Aesthetic ways of knowing: exploring mental health nurses’ experiences of delirium superimposed on dementia

Claire Anne Pryor

Abstract
Background In the UK, people with delirium superimposed on dementia may be cared for by mental health nurses, however there is little in the literature about the experience of caring for people with the condition from the perspective of mental health nurses.

Aim To illuminate the experiences of mental health nurses caring for people with delirium superimposed on dementia and to explore how mental health nurses ‘know’ the people they care for using ‘aesthetic ways of knowing’.

Method A mixed-methods design was used guided by the principles of activity theory. Participants were registered mental health nurses with experience of caring for people with delirium superimposed on dementia within a 24-hour care environment, including an NHS mental health foundation trust and care homes. Data were collected in two ways and at two different time points: first via semi-structured interviews (n=7), second via a questionnaire (n=25). Thematic analysis of the qualitative data was paired with simple descriptive statistics of the quantitative data to describe participants’ experience.

Findings This article discusses one finding from the larger study, which was undertaken as part of the author’s PhD, in relation to the way in which mental health nurses ‘know’ the people they care for. Overall, participants showed a preference for aesthetic ways of knowing, rather than the use of formal assessment tools or scores. Participants experienced caring for people with delirium superimposed on dementia by valuing the person and concentrating on their behaviours, responses and personality, thus enabling them to anticipate and/or recognise potential triggers, precipitating factors and any changes in behaviours.

Conclusion The ways in which mental health nurses know the people they care for influences their care delivery. Mental health nurses’ use of aesthetic ways of knowing should be recognised and valued as a way of better understanding and supporting the person with delirium superimposed on dementia.

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Keywords
clinical, delirium, dementia, mental health, neurology, nursing care, nursing models and theories, patients, person-centred care, professional, professional issues, signs and symptoms
In the UK, people whose main care needs are driven by dementia are often cared for in mental health settings, such as mental health hospitals or specialist care homes in which nurses are predominantly mental health nurses. While this supports the delivery of specialised mental healthcare, it could be argued that, compared with nurses in other fields of nursing, mental health nurses may be less aware of people's physical health needs and less experienced in addressing those needs. However, in the author's view, using aesthetic knowing may feel more natural or intuitive to mental health nurses than using assessment tools or scores to recognise, and act on, changes in a person's condition that may indicate delirium superimposed on dementia. This article describes one main finding from a study of mental health nurses’ experiences of caring for people with delirium superimposed on dementia and their use of aesthetic ways of knowing in their delivery of care, which was undertaken as part of the author’s PhD (Pryor 2021). The complete study can be accessed at nrl.northumbria.ac.uk/id/eprint/46715/

Aim
To illuminate the experiences of mental health nurses caring for people with delirium superimposed on dementia and to explore how mental health nurses ‘know’ the people they care for using ‘aesthetic ways of knowing’.

Method
Design
The study used a pragmatic exploratory sequential mixed-methods design based on Creswell and Plano Clark’s (2011) three phase framework – that is, qualitative data collection and analysis (phase one), which informs quantitative data collection and analysis (phase two), which informs interpretation (phase three) – and guided by the principles of activity theory. Findings were interpreted and organised in a second-generation activity theory system.

Activity theory considers that experiences are mediated, influenced and changed by the society or community in which they take place (Engeström 2003, Wilson 2008); as such, the society or community and the individuals within it are continually evolving (Bedny and Karwowski 2007). This theory fitted with the purpose of the research, since it supports expansive explorations within systems such as healthcare settings, including considering multiple influences on people's actions.

Second-generation activity theory explains on activity theory by considering the subject (the individual within the system), the object

Implications for practice
● Practice areas should recognise, support and celebrate mental health nurses’ aesthetic ways of knowing the people they care for
● Practice areas should consider providing education on delirium superimposed on dementia that focuses on the different ways of knowing a person
● Nurses could benefit from support to enhance their ability to combine aesthetic and empirical ways of knowing to detect delirium superimposed on dementia
● Further research is required to explore how care teams can develop a shared language to support the understanding of delirium superimposed on dementia

Fundamental Patterns of Knowing in Nursing, by the way they ‘know’ the people they care for. There has been a rapid increase in the availability of tools and scores, such as the 4AT Rapid Clinical Test for Delirium (MacLullich 2023) and the Single Question in Delirium (SQiD) (Sands et al 2010), designed to support the recognition and assessment of delirium in a range of settings and thus reduce the risk of missed diagnosis. However, although nurses’ experience of care may be influenced by such assessment tools or scores, it is also influenced by the way they ‘know’ the people they care for.

Carper (1978), in her influential work "Fundamental Patterns of Knowing in Nursing," described four main ways of knowing:

> Empirical – using objective and scientific external sources.
> Aesthetic – using one’s awareness and perception of the situation, the patient and their circumstances.
> Personal – using one’s understanding of, and empathy with, the patient.
> Ethical – using an ethical framework and an awareness of moral questions.

Delirium superimposed on dementia is a complex convergence of the two conditions occurring at the same time (Kolanowski et al. 2011a, Morandi and Bellelli 2020). Despite being a potentially fatal medical emergency (Kolanowski et al. 2011b), and a relatively common condition (Gibb et al. 2020), delirium superimposed on dementia is often missed or misdiagnosed as worsening dementia if the acute presentation of deteriorating cognition or changes in the person's behaviours are not recognised.

Practical implications are required to explore how care teams can develop a shared language to support the understanding of delirium superimposed on dementia.
Recruitment and participants
Purposive sampling was undertaken of registered mental health nurses with experience of caring for people with delirium superimposed on dementia in a 24-hour care environment. Participant recruitment for one-to-one interviews (phase one) took place in one large NHS mental health foundation trust. Participant recruitment for the questionnaire (phase two) took place in local care homes and among attendees at a regional delirium conference.

Seven mental health nurses took part in the interviews, which were undertaken between December 2016 and February 2017. Twenty-five mental health nurses completed the questionnaire between September and October 2018. Detailed information about recruitment and participants can be accessed at nrl.northumbria.ac.uk/id/eprint/46715/

Data collection
Data were collected between 2016 and 2018. The study was completed in 2021.

Interviews
Qualitative data were collected via one-to-one semi-structured interviews which were audio-recorded, transcribed verbatim and uploaded to a software data management and analysis programme. Framework analysis (Spencer et al 2014) was used to analyse the data. The findings were then considered in line with the facets of a second-generation activity system and reviewed and analysed for emerging tensions or influencing factors.

Questionnaire
There were no validated questionnaires available at the time of the study to support the exploration of mental health nurses’ experience of caring for people with delirium superimposed on dementia, therefore the author devised a questionnaire based on the literature and on data derived from analysis of the interviews, following the seven-step approach detailed by Artino et al (2014).

The questionnaire comprised seven sections, each of which contained statements to which participants were asked to respond using a five-point Likert-type scale (strongly disagree, disagree, neither agree nor disagree, agree, strongly agree), multiple-choice questions and free-text boxes for additional comments. Descriptive statistics were used to analyse the quantitative data. Comments in the free-text boxes were subjected to thematic coding and quantification.

Ethical considerations
Research ethics approval to undertake the study was secured initially from Northumbria University. Subsequent approvals were granted by the NHS trust’s research and development department, Northumbria University and the delirium conference research committee. Governance processes for research and participant recruitment in the care homes were followed.

All participants were given an information sheet about the study to support informed consent. Participants gave verbal consent before taking part in the interviews and written consent before completing the questionnaire. Responses to the interviews and questionnaires were coded to ensure anonymity. Detailed information about informed consent can be accessed at nrl.northumbria.ac.uk/id/eprint/46715/

Findings
This article discusses one main finding from the original study (Pryor 2021) which suggested that overall, in the context of recognising and caring for people with delirium superimposed on dementia, participants favoured aesthetic ways of knowing.

Interviews
Analysis of the interview data suggested that participants felt more at ease using their personal understanding of the person to recognise any changes in behaviour that may indicate delirium superimposed on dementia rather than using an assessment tool or score. One participant expressed this when discussing an episode of care:

‘A gentleman who had been well known to us, there were changes in his behaviour, he was more confused, he was more aggressive and impulsive.’ (Participant A)

All seven participants firmly believed that their personal knowledge of the people they cared for was a significant part of the assessment. Some participants used the knowledge they had gained through personal and aesthetic ways of knowing to create a tangible repository of information about people in their care that the entire care team could draw on. This repository became part of what participants called the ‘formulation’ of the person receiving care:
‘What I think we do rely on is the formulations, knowing the patient, knowing a possible trigger.’ (Participant A)

‘The formulation is basically an A4 piece of paper that described a person altogether, you’ve got a life story section […] about the person’s history, who their family are, what they did for a living, what led up to admission […] so it’s a really in-depth analysis of that one person, as person centred as we can be.’ (Participant F)

The quotes demonstrate that participants experienced the care of people with delirium superimposed on dementia by valuing the individual and concentrating on their behaviours, responses and personality to anticipate and/or recognise potential triggers, precipitating factors and changes in behaviours.

**Questionnaire**

One section of the questionnaire explored what informed participants’ practice through two sets of statements. In one set of statements, participants were asked to select the statement that accurately represented their nursing intuition in terms of recognising delirium superimposed on dementia. In the other set of statements, participants were asked to select the statement that best represented their opinion on what informed their practice. Out of the 25 participants who completed the questionnaire, only 23 responded to this section of the questionnaire.

When asked to select a statement that accurately represented their nursing intuition, 91% of participants \(n=21/23\) agreed or strongly agreed with the statement ‘My intuition is based on my knowledge of the individual’ and 83% \(n=19/23\) agreed or strongly agreed with the statement ‘My intuition is based on clinical guidance’. Only 57% \(n=13/23\) agreed or strongly agreed with the statement ‘If I suspect delirium superimposed on dementia I always complete an assessment tool’. Table 1 shows participants’ responses to the statements regarding their nursing intuition.

When asked to select the statement that best represented their opinion on what informed their practice, 74% \(n=17/23\) agreed or strongly agreed with the statement ‘The clinical team’s knowledge of a person is more important than a score or written guidance when considering delirium superimposed on dementia’ and 96% \(n=22/23\) agreed or strongly agreed with the statement ‘Gathering information from family and friends is important when considering delirium superimposed on dementia’.

In this section of the questionnaire, participants appeared to express a preference for basing their suspicion of delirium superimposed on dementia on their knowledge of the patient as an individual rather than on a formal assessment tool or score.

**Discussion**

The finding reported in this article emphasises that participants placed greater value on their experiences and on subjective and reflective components of knowledge than on assessment tools or scores and on objective components of knowledge in isolation to recognise delirium superimposed on dementia in their patients. Participants’ practice was informed more by knowledge gained through aesthetic and personal ways of knowing than by knowledge gained through empirical ways of knowing.

In second-generation activity theory, the object is the reason for undertaking an activity (Kaptelinin 2005). The object – in this instance the reason for undertaking a nursing activity – appeared to be motivated by participants’ desire to know people in their care as individuals. Participants demonstrated an affinity with aesthetic and personal ways of knowing, as defined by Carper (1978). These ways of knowing permeated and influenced participants’ care delivery, which echoes Barker and Buchanan-Barker’s (2004) assertion that nurses must have an empathy with, and an awareness of, their patient as a person to provide person-centred care.

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**Table 1. Participants’ responses to the statements regarding their nursing intuition \(n=23^*\)**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Number of participants who:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly disagreed or disagreed</td>
</tr>
<tr>
<td>Using my own intuition influences my care decisions and plans for people with delirium superimposed on dementia</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>My intuition is based on previous experience</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>My intuition is based on my knowledge of the individual</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>My intuition is based on clinical guidance</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Using my own intuition, I can recognise delirium superimposed on dementia</td>
<td>3 (13%)</td>
</tr>
<tr>
<td>If I suspect delirium superimposed on dementia I always complete an assessment tool</td>
<td>4 (17%)</td>
</tr>
</tbody>
</table>

* Although the questionnaire was completed by 25 participants, only 23 responded to the statements in this section of the questionnaire.
Knowing what it is to be that person and taking time to understand them is central to the mental health nursing premise of care (Barker and Buchanan-Barker 2004). The concept of knowing the person is not new and forms the hypothetical foundation of nursing care. The contemporary nursing ethos has moved away from 'patient-centred care', which has connotations of making the patient's life functional, towards the concept of personhood (Kitwood 1997) and person-centred care, which implies supporting the person to live a meaningful life (Eklund et al 2013). Part of the ethos of person-centredness is to recognise how nurses' personal attributes, the care environment and activities for people with dementia influence care provision (McCormack and McCance 2006). It could be argued that the increase in the use of assessment tools and scores may detract nurses from using aesthetic ways of knowing to recognise changes in people's health status. It is essential, therefore, that nurses uphold the principle that care should be individualised and that they value the person receiving care irrespective of their health condition, to ensure people with dementia who are at risk of delirium superimposed on dementia receive person-centred care (Kitwood 1997, Clissette et al 2013).

The finding reported in this article demonstrated that participants had a strong sense of person-centred care and appeared to favour information collected informally through aesthetic ways of knowing to support their assessments and care planning. This supports Delaney's (2006) and MacNeeal's (2010) assertions that mental health nurses favoured informal information over formal information across a wide range of clinical settings and conditions. In addition, the present study found that participants’ use of formal assessment tools or scores was secondary to their knowledge of the person as an individual. This could suggest that they were uncomfortable with ‘reducing’ a person to a number or score – which removes the focus on the person as an individual – for the purpose of using a clinical pathway.

In the present study there appeared to be low levels of use of assessment tools and scores among participants when they suspected delirium superimposed on dementia compared with using their own knowledge of the person. Assessment tools and scores have a place in high-quality delirium assessment, but the outcome or goal of using such tools must be seen by clinicians as appropriate and useful in supporting care provision (Bryce et al 2018). In a Danish study of 23 hospital nurses’ experiences of using delirium guidelines, participants did not perceive such guidelines as useful and reported feeling frustrated by the organisation’s requirement for habitual screening of patients (Emme 2020). Participants described the guidelines as ‘a paper to make some marks on’ and their use as being mandated by the organisation, rather than dictated by patient need or usefulness (Emme 2020).

Contemporary delirium assessment tools and scores, such as the SQiD (Sands et al 2010) and the 4AT (MacLullich 2023), place an emphasis on recognising and identifying changes in a person's behaviour or personality, which requires a level of knowledge of the person and not solely relying on clinical tests or laboratory results. However, combining these factors can ensure a robust assessment of delirium superimposed on dementia and subsequent care planning. For example, NICE (2023) advises clinicians to ‘observe, at least daily, all people in hospital or long-term care for recent (within hours or days) changes or fluctuations indicating delirium’. NICE (2023) also states that these observations may be ‘reported by the person at risk, or a carer or relative’ and that ‘if any of these changes are present the person should have an assessment using an appropriate tool’.

The mention of ‘a carer or relative’ implies that a level of personal knowledge is useful in the assessment of delirium, and a parallel can be drawn with the use of aesthetic ways of knowing by participants in this study. Additionally, in contemporary health and social care systems, where nursing teams may include temporary staff, it should not be assumed that all mental health nurses will have personal knowledge of all the people they care for. Participants in this study mentioned the use and usefulness of ‘formulations’ to share knowledge gained through aesthetic ways of knowing across the care team. Such ‘formulations’ may offer one solution to workforce issues, when not everyone on the team has one-to-one personal knowledge of every patient.

While nurses’ aesthetic ways of knowing people is valuable in delirium assessment and care, a balance must be struck between aesthetic and empirical ways of knowing to ensure optimal practice. For example, the minimal use of assessment tools and scores could result in a lack of a ‘shared language’ between the people involved in an individual’s care, such as nurses, doctors, physiotherapists, activity coordinators and family members. If there is no shared language for them to describe their observations, vital information may be missed. It is important that care teams have a shared language to support collaborative working.
and ensure patient safety (Rabøl et al 2011, Stühlinger et al 2019). This does not mean, however, that nurses should change their method of presenting their assessments. If nurses attempt to ‘medicalise’ the language they use, for example, this could risk losing the quality of understanding of the patient as a person.

Effective prevention, recognition, assessment and care of the person with delirium superimposed on dementia require a comprehensive knowledge of the person as an individual. Therefore, mental health nurses’ knowledge of the people they care for, and their understanding of people’s health status, should be appreciated on an equal level with formal assessment tools and scores.

Limitations
Phased one of this study involved collecting qualitative data from a sample of nurses in one NHS trust, which could negate the transferability of the finding to other settings. However, in phase two, quantitative data were collected from participants in a wider range of settings and the two sets of data were integrated, which could support transferability to a range of clinical settings.

Conclusion
The study finding discussed in this article suggests that participating mental health nurses’ practice in relation to delirium superimposed on dementia is informed by aesthetic ways of knowing the people they care for. Participants favoured this type of personal and intuitive knowledge over the use of formal assessment tools and scores. However, although aesthetic ways of knowing people should be valued and celebrated, combining these with the use of formal assessment tools can enhance patient safety in the context of assessing people for delirium superimposed on dementia. Mental health nurses may need support to enhance their ability to translate aesthetically gained knowledge within the context of evidence-based assessment tools and scores for delirium superimposed on dementia and to translate the outcomes of such tools within the context of their aesthetically gained knowledge.

References

Alzheimer’s Society (2023) Delirium - Symptoms, Diagnosis and Treatment. www.alzheimers.org.uk/get-support/daily-living/delirium (Last accessed: 9 October 2023.)


Emme C (2020) “It should not be that difficult to manage a condition that is so frequent”: a qualitative study on hospital nurses’ experience of delirium guidelines. Journal of Clinical Nursing. 29, 15-16, 2849-2862. doi:10.1111/jocn.15500


Pryor CA (2020) The Mental Health Nurse Experience of Providing Care for People with Delirium Superimposed on Dementia: Influences in an Activity System. nrl.northumbria.ac.uk/id/eprint/46715 (Last accessed: 9 October 2023.)


