

Management Tips for Suspected Delirium in patients with COVID-19

Delirium involves an acute disturbance of brain function that presents with cognitive impairment ('confusion') and behavioural disturbance that can significantly impact upon the ability to receive care. Delirium is expected to be common and pose a particular challenge in patients with COVID-19. The best treatment for delirium is to treat the underlying cause.

1. 4AT Rapid Clinical Test for Delirium

1. Alertness

Normal (fully alert, not agitated)	0
Mild sleepiness (for <10 secs after waking but then normal)	0
Clearly abnormal	4

2. AMT4 (Age, DOB, name of hospital, current year)

No mistakes	0
1 mistake	1
≥ 2 mistakes/ untestable	2

3. Attention (Months of year backwards)

Achieves ≥7 months correctly	0
Starts but scores < 7 months	1
Untestable (too unwell / drowsy / inattentive)	2

4. Acute change or Fluctuating symptoms

No	0
Yes	4

Total Score

≥ 4 : Probable delirium +/- cognitive impairment

1-3 : Possible cognitive impairment

0 : Delirium unlikely

2. Assess Potential Causes of Delirium: 'PINCH ME'

P – Is the person in pain? Has urinary retention been excluded?

IN – Infection: is there a possible infection?

C – Constipation: When was the last bowel movement?

H – Hydration/nutrition: Consider electrolyte imbalance, hypoxia, hypotension, hypoglycaemia?

M – Medication: omission of regular medication or addition of new medication

E – Environment: change of environment, noise or activity levels impacting sleep/ rest

3. Non-pharmacological strategies

In the COVID-19 outbreak, many of the usual strategies for delirium management may not be feasible, but three key things can still be done:

- **3 R's**: verbally Reassure (loud, clear, slow voice), Re-orientate, and Repeat (retention of information can be poor in delirium)
- **Ensure** (working) hearing aids / clean glasses are available
- **Medication review** for any omitted medications, or new medications (balancing need for opioids for dyspnoea with potential to worsen delirium)

4. Consider Pharmacological intervention for delirium if the patient or others are at immediate risk and/or urgent care is compromised

For a patient with COVID-19:

- The preferred First line oral antipsychotic is **Olanzapine** as it appears to interact minimally with other COVID-19 medications - give 2.5mg orally, up to 10mg per day (see www.covid19-druginteractions.org)

• If intramuscular medication is required, **Haloperidol** 0.5mg-1mg may be considered (maximum of 4mg in 24 hours), if an ECG out rules QT prolongation/other arrhythmias and noting the risk of potential myocarditis in COVID-19.

• **Benzodiazepines** are more likely than antipsychotics to cause respiratory depression and are associated with prolongation and worsening of delirium symptoms. Use should be limited to where antipsychotics are not tolerated or contra-indicated (e.g. Lewy Body dementia or Parkinson's disease) Where used, Flumazenil should be available for reversal.

More detailed guidance is available at Early Identification and Management of Delirium in the Emergency Department/ Acute Medical Assessment Unit. <https://dementiapathways.ie/care-pathways/acute-hospital-care>