitative study proposal with a POD focus and I am interested in recruiting staff on XX to participate in this study.

The research study I plan to conduct focuses on the discursive practices that shape and discipline nurses' response to POD, compared to nurses' response to other acute onset symptoms (for example, chest pain). Because orthopedic patients have a significantly high incidence of delirium I believe XX is an ideal ward to access for this study. It is my hope that the data obtained from this study will contribute to improved outcomes for patients who present with POD, as well as increased knowledge for staff regarding the complexities of POD.

I have obtained approval from the Interior Health Research Ethics Board as well as the University of British Columbia Research Board to conduct this study. To obtain the data, I am seeking Registered Nurses and Licensed Practical Nurses that have cared for a patient with POD within the last 6 months. For those nurses who consent, I will conduct in-depth interviews, which will be arranged at a time and place that is convenient for them.

I would like to provide your staff with information packages, which outline the purpose of the study and request, volunteer participation (see attached). This package also includes a consent form. With your permission, XX, the Clinical Practice Educator for XX, has volunteered to attend the next staff meeting held on XX, and read a prepared statement to staff regarding the study (see attached). It has been decided that if I were to attend in person, it might problematize ethics (coercion issues), because of my possible influence as an educator and colleague of these nurses.

Please contact me at the address or phone numbers above if you have any questions regarding this proposed research.

Your support for this project is greatly appreciated.

Yours truly,

Mary Kjorven

Appendix B: Statement for Staff Meeting

Mary Kjorven asked that I (XXX) attend this staff meeting to provide the staff on XX with information packages regarding a research study that she is conducting as partial fulfillment for her Master's in Nursing degree.

It was decided by Mary, in conjunction with her research committee that she should not attend in person because her presence may be interpreted as coercion, and she is committed to abiding by ethical principles.

As many of you know, post operative delirium has been an interest of Mary's for quite some time, and she is especially interested in hearing from '2A' nursing staff (both RNs and LPNs) about their experiences of caring for pts that present with an acute onset, including delirium.

You will be asked to participate in an interview with Mary lasting 30 minutes to one hour and a short follow up session lasting 15 to 30 minutes. All the information that you give will be kept confidential.

Mary has provided information packages that you may take with you today that provide more information on this study. If you are interested in participating or if you have any questions regarding the study, please contact Mary at the numbers provided in the package.

Appendix C: Recruitment Brochure

Nurse Information Brochure for Nurses on '2A'

Title of Research Project: An Exploration of the Discursive Practices that Shape and Discipline Nurses' Response to Postoperative Delirium (POD)

Principle Investigator and Supervisor: Dr. Kathy Rush, Associate Professor, Faculty of Nursing, University of British Columbia Okanagan.
Email: KathyRush@ubc.ca

Co-Investigator: Mary Kjorven, RN, Clinical Nurse Educator, Kelowna General Hospital, MsN Candidate, University of British Columbia Okanagan. Phone (250) 862-4424, local 3229
Email: Mary.Kjorven@interiorhealth.ca

What Is This Study About?

The purpose of this study is to critically examine nurses' language and practices related to care of patients who present with an acute onset, including delirium. This study is part of Masters studies in the Faculty of Nursing at the University of British Columbia Okanagan.

Who Can Participate?

To participate in this study:

- You must be either a Licensed Practical Nurse or a Registered Nurse
- Work on '2A' at "Canora Jubilee Hospital" either as a full-time, part-time or casual position
- Have cared for a patient that presented with POD in the last 6 months

What Will I Be Asked To Do?

- Participate in a face-to-face in-depth interview with the researcher (Mary Kjorven).
- Answer questions about your experiences of caring for patients that present with an acute onset
- Commit about 30 minutes to 1 hour of your time
- Agree to have the interview digitally recorded and later transcribed for analysis.
- Complete questions about you personally such as your age, level of education and years of experience in nursing
- Sign a consent form.

What Do I Do If I Am Interested in Participating?

If you agree to take part in this study, please contact me, Mary Kjørven at XXX or Mary.Kjørven@interiorhealth.ca and I will take your consent.

For additional information or information any time during the study, please contact Mary Kjørven at XXX or Kathy Rush at XXX

If you have any concerns, you may contact the ethics board at the University of British Columbia and/or the ethics board at Interior Health Authority (IHA).

Appendix D: Nurse Consent and Information Form

CONSENT AND INFORMATION FORM

Title: An Exploration of the Discursive Practices that Shape and Discipline Nurses' Response to Postoperative Delirium (POD)

Principal Investigator:

Dr. Kathy Rush - Associate Professor, UBC Okanagan School of Nursing
Contact Phone: XXX XXX-XXXX

Co-Investigator:

Mary Kjorven – RN, BsN, Clinical Nurse Educator, Kelowna General Hospital, MsN
Candidate, University of British Columbia Okanagan Contact
Phone: (250) 862-4424 local 3229

Study Information and Purpose

Delirium is a common, costly and dangerous condition, especially among older adults. Delirium leads to negative outcomes, which include increased hospital costs, lengths of patient stay and morbidity and mortality. Nurses are in an ideal position to identify POD and therefore predict, prevent and should it occur, reduce the incidence of delirium. The purpose of this study is to critically examine the language practices and discourses that shape and discipline nurses' care of older adults with POD. This study is part of Masters studies in the Faculty of Nursing at the University of British Columbia Okanagan.

Who Can Participate?

To participate in this research study you must be either a Registered Nurse or a Licensed Practical Nurse, speak English, work on '2A' at 'Canora Jubilee Hospital', and have cared for a patient presenting with POD within the last 6 months.

What Does the Study Involve?

I will ask you a few open-ended questions regarding nurses' responses to acute onset presentations in patients, including POD. I will take notes during and after the interviews. Interviews will take place at a time and place that is convenient for you. There is no right or wrong answer. The discussion will take approximately 30 minutes to 1 hour of your time. With your consent, our conversation will be digitally recorded. After the preliminary findings are analyzed I will ask you to validate your responses. If new findings emerge at this time, additional sessions may be arranged. In addition you will be asked to complete a form that asks you information about you personally such as your age, level of education, and years of experience in nursing.

Risks

There are no perceived risks to participating in this study except perhaps the time involved.

Benefits

One of the benefits of participating in the study is increasing your awareness of nurses' practices toward acute onset presentations in patients including POD. The information you provide may not contribute to any immediate changes for you but may help to promote greater understanding of nursing practice. Participating in this study may bring you the satisfaction that you are helping to improve the lives of older adults.

Confidentiality

A number of measures will be used to keep your identity confidential. The recordings and printed discussions will be kept in a locked cabinet, made available only to members of the research committee, and destroyed in 5 years. The printed discussions will use code numbers so no participant can be identified. All documents will be identified only by code number and kept in a locked filing cabinet.

The information you provide will be shared with others who study and work with POD and be communicated in written papers or oral presentations. We are asking your permission to communicate your information in this way without personally identifying you. It is anticipated that results from the study will be used to guide future research in this area. If you would like a report of the findings please include your mailing address in the space provided at the bottom of this form. You will also be provided with a copy of the signed consent form.

Contact for information about the study:

If you have any concerns, questions or would like further information about the study, you may contact Dr. Kathy Rush at XXX. Signing this consent form in no way limits your legal rights against the investigators.

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.

Consent

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time during the course of this study without jeopardy to your position or participation in the seniors group.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

All participants will receive a beverage gift card as an honorarium up to a value of \$10.00 whether or not the study is completed.

Participant Signature

Date

Printed Name of the Participant

Witness Signature

Date

Address of Participant (For Sending Study Results)

Thank you for your time!

Appendix E: Interview Questions

The interview questions were developed in consultation with Lynda Keery (committee member, Clinical Nurse Specialist in Gerontology) during a pilot interview where she assumed the role of respondent.

1. Tell me about that patient that you cared for within the last six months who presented with POD.

Prompts:

How did you make decisions around that?

Where did you learn how to practice that way?

How did you feel about your practice?

What did you chart about that?

What supports are there, what barriers are there for your practice?

2. Now think about another patient that you cared for within the last six months who presented with an acute onset, for example, chest pain. How did your care of these two patients differ? (Assumption is that care differs between all pts, due to individualized care practices).

Prompts:

How did you make decisions around that?

Where did you learn how to practice that way?

How did you feel about your practice?

What did you chart about that?

What supports are there, what barriers are there for your practice?

Appendix F: Demographic Form

1. **Sex:** Male Female

2. **Age:** _____

3. **Ethnic Background:** Caucasian

First Nations

Indian

Asian/Pacific Islander

Other (specify) _____

4. **Highest Level of Education in Nursing:**

Licensed Practice Nurse (LPN)

Diploma in Nursing or Associate Degree in Nursing (RN)

Bachelor's Degree in Nursing

Other _____

5. **Years of Experience in Nursing:**

< 2 years

11-15 years

2 – 5 years

16-20 years

6-10 years

> 20 years

6. **Years of Experience in Orthopedic Nursing:**

< 2 years

11-15 years

2 – 5 years

16-20 years

6-10 years

> 20 years

7. **Have you cared for a patient with POD in the last 6 months?**

Yes No

8. **How often do you care for patients experiencing POD?**

Daily Once per week 2-3 times per week 1-3 times per month

Appendix G: Demographic Findings

Demographics	
1. Sex (N=6)	Male = 1 Female = 5
2. Age (N= 6)	23 yrs 27 yrs 37 yrs 41 yrs 48 yrs 52 yrs Average: 38 yrs
3. Ethnic Background (N=6)	4 = Caucasian 0 = First Nations 0 = Indian 1 = Asian/Pacific Island 1 = Other (Metis)
4. Level of Education (N=6)	2 = LPN 2 = RN 2 = BN 0 = Other
5. Years of Experience in Nursing (N=6)	1 = < 2 yr 2 = 2-5 yr 1 = 6 – 10 yr 0 = 11-15 yr 0 = 16-20 yr 2 = > 20 yr
6. Years of Experience in Orthopedic Nursing (N= 6)	2 = < 2 yr 1 = 2-5 yr 1 = 6 – 10 yr 0 = 11-15 yr 1 = 16-20 yr 1 = > 20 yr
7. Frequency Caring for Patients Experiencing POD (N=6)	0 = Daily 3 = 1 X wk 2 = 2-3 X wk 1 = 1-3 / mo

Appendix H: University of British Columbia Research Ethics Approval Certificate



The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - MINIMAL RISK

PRINCIPAL INVESTIGATOR: Kathy Rush	INSTITUTION / DEPARTMENT: UBC/UBCO Health & Social Development/UBCO Nursing	UBC BREB NUMBER: H08-01042
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
Institution		Site
N/A		N/A
Other locations where the research will be conducted: Kelowna General Hospital; researcher's home, subject's home		
CO-INVESTIGATOR(S): Kathy Rush Mary Kjørven		
SPONSORING AGENCIES: N/A		
PROJECT TITLE: An Exploration of the Discursive Practices That Shape and Discipline Nurses' Response to Postoperative Delirium		

CERTIFICATE EXPIRY DATE: May 23, 2009

DOCUMENTS INCLUDED IN THIS APPROVAL:	DATE APPROVED: May 23, 2008	
Document Name	Version	Date
Protocol:		
Thesis Proposal: Complete	1.0	May 10, 2008
Consent Forms:		
Appendix D: Information and Consent Form	1.0	May 10, 2008
Advertisements:		
Appendix C: Recruitment Brochure	2.0	May 8, 2008
Appendix B: Statement	1.0	May 10, 2008
Questionnaire, Questionnaire Cover Letter, Tests:		
Appendix F: Demographic Form	2.0	May 8, 2008
Appendix E: Interview Questions	1.0	May 10, 2008
Letter of Initial Contact:		
Appendix A: Letter to Unit Manager	2.0	May 8, 2008

The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

- Dr. M. Judith Lynam, Chair
- Dr. Ken Craig, Chair
- Dr. Jim Rupert, Associate Chair
- Dr. Laurie Ford, Associate Chair
- Dr. Daniel Salhani, Associate Chair
- Dr. Anita Ho, Associate Chair

Appendix I: Interior Health Research Ethics Approval Certificate



Research Office
 Research Ethics Board
 Suite 104 - 1815 Kirschner Road
 Kelowna, B.C., V1Y 4N7

Certificate of Research Ethics Board Delegated Approval

Principal Investigator: Dr. Kathy Rush UBC - Okanagan	Institution of Primary Association UBC - Okanagan	IH Research File Identifier 2008-028
Research Study Title: An Exploration of the Discursive Practices that Shape and Discipline Nurses' response to Postoperative Delirium		
IH Administrative Contact Denise Dunton	Co-Investigators Mary Kjørven	
Sponsoring/Funding Agencies Unfunded	IH Departments Involved in Research Study KGH 4West	
Documents Covered by this Approval Thesis Proposal V 1.0 May 10/08 Nurse Information Brochure V 3.0 Jun 5/08 Recruitment letter to unit manager V 3/0 Jun 5/08 Statement for Staff Meeting V2.0 Jun 5/08 Consent and Information Form V 2.0 Jun 5/08 Interview Questions V 1.0 May 10/08 Demographic Form V 3.0 Jun 5/08	Certificate of Approval from Primary REB UBC BREB May 23, 2008	
Certification It is the assessment of IH that this research study poses minimal risk to human subjects, and therefore qualifies for delegated review. This Certificate of Approval is valid for the term specified below provided there are no changes in the experimental procedures. <i>The Interior Health Research Ethics Board is in compliance with the ethical principles presented in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans</i>		
Conditions for Approval It is the responsibility of the principal investigator to inform the IH Research Office if the assessment is deemed at any time to be greater than minimal risk for human subjects. It is the responsibility of the principal investigator to inform the IH Research Office if there are changes to consents or other materials used with human subjects – these must be submitted to the IH Research Office for review and approval prior to implementation.		
Approval Date June 18, 2008	Approval Term 1 year	
IH Authorized Signature 		<i>June 18, 2008</i> Date
B. Ann Ferguson, Chair, Interior Health Research Ethics Board		