COVID-19

CONSIDERATIONS FOR PREVENTING AND MANAGING DELIRIUM IN OLDER ADULTS DURING THE COVID-19 PANDEMIC, ACROSS THE CARE CONTINUUM

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April 1, 2020

Clinicians who are not familiar with delirium may want to review Introduction to Delirium- Clinicians Learning Series

In the older adult, COVID-19 may present with atypical symptoms, including delirium. Acute confusion may precede symptoms of fever and cough.[1] Confusion in an older adult that is a change from their baseline mental status must be treated as a medical emergency; they may have delirium, COVID-19, or both. Delirium is linked with increased mortality and morbidity. The delivery of quality care to prevent and manage delirium remains crucial during the COVID-19 pandemic in order to optimize outcomes for older adults. COVID-19 precautions can make the management of delirium challenging. Below are seven evidence-based recommendations for quality delirium care adapted from published standards[2, 3], accompanied by special considerations from delirium experts for the pandemic context.

1 IDENTIFY RISK FACTORS – all older adults should be assessed for risk factors for delirium.

- Age over 65 is a risk factor for delirium. Consider underlying conditions that increase risk (e.g., dementia, depression, chronic medical conditions, polypharmacy, and sensory impairments) and precipitating events, such as acute illness and hospitalization.
- COVID-19-related pneumonia and acute respiratory distress syndrome (ARDS) are severe conditions that can put any person at risk for delirium.

2 USE INTERVENTIONS TO PREVENT DELIRIUM – all older adults should receive interventions to prevent delirium that are tailored to their individual needs and care setting.

- Use proven interventions to prevent and support older adults with delirium – these strategies remain important even in the setting of COVID-19. Use our poster "6-proven strategies to prevent delirium in older adults".
- Promote mobilization early, and regularly – even in the ICU setting. Use our poster "Movement is good medicine".
- Maintain hydration – encourage the older adult to drink regularly; ensure a water jug is in the room with a reminder, such as a large sign in the room, or message on the water cup.
- Orientation – use a simple script to help orient the older adult frequently throughout the day. "Hello, ____________ (use preferred name). My name is _______________, and I am your ___________(role). You are admitted in _____________ because you got sick. It is __________ (day/ month/date/time). Can I get you anything?". If using an intercom, you may need to explain that to the person: "I am talking to you over the intercom right now".
- Support virtual presence for family, caregivers, and volunteers; ensure older adults have access to a phone or tablet wherever possible and assist with charging devices as needed. Provide our pamphlet "How to prevent and support delirium in an older adult in hospital or a care home, when you can't visit in person".
- Optimize sensory inputs – help the older adult use their hearing aids and/or eyeglasses.
- Adapt communication style – isolation protocols and use of personal protective equipment can make people feel even more fearful and confused. People with hearing loss may have difficulty understanding verbal communication through a mask. Use our pamphlet "Communication tips for clinicians caring for older adults experiencing delirium during the COVID-19 pandemic".

3 SCREEN EARLY – all older adults who present to hospital or long term care home should be screened for delirium. An acute change in condition, behaviour or mental status should prompt a delirium screen by a healthcare professional who is trained in validated delirium screening tools. The older adult and their family or caregiver are asked about any acute changes in the person's behaviour or mental status.

- Remember that COVID-19 can present with atypical symptoms in older adults. Delirium may be the first sign of infection.

4 **PROVIDE EDUCATION TO OLDER ADULTS, THEIR FAMILY OR CAREGIVERS** – information should explain the condition and strategies to prevent and manage delirium.

- Where visitor restrictions are in place, email delirium information to family and caregivers, including our pamphlet "How to prevent and support delirium in an older adult in hospital or a care home, when you can't visit in person".

5 **MANAGE DELIRIUM, IDENTIFY AND TREAT UNDERLYING CAUSES** – older adults with delirium should have a comprehensive assessment which identifies the causes, and a multicomponent interprofessional management plan which addresses the causes and manages the symptoms of delirium.

- Look for the root cause of delirium, don't assume it is COVID-19-related. Other common issues such as pain, constipation, need to void, hunger, and thirst remain as common precipitants or contributors to delirium.
- Continue using all prevention interventions.
- Older adults experiencing delirium are vulnerable. In some circumstances, a family caregiver may be considered an essential member of the person's care team, contributing to reorientation and de-escalation of behaviours. To support the necessary care of a person with delirium, especially in the situation of a hyperactive delirium, special re-consideration of the visitor restrictions may be warranted. [4] An ethical framework can guide decision-making of this nature.

6 **MINIMIZE USE OF ANTIPSYCHOTIC MEDICATION** – use of antipsychotic medication should only be considered if the person is suffering from severe distress or if they are at immediate risk of harm to themselves or others. These medications should always be used in combination with first-line management strategies. If antipsychotic medication is started, it should be reviewed daily and discontinued as soon as possible.

- Antipsychotic medication does not treat delirium; it provides chemical sedation.
- Isolation precautions may make it challenging to provide usual first-line delirium management strategies.
- If medications are needed, adhere to the lower doses appropriate for the older adult. If doses exceed the recommendations, expert consultation is advised.
    - **Haloperidol**: 0.25mg start PO/SC/IV q4h (max 2mg/24h period
    - **Risperidone**: 0.125–0.25mg start PO bid (max 1mg/24h period
    - **Quetiapine**: 12.5–25mg start PO bid (max 100mg/24h period
    - If antipsychotics are contraindicated, consider **Lorazepam**: 0.5-1mg start PO prn (max 2 mg/24h period)

7 **COMMUNICATE ABOUT DELIRIUM DURING TRANSITIONS IN CARE** – At transitions in care, the older adult, their family caregivers, and healthcare professionals involved in the circle of care should be provided with information about the management of the person's current or resolved delirium.

- Ensure there is communication about the presence of delirium and the person's baseline mental status. If symptoms of delirium persist, the receiving care team needs to understand that the delirium is not the person's baseline.

1. D'Adamo H, Yoshikawa T, Ouslander, JG. Coronavirus disease 2019 in geriatrics and long-term care: The ABCDs of COVID-19. JAGS. [Internet] accepted 2020 Mar 25 [cited 2020 Mar 31]. Available from: https://doi.org/10.1111/jgs.16445
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