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# Coronavirus: Managing delirium in confirmed and suspected cases

## GOOD PRACTICE GUIDE

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### Authors:

British Geriatrics Society;  
European Delirium Association;  
Old Age Psychiatry Faculty (Royal College of Psychiatrists)

Some of our members have been alerted to some difficulty in managing patients with delirium testing positive with COVID-19. This consensus advice has been drawn up by experts from the organisations listed above. It should be used in conjunction with local policy and governance practice employed within your own organisation.

Delirium, the clinical expression of encephalopathy, is important in the context of COVID-19, because (a) delirium may be a symptom at presentation and/or during management, and (b) the behavioural changes commonly seen in delirium, particularly agitation, may make management including delivery of care and reducing the risk of cross-infection more challenging.

## Delirium as a feature of COVID-19

Older people are at the greatest risk from COVID-19. If infected they may present with or develop a delirium. However, delirium is not exclusive to older people and may well be seen in any patient with severe infection, adult respiratory distress syndrome, and those requiring invasive ventilation on ICU units.

# Delirium and the management of COVID-19

Delirium, especially its hyperactive motor form, will present significant additional challenges in the context of the COVID-19 crisis. Standard non-pharmacological measures to treat or prevent delirium may well be not possible in isolation environments, and these environments may themselves worsen delirium.

## Recommendations

The recommendations follow two key themes. First, good general care including prevention, early detection, and non-pharmacological management should be provided as systems allow. Second, because of the ease of transmission of COVID-19, the risk of harm to others may exceed risk of harm to the individual and this may necessitate earlier use of pharmacological treatments for potentially risk behaviour. However even in complex situations where a patient has a delirium in the context of COVID-19, with added risks of transmission to others and possibly limited human resource, the same basic principles of risk assessment and the mental capacity act apply.

We make the following recommendations:

1. Enhanced implementation of screening for delirium in at risk groups and also regular assessment for delirium using a recommended tool (eg. the 4AT [www.the4AT.com](http://www.the4AT.com)<sup>1</sup>). This may be increasingly constrained by staff and time limitations.
2. Reduce the risk of delirium by avoiding or reducing known precipitants. Actions include: regular orientation, avoiding constipation, treating pain, identification and treatment of superadded infections early, maintaining oxygenation, avoiding urinary retention and medication review. See the SIGN delirium guidance <sup>2</sup>
3. With respect to behavioural disturbance, always look for and treat direct causes including pain, urinary retention, constipation, etc. 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. In these circumstances we would recommend the guidance provided in the SIGN guidance<sup>2</sup>, but in more urgent situations would advise referring to the NICE Guidance on Violence and Aggression<sup>3</sup>.
4. If patients are treated using the NICE rapid tranquillisation interventions, please monitor for side effects, vital signs, hydration level and consciousness at least every hour until there are no further concerns about the person's physical health. Be mindful of use of benzodiazepine with respiratory depression. In older adults note the British National Formulary maximum

dosage for haloperidol is 5mg in 24 hrs, but we would suggest a more conservative approach with maximum 2mg in 24 hours in the first instance. Where higher dosages are required please seek specialist advice.

5. Note the usual guidance of caution with use of medication in older people, and especially certain medications in people with Parkinson's disease or dementia with Lewy bodies (e.g. antipsychotic medication)
6. Delirium may cause considerable distress amongst both staff and families in addition to the patient. Provision of information around delirium is important using locally available resources. Booklets are available through the SIGN website: <https://www.sign.ac.uk/pat157-delirium><sup>4</sup>

The above guidance should be used in parallel with the legal framework for the mental capacity act. The WHO<sup>5</sup> also provided guidance on caring for older people in quarantine, particularly pertinent to people living with dementia and/or who experience a delirium:

*“Older adults, especially in isolation and those with cognitive decline/dementia, may become more anxious, angry, stressed, agitated, and withdrawn during the outbreak/while in quarantine. Provide practical and emotional support through informal networks (families) and health professionals.*

*Share simple facts about what is going on and give clear information about how to reduce risk of infection in words older people with/without cognitive impairment can understand. Repeat the information whenever necessary. Instructions need to be communicated in a clear, concise, respectful and patient way. and it may also be helpful for information to be displayed in writing or pictures. Engage their family and other support networks in providing information and helping them practice prevention measures (e.g. handwashing, etc)<sup>4</sup> ”*

## References

1. 4AT Assessment test of delirium and cognitive impairment. Available from: <https://www.the4at.com/> [Accessed 17 March 2020]
2. Scottish Intercollegiate Guidelines Network. Risk reduction and Management of delirium (2019). Available from : <https://www.sign.ac.uk/sign-157-delirium> [Accessed 16 March 2020]
3. Violence and aggression: short-term management in mental health, health and community settings. National Institute for Health and Care Excellence. (2015). Available at: <https://www.nice.org.uk/guidance/ng10/resources/violence-and-aggression-shortterm-management-in-mental-health-health-and-community-settings-pdf-1837264712389> [Accessed 17 March 2020]
4. Scottish Intercollegiate Guidelines Network. Delirium: patient booklet (2020) Available from: <https://www.sign.ac.uk/pat157-delirium> [Accessed on 16 March 2020]
5. Briefing note on addressing mental health and psychosocial aspects of COVID-19 outbreak. Version 1.1. Inter-Agency Standing Committee IASC Reference group for Mental Health and Psychosocial Support in Emergency Settings (2020). Available from: <https://nam12.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.epi-win.com%2Fsites%2Fepiwin%2Ffiles%2Fcontent%2Fattachments%2F2020-03-11%2FMHPSS%2520COVID19%2520Briefing%2520Note%25202%2520March%25202020-English.pdf&data=02%7C01%7C%7Ca0924c164b1a4129084208d7c8d36326%7C84df9e7fe9f6>

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6. Delirium prevention, diagnosis and management guideline (updated 2019). Available at: <https://www.nice.org.uk/guidance/cg103> [Accessed 18 March 2020]

## Appendix: Medications that may be used in delirium

(based on the SIGN guidelines<sup>2</sup>)

Medication	Single starting dose	Maximum dose in 24 hours*	Cautions/Contraindications
Haloperidol**	0.5mg orally 0.5mg im	2mg orally 2mg im	Prolonged QTc interval in ECG  Signs of parkinsonism or lewy body dementia  When used with any medication that prolongs QT interval this is off-license
Risperidone	0.25mg orally	1mg in divided doses	Signs of parkinsonism or lewy body dementia  Not licensed in delirium
Lorazepam if antipsychotics are contraindicated	0.5mg orally 0.5mg-1mg im	2mg orally 2mg im	Caution in renal impairment  Not licensed in delirium

\*unless on the specific advice of a specialist, e.g. mental health liaison.

\*\*note the BNF max dose for haloperidol is 5mg in 24 hrs, but we would suggest a more conservative approach with max 2mg in 24 hours in the first instance. Where higher dosages are required please seek specialist advice.

*As per the SIGN guidelines recommendations within this table are based on the best clinical evidence. Some recommendations may be for medicines prescribed out with the marketing authorisation (MA) also known as product licence. This is known as 'off-label' use.' Haloperidol is only licensed when used without other drugs that prolong the QT interval (SIGN guidelines<sup>2</sup>, NICE delirium guideline<sup>6</sup>).*

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