## DELIRIUM MANAGEMENT IN COVID-19 PATIENTS OUTSIDE OF ITU

<table>
<thead>
<tr>
<th>CATEGORY:</th>
<th>Guideline</th>
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<td>CLASSIFICATION:</td>
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<td>PURPOSE</td>
<td>To advise Clinicians on management of delirium during the COVID19 phase</td>
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<tr>
<td>- <strong>Recomended Reading for:</strong></td>
<td>Clinicians, all non medical Prescribers, Pharmacists and nurses</td>
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<td>- <strong>Information for:</strong></td>
<td>Wards Managers, Senior Nurses, ADNs, Divisional Directors</td>
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DELIRIUM MANAGEMENT IN COVID-19 PATIENTS OUTSIDE OF ITU

Version 2

Date: 9/11/2020
Delirium Suspected?
Use 4AT to diagnose, or ‘Single Question in Delirium’ – ‘has the patient been more confused than usual?’

Attempt non-pharmacological measures and monitor for:
1: Severe distress
2: Indirect spread of infection
3: Risk of harm to self or others

If Parkinsonism or Lewy Body disease use risperidone first line

1st Line
Haloperidol PO, IV or SC
0.5-1.0mg every 30 minutes
Up to 5mg ideally, but 10mg may be needed in exceptional circumstances

1st Line if CI to haloperidol
Risperidone PO
1mg every 30 minutes
Up to 4mg
OR
Quetiapine PO
Ideally BD 100-200 mg

OR

2nd Line
Lorazepam PO, IV or SC Incremental doses of 0.5mg up to 2 mg
OR
Clonidine IV 75 μg 3 hourly to max 300 μg, then BD

End of Life Care
Haloperidol 0.5-1.5mg SC (24hr syringe driver 1.5-5mg) AND/OR
Levomepromazine 2.5-12.5mg SC (24hr syringe driver 5-75mg) AND/OR
Midazolam 2.5-5mg SC prn (24hr syringe driver 10-60mg) AS NEEDED
Delirium is a common complication of COVID-19 infection, and in some cases may be the only initial presenting feature. Delirium is the clinical expression of an acute encephalopathy, and is associated with worsened outcomes across different clinical pictures. There is no reason to suggest it is any different in COVID-19 infections. It is seen mainly in older people, but can affect any age, especially in those on ITU. Dementia and frailty are important vulnerabilities to delirium. There is a higher incidence of delirium in people with COVID-19 than you would expect in other respiratory illness (Expert consensus). Anecdotally there is a preponderance towards the hyperactive motor subtype and psychotic features.

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

- Delirium may lead to difficulties with ensuring adequate isolation, and in this context will make the delivery of care difficult, and potentially expose staff and other patients to risk
- Isolation precautions, staff PPE, and the lack of carers visiting, all risk exacerbating delirium
- Delirium may be particularly distressing to patients and staff in those that are dying

The usual principles of delirium management remain the same. Prompt identification, and rigorous medical assessment to identify and treat the causes. The Scottish Delirium Guidelines set this out in a structured fashion [https://www.sign.ac.uk/sign-157-delirium](https://www.sign.ac.uk/sign-157-delirium)

The symptoms of delirium, especially hyperactive, and aggressive or psychotic features, are ideally managed non-pharmacologically (quiet environment, de-escalation etc) but these are very unlikely to be able to be implemented during the extreme pressures of the pandemic.

Therefore, we will find ourselves using much more pharmacological treatment, and in higher doses to treat distress and to make the patient safe. This is not ideal practice, but is pragmatic practice. The balance of risk and benefit changes, and relieving symptoms with available resources becomes the priority.

The following principles are key

- Stick with one drug and review effect– mixing anti-psychotics with benzodiazepines should be a last resort
- In patients with Parkinsonism and Lewy Body Dementia typical antipsychotics should be avoided
- The oral route is preferred, but if this is not available, then IV, SC are alternatives – IM should be avoided if possible
- Giving regular doses, for example TDS haloperidol, or BD risperidone, should be considered.
This is an evidence free zone, both in terms of best drugs, and evidence of benefit verses harm. Risks to consider are:

- respiratory depression – especially if using benzodiazepines
- acute dystonic reactions – manage with procyclidine
- QTc prolongation
- Over sedation

There is separate guidance for patients being treated in a critical care / high dependency environment where there are different challenges in terms of management and drug administration.