NURSING MANAGEMENT OF DELIRIUM IN PEOPLE WITH COVID-19

Delirium is very common in serious illness. Although usually associated with terminal illness, many episodes of delirium are reversible. In a study of COVID-19 patients referred to hospital palliative care, 24% experienced delirium.

**Types of delirium:**
- Hyperactive – usually includes agitation
- Hypoactive - withdrawn behaviors (more likely to be missed on assessment)
- Mixed

**Presentation of delirium:**
- Agitation
- Impaired cognition
- Altered attention span
- Change in consciousness
- Altered perceptions and hallucinations

**Potential Causes or Contributors to Delirium:**
- Constipation or bladder distension - especially with older adults
- Dehydration
- Dementia
- Electrolyte imbalance (hypercalcemia, hyponatremia, hypernatremia, hypomagnesemia)
- Hearing impairment
- Hypoxemia
- Immobility
- Infection (pneumonia, urinary tract infection)
- Intracranial disease (primary or metastatic brain tumor, leptomeningeal disease, stroke)
- Medications (opioids, anticholinergics, corticosteroids, antidepressants, benzodiazepines)
- Metabolic abnormalities (hypoglycemia, hypothyroidism)
- Nutritional or vitamin deficiencies
- Older age (> 75 years of age)
- Rapid withdrawal of medications (opioids, benzodiazepines) and/or alcohol, nicotine
- Renal, cardiac and/or hepatic failure
- Unrelieved pain
- Urinary tract infection
- Use of restraints

**Assessment:**
Several delirium assessment tools are available; select a tool based upon your setting and population. In many circumstances, delirium can be identified based upon a strong history and physical examination.

**Conduct history and physical assessment:**
- Review common signs including disturbed sleep/wake cycle, agitation, restlessness, moaning, hallucinations, and delusional thoughts.
- Assess for signs of sepsis, dehydration, urinary retention or urinary tract infection, constipation, unrelieved pain.
- Evaluate the medication list for possible causes or contributors; consider polypharmacy
- Weigh the potential for possible withdrawal from alcohol, nicotine, opioids, benzodiazepines, antidepressants, cannabis, or other sedatives

**The Confusion Assessment Method (CAM) is a commonly used, sensitive, and brief (5 minutes) tool.** There is a brief version (bCAM – 2 minutes), critical care (CAM-ICU), family caregiver recognition (FAM-CAM) and a 3 minute diagnostic version (3D-CAM). Mobile apps are also available.

**Potential Causes or Contributors to Delirium:**
- Consider laboratory and radiological tests, depending on the patient’s goals of care (e.g., CBC, electrolytes, calcium, renal/liver function, UA, CXR, O2 saturation, imagery of the brain via CT or MRI).

**Pharmacologic Management:**

When possible address potentially reversible etiologies such as fever (antibiotics/antivirals), constipation (bowel regimen), dehydration (oral or IV/SQ fluids), urinary retention (catheterization), polypharmacy (discontinue unnecessary medications), metabolic abnormalities (correct electrolytes), and sleep deprivation (promote day/night cycles).

**Benzodiazepines are generally not recommended in the treatment of delirium, except for midazolam given IV or SQ for palliative sedation.**

**1st Generation Antipsychotics**
- Haloperidol 0.5 - 2 mg PO every 2-4 hours as needed (lower doses in elderly); IV or SQ – use 50% of oral dose

**2nd Generation Antipsychotics**
- Olanzapine 2.5 - 15 mg PO at night
- Quetiapine 25 – 50 mg PO daily
- Risperidone 1 - 2 mg PO at night
- Azapirone
- Buspirone 5 - 20 mg PO tid

**Nonpharmacologic Management**
- Ensure eyeglasses and/or hearing aids are in place and functioning
- Promote sleep/wake cycle with daytime light, reduce nighttime interruptions
- Provide soothing or favorite music
- Orient gently, do not aggressively reorient
- Reduce noise, pump alarms
- Use clocks, calendars and whiteboards
- Support family – this is extremely distressing to loved ones!

**References:**
- ELNEC – aacnnursing.org/ELNEC/COVID-19

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