

# Guidance on delirium management in hospital (not ITU), care homes and community during COVID-19

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## 1. Introduction

Delirium is an acute disorder of consciousness arising over hours or days. It is a common complication of severe illness, including COVID-19, and in some cases may be the only initial presenting feature. Factors that increase delirium risk include dementia, older age, frailty, multiple comorbidities and sensory impairments. There appears to be a high incidence of delirium in COVID-19, likely reflecting the high proportion of older patients and the severity of the illness.<sup>1</sup>

The main features of delirium are fluctuating cognitive deficits and altered levels of arousal; up to half of patients also experience hallucinations or delusions.<sup>2</sup> There appears to be a higher proportion of hyperactive (rather than hypoactive) delirium in COVID-19 patients.<sup>1</sup>

Delirium varies in duration, mostly resolving within days, but in 20% of cases it can last weeks or months.<sup>3</sup> Delirium is linked with poorer outcomes including medical complications, falls, increased length of hospital stay, new institutionalisation, accelerated cognitive decline and mortality.<sup>4</sup>

Delirium presents unique challenges in the management of COVID-19 infection:

- Delirium, particularly the hyperactive subtype, may lead to difficulties maintaining adequate isolation, making the delivery of care difficult, and potentially exposing staff and other patients to risk
- Isolation precautions, staff PPE and the lack of visitors all risk exacerbating delirium
- Delirium causes significant carer distress,<sup>5</sup> leading to challenges for care homes, formal and informal carers

People with delirium may lack mental capacity to make key decisions; their capacity may fluctuate, necessitating regular re-assessment. The Department of Health and Social Care has produced guidance on [MCA and DoLS during COVID-19](#); see Annex A in the guidance for decision making flow chart.

## 2. Principles of delirium management

The principles of delirium management in patients with COVID-19 remain the same with regards to risk reduction, identification and management. The symptoms of delirium are ideally managed [non-pharmacologically](#); where these interventions are ineffective or more rapid control is required to reduce the risk of harm to the patient and others, it may be necessary to move to [pharmacological management](#) earlier than would normally be considered.<sup>6</sup>



## 2.1 Delirium prevention

Where possible, patients/residents with suspected COVID-19 who are at risk of delirium (including older people, people with dementia and people with learning disabilities) should have a care plan in place to reduce the risk of delirium.

The following components should be considered for delirium prevention:<sup>7</sup>

- Promoting sleep hygiene
- Ensuring the person has their glasses and hearing aids
- Regular reorientation
- Early mobilisation
- Pain control
- Maintaining optimal hydration and nutrition
- Avoiding constipation and urinary retention
- Medication review
- Provision of **oxygen therapy** if appropriate

## 2.2 Delirium identification

Delirium detection should ideally be undertaken at the earliest opportunity. The [4AT](#) or other validated tool should be used in acute hospital and community settings (note the [CAM-ICU or ICDSC](#) should be considered in ITU/HDU settings). It is important to be aware that a single assessment for delirium may be insufficient due to its fluctuating nature. If it is unclear whether the patient has delirium or dementia or both it should be treated as delirium until this can be clarified through information-gathering (from family and GP) and further assessment.

If the 4AT cannot be completed due to time pressures then ask the **single question to identify delirium** (SQID) *“Is this patient more confused than before?”*

Where delirium is detected patients and their family/carers should be informed of the diagnosis. The diagnosis should be clearly documented; this is particularly important during transfers of care e.g. discharge from hospital.

## 2.3 Non-pharmacological management

The underlying cause of the delirium should be identified and treated:

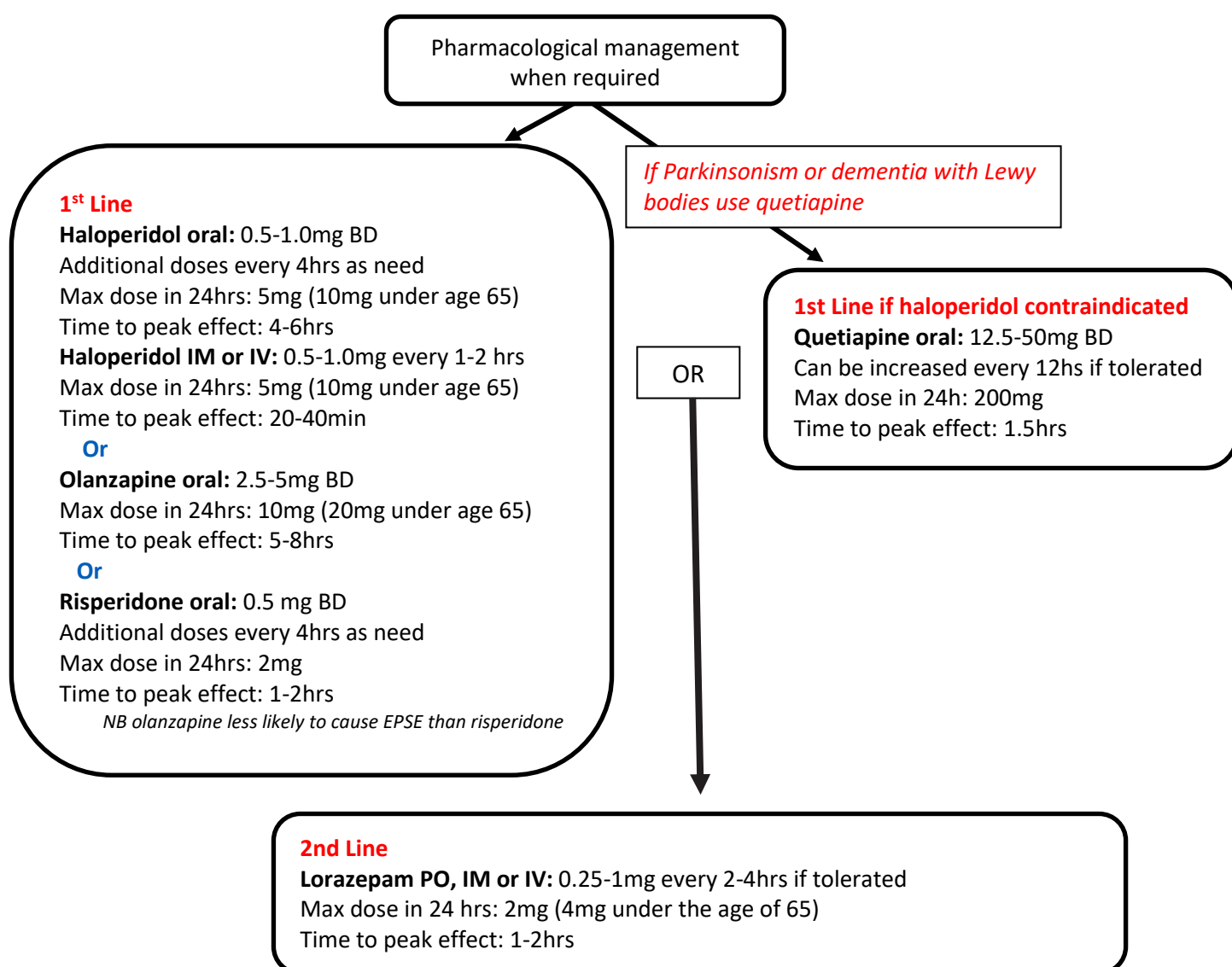
- Firstly, consider life threatening causes such as low oxygen levels
- Identify and treat potential causes (these may be multiple) such as pain, medication, constipation and urinary retention



### Other measures to manage delirium:

- Where possible optimise the environment e.g. promoting sleep hygiene, reducing distracting noise, providing re-orientating cues such as a clock etc.
- Ensure effective communication and reorientation – explaining where the person is and why and what your role is and providing reassurance
- People with delirium may find PPE distressing; having your name, role and picture to show people may help.
- Aim to prevent complications of delirium such as falls, pressure ulcers, dehydration and malnourishment
- Avoid moving people between rooms (care homes), wards (hospitals) and care settings where possible

## 2.4 Pharmacological management



*Please take into account local policy/guidance*

There is specific guidance for delirium during end of life care [here](#)



The following principles are key:

- Use one drug and review effect – mixing anti-psychotics with benzodiazepines should be a last resort
- In patients with Parkinsonism and dementia with Lewy bodies typical antipsychotics should be avoided
- Olanzapine is less likely to cause extrapyramidal side effects than risperidone
- Giving regular doses, for example TDS haloperidol, or BD risperidone, should be considered

Risks to consider are:

- Some patients are being treated for COVID-19 infection with antiretroviral drugs, antimalarial drugs and monoclonal antibodies. These drugs may interact with psychotropics
- Respiratory depression – especially if using benzodiazepines
- Acute dystonic reactions following antipsychotic use – manage with procyclidine
- QTc prolongation
- Paradoxical agitation with benzodiazepines, particularly in older people
- Over sedation
- Falls

### 3. Additional considerations for Acute hospitals

NHS England [visiting guidance](#) states that in certain exceptional circumstances, patients may receive one visitor; this includes patients with a mental health issue such as dementia or a learning disability, where the absence of an informal carer would cause the patient distress. This should be taken into account for people with dementia or a learning disability with delirium who are distressed, and it is felt that a visit by a family member or carer will help.

Tools such as [This is me](#) can be used to record details about a person who can't easily share information about themselves. These can help staff support someone with dementia, delirium or communication difficulties in an unfamiliar place.

Patients may have prolonged delirium after recovery from the acute phase of COVID-19. Wherever possible they should be discharged back to their usual place of residence with a short-term increased care package (a 24-hour care package may be required initially). If this is not possible a step-down bed may be required.

### 4. Additional considerations for Care home

Consider delirium as a presenting feature of COVID-19, particularly in people living with dementia. Consider and check for causes of delirium other than COVID-19; where possible healthcare professionals should review, investigate and treat patients remotely e.g. by video link, although or face to face review may be necessary in some cases.



Delirium may contribute to residents 'walking with purpose' (also known as wandering). This can be difficult to manage during isolation. Physical restraint should not be used; a behavioural and environmental approach is recommended to interpret behaviours (e.g. pain, boredom) and modify these where possible.

Care home [guidance](#) states that states that in exceptional circumstances, such as end of life, visits from next of kin can be permitted.

## 5. Additional considerations for community care

Causes of delirium other than COVID-19 should continue to be considered in people living at home. Where appropriate healthcare professionals should review, investigate and treat. This should be done remotely if possible, e.g. by video link or face to face if necessary. Joint working e.g. between primary care, mental health and social care can be particularly useful.

Delirium may be particularly distressing for informal carers and they will need support and reassurance to manage it. Where possible family carers can help with delirium management, for example, re-orientation.

Consider adding a short term package of care to support the informal carer until the episode of delirium is resolving.

## 6. Post-delirium follow up

Research studies suggest that one in three acutely ill older adults who experience delirium in hospital subsequently develop dementia.<sup>8</sup> Therefore, mechanisms need to be in place to review people who develop delirium in relation to COVID-19 e.g. primary care follow-up six months after hospital discharge and referral to memory service in patients with ongoing cognitive impairment.

The IQCODE can be used in patients with delirium to predict who is most likely to have ongoing cognitive difficulties that require further investigation. A score of >3.82 has >90% sensitivity and specificity for ongoing cognitive impairment three months later.<sup>9</sup> The [IQCODE](#) can be completed on the phone by any member of clinical staff (including healthcare assistants) with a close family member and provides an opportunity for the treating medical team to learn more about their patient's baseline level of cognitive and social functioning.



## 7. Resources

University of Toronto [COVID-19 in older adults](#) – includes a section on considering COVID-19 as the cause of delirium

[Acute delirium: information for patients and carers](#) 10 page document compiled by Guy's and St. Thomas' NHS Foundation Trust

[SIGN Delirium risk & management poster](#) a poster outlining recognising delirium, reducing the risk and non-pharmacological treatment

Ontario [delirium prevention poster](#)

[COVID Delirium Guidance](#) BGS paper outlining the management of delirium in confirmed and suspected cases of COVID-19

Delirium videos:

- (i) [Delirium Awareness](#)
- (ii) [Delirium awareness and management Delirium superimposed on dementia](#)  
The above two are short videos helping carers understand delirium
- (iii) [Delirium in the context of COVID-19](#) 10 minutes teaching video by Dr Krishnan
- (iv) Short video on [completing the 4AT](#)

## References

- <sup>1</sup> Letter to The New England Journal of Medicine 2020 DOI: 10.1056/NEJMc2008597
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- <sup>3</sup> Cole MG. Persistent delirium in older hospital patients. *Curr Opin Psychiatry* 2010;23(3):250-4.
- <sup>4</sup> Marcantonio ER. Delirium in hospitalized older adults. *N Engl J Med* 2017;377(15):1456-66.
- <sup>5</sup> Partridge JS, Martin FC, Harari D, Dhesi JK. The delirium experience: what is the effect on patients, relatives and staff and what can be done to modify this? *Int J Geriatr Psychiatry* 2013;28(8):804-12.
- <sup>6</sup> British Geriatric Society Managing [Coronavirus: Managing delirium in confirmed and suspected cases](#)
- <sup>7</sup> SIGN 157 [Risk reduction and management of delirium](#)
- <sup>8</sup> Garcez F et al. Delirium and post-discharge dementia: results from a cohort of older adults without baseline cognitive impairment. *Age and Ageing* 2019;48(6): 845–851
- <sup>9</sup> Jackson TA et al. Diagnostic test accuracy of informant-based tools to diagnose dementia in older hospital patients with delirium: a prospective cohort study. *Age and Ageing* 2016; 45(4)505-511

