

The Social Worker's Role in Delirium Care for Hospitalized Veterans

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Social workers can play an important role as part of the health care team in delirium risk identification, prevention, and care.

Delirium, or the state of mental confusion that may occur with physical or mental illness, is common, morbid, and costly; however, of the diagnosed cases, delirium is mentioned in hospital discharge summaries only 16% to 55% of the time.¹⁻³

Social workers often coordinate care transitions for hospitalized older veterans. They serve as interdisciplinary team members who communicate with VA medical staff as well as with the patient and family. This position, in addition to their training in communication and advocacy, primes social workers for a role in delirium care and provides the needed support for veterans who experience delirium and their families.

BACKGROUND

Delirium is a sudden disturbance of attention with reduced awareness of

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the environment. Because attention is impaired, other changes in cognition are common, including perceptual and thought disturbances. Additionally, delirium includes fluctuations in consciousness over the course of a day. The acute development of these cognitive disturbances is distinct from a preexisting chronic cognitive impairment, such as dementia. Delirium is a direct consequence of underlying medical conditions, such as infections, polypharmacy, dehydration, and surgery.⁴

Delirium subtypes all have inattention as a core symptom. In half of the cases, patients are hypoactive and will not awaken easily or participate in daily care plans readily.⁴ Hyperac-

tive delirium occurs in a quarter of cases. In the remaining mixed delirium cases patients fluctuate between the 2 states.⁴

Delirium is often falsely mistaken for dementia. Although delirium and dementia can present similarly, delirium has a sudden onset, which can alert health care professionals (HCPs) to the likelihood of delirium. Another important distinction is that delirium is typically reversible. Symptom manifestations of delirium may also be confused with depression.

Preventing delirium is important due to its many negative health outcomes. Older adults who develop delirium are more likely to die

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sooner. In a Canadian study of hospitalized patients aged ≥ 65 years, 41.6% of the delirium cohort and 14.4% of the control group died within 12 months of hospital admission.⁵ The death rate predicted by delirium in the Canadian study was comparable to the death rate of those who experience other serious medical conditions, such as sepsis or a heart attack.⁶

Those who survive delirium experience other serious outcomes, such as a negative impact on function and cognition and an increase in long-term care placement.⁷ Even when the condition resolves quickly, lasting functional impairment may be evident without return to baseline functioning.⁸ Hospitalized veterans are generally older, making them susceptible to developing delirium.⁹

Prevalence

Delirium can result from multiple medical conditions and develops in up to 50% of patients after general surgery and up to 80% of patients in the intensive care unit.^{10,11} From 20% to 40% of hospitalized older adults and from 50% to 89% of patients with preexisting Alzheimer disease may develop delirium.¹²⁻¹⁵ The increasing number of aging adults who will be hospitalized may also result in an increased prevalence of delirium.^{1,16}

Delirium is a result of various predisposing and precipitating factors.¹ Predisposing vulnerabilities are intrinsic to the individual, whereas precipitating external stressors are found in the environment. External stressors may trigger delirium in an individual who is vulnerable due to predisposing risk. The primary risk factors for delirium include dementia, advanced age, sensory impairment, fracture, infection, and dehydration (Table 1).¹²

Predisposing factors for delirium, such as age and sex, lifestyle choices (alcohol, tobacco), and chronic conditions (atherosclerosis, depression, prior stroke/transient ischemic attack) are more prevalent in the veteran population.^{9,17-20}

In 2011, the median age for male veterans was 64 and the median age for male nonveterans was 41. Of male veterans, 49.9% are aged ≥ 65 years in comparison with 10.5% of the nonveteran male population.²¹ Veterans also have higher rates of comorbidities; a significant risk factor for delirium.²⁰ A study by Agha and colleagues found that veterans were 14 times more likely to have 5 or more medical conditions than that of the general population.⁹ In a study comparing veterans aged ≥ 65 years with their age matched nonveteran peers, the health status of the veterans was poorer overall.²² Veterans are more likely to have posttraumatic stress disorder, which can increase the risk of postsurgery delirium and dementia, a primary risk factor for delirium.²³⁻²⁶

Delirium Intervention

Up to 40% of delirium cases can be prevented.²⁷ But delirium may remain undetected in older veterans because its symptoms are sometimes thought to be the unavoidable consequences of aging, dementia, preexisting mental health conditions, substance abuse, a disease process, or the hospital environment.²⁸ Therefore, to avoid the negative consequences of delirium, prevention is critical.²⁸

The goals of delirium treatment are to identify and reverse its underlying cause(s).²⁹ Because delirium is typically multifactorial, an HCP must

Table 1. Predisposing Factors and External Stressors

Predisposing Factors	External Stressors
Dementia	Infection
Advanced age ^a	Fracture
Male gender ^a	Alcohol and tobacco use ^a
Sensory deficits	Dehydration
Multiple comorbidities ^a	Severe illness ^a
Cardiovascular disease ^a	Surgery
Depression ^a	Sleep deprivation

^aMore common in veterans.

carefully consider the various sources that could have initiated a change in mental status. Delirium may be prevented if HCPs can reduce patient risk factors. The 2010 National Institute for Health and Clinical Excellence (NICE) Delirium Guideline recommended a set of prevention strategies to address delirium risk factors (Table 2).¹²

As a member of the health care team, social workers can help prevent delirium through attention to pain management, infection control, medication review, sensory improvement, adequate nutrition and hydration, hypoxia prevention, and mobilization.¹²

No pharmacologic approach has been approved for the treatment of delirium.³⁰ Drugs may manage symptoms associated with delirium, but they do not treat the disease and could be associated with toxicity in high-risk patients. However, there are a variety of nonpharmacologic preventative measures that have proven effective. Environmental interventions to prevent delirium include orientation, cognitive stimulation, and sensory aids. A 2013 meta-analysis of 19 delirium prevention programs

Table 2. Delirium Prevention Strategies

Prevention Strategy	Social Work Action
Communication	Offer orienting information to person, place, and time; encourage staff to reintroduce themselves to the patient and to explain why they are in the room
Therapeutic activities	Provide personalized, cognitive stimulation based on patient's interests (eg, crosswords, meaningful conversation)
Sleep promotion	Encourage sleep in collaboration with other team members who can provide sleep promotion supplies (eg, earplugs)
Pain management	Ask whether pain is new or has changed; report to medical team
Infection control	Empower patient to encourage staff and visitors to wash hands
Medication review	Assess whether patient has difficulty with medication adherence
Sensory improvement	Ensure patient has access to glasses and/or hearing aids
Adequate nutrition/hydration	Provide water if patient is medically cleared to receive it
Hypoxia prevention	Report whether patient is experiencing significant shortness of breath
Mobilization	Discuss prior patterns or barriers to ambulation

found that most were effective in preventing delirium in patients at risk during hospitalization.³¹ This review found that the most successful programs included multidisciplinary teams providing staff education and therapeutic cognitive activities.³¹ Social workers can encourage and directly provide such services. The Delirium Toolbox is a delirium risk modification program that was piloted with frontline staff, including social workers, at the VA Boston Healthcare System in West Roxbury, Massachusetts, and has been associated with restraint reduction, shortened length of stay (LOS), and lower variable direct costs.³²

SOCIAL WORKER ROLE

Several studies, both national and international, have indicated that little

has been done over the past 2 decades to increase the diagnosis of delirium, because only 12% to 35% of delirium cases are clinically detected within the emergency department and in acute care settings.³³⁻³⁷ Patients may hesitate to report their experience due to a sense of embarrassment or because of an inability to describe it.³⁸

Social workers are skilled at helping individuals feel more at ease when disclosing distressing experiences. Delirium is relevant to HCPs and hospital social workers with care transition responsibilities, because delirium detection should impact discharge planning.^{1,39} Delirium education needs to be included in efforts to improve transitions from intensive care settings to lower levels of care and from lower levels of care to discharge.⁴⁰ Hospital social workers are

in a position to offer additional support because they see patients at a critical juncture in their care and can take steps to improve postdischarge outcomes.⁴¹

Prior to Onset

Social workers can play an important role prior to delirium onset.⁴² Patient education on delirium needs to be provided during the routine hospital intake assessment. Informing patients in advance that delirium is common, based on their risk factors, as well as what to expect if delirium is experienced has been found to provide comfort.³⁸ Families who anticipated possible delirium-related confusion reported that they experienced less distress.³⁸

During hospitalization, social workers can ascertain from families whether an alteration in mental status is a rapid change, possibly indicating delirium, or a gradual dementia onset. The social work skills of advocacy and education can be used to support delirium-risk identification to avoid adverse outcomes.⁴³ When no family caregiver is present to provide a history of the individual's cognitive function prior to hospitalization, the social worker may be the first to notice an acute change in cognitive status and can report this to the medical team.

During Delirium

Lack of patient responsiveness and difficulty following a conversation are possible signs of delirium. This situation should be reported to the medical team for further delirium assessment and diagnosis.⁴ The social worker can also attempt to determine whether a patient's presentation is unusual by contacting the family. Social work training recognizes the important role of the family.⁴⁴ Social workers often interact with families

at the critical period between acute onset of delirium in the hospital and discharge.⁴² Studies have shown that delirium causes stress for the patient's loved ones. Moreover, caregivers of patients who experience the syndrome are at a 12 times increased risk of meeting the criteria for generalized anxiety disorder.³⁰ In one study, delirium was rated as more distressing for the caregivers who witnessed it than for the patients who experienced it.³⁸ Education has been shown to reduce delirium-related distress.³⁰

In cases where delirium is irreversible, such as during the active dying process, social workers can serve in a palliative role to ease family confusion and provide comfort.³⁰ The presence of family and other familiar people are considered part of the nonpharmacologic management of delirium.²⁸

Posthospitalization

Delirium complicates physical aspects of care for families, as their loved one may need direct care in areas where they were previously independent due to a loss of function. Logistic considerations such as increased supervision may be necessary due to delirium, and the patient's condition may be upsetting and confusing for family members, triggering the need for emotional support. During the discharge process, social workers can provide support and education to family members or placement facilities.³⁸

Social workers in the hospital setting are often responsible for discharge planning, including the reduction of extended LOS and unnecessary readmissions to the hospital.⁴⁵ Increased LOS and hospital readmissions are 2 of the primary negative outcomes associated with delirium. Delirium can persist for months beyond hospitalization, mak-

Figure. Social Work Elements in Delirium Care

<p style="text-align: center;">Advocacy</p> <ul style="list-style-type: none"> • Patient safety • Environmental change • Treatment of underlying cause 	<p style="text-align: center;">Assessment</p> <ul style="list-style-type: none"> • Cognitive • Social • Functional
<p style="text-align: center;">Education</p> <ul style="list-style-type: none"> • Patient • Caregiver • Health care provider 	<p style="text-align: center;">Coordination</p> <ul style="list-style-type: none"> • Safe transitions of care • Community resources • Placement if necessary

ing it a relevant issue at the time of discharge and beyond.⁴⁶ Distress related to delirium has been documented up to 2 years after onset, due to manifestations of anxiety and depression.³⁸

Distress impacts patients as well as caregivers who witness the delirium and provide care to the patient afterward.³⁸ Long-term changes in mood in addition to loss of function as a result of delirium can lead to an increase in stress for both patients and their caregivers.³⁰ The social work emphasis on counseling and family dynamics as well as the common role of coordinating post-discharge arrangements makes the profession uniquely suited for delirium care.

Barriers

Social workers can play a key role in delirium risk identification and coordination of care but face substantial barriers. Delirium assessments are complex and require training and education in the features of delirium and cognitive assessment.⁴⁷ To date, social workers receive limited education about delirium and typically do not make deliberate efforts in prevention, support, and follow-up care.

CONCLUSION

Social workers will encounter delirium, and their training makes them

particularly suited to address this health concern. An understanding of the larger ecologic system is a foundational aspect of social work and an essential component of delirium prevention and care.⁴¹ The multipathway nature of delirium as well as the importance of prevention suggests that multiple disciplines, including social work, should be involved.¹ The American Delirium Society and the European Delirium Association both recognize the need for all HCPs to be engaged in delirium care.^{1,48}

Social workers in the hospital setting provide communication, advocacy, and education to other HCPs, as well as to patients and families (Figure). Because delirium directly impacts the emotional and logistic needs of patients and their families, it would be advantageous for social workers to take a more active role in delirium risk identification, prevention, and care. Fortunately, the nonpharmacologic approaches that social workers are skilled in providing (eg, education and emotional support) have been shown to benefit patients with delirium and their families. ●

Author disclosures

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