Northern Care Alliance NHS Group

Management of delirium COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Delirium is an acute confusional state that can happen when someone is ill. It is a SUDDEN change over a few hours or days, and tends to vary at different times of day. People may be confused at some times and then seem their normal selves at other times. People who become delirious may start behaving in ways that are unusual for them- they may become more agitated than normal or feel more sleepy and withdrawn.

Non-pharmaceutical measures

- identify and manage the possible underlying cause or combination of causes
- ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- consider involving family, friends and carers to help with this
- ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk
- avoid moving people within and between wards or rooms unless absolutely necessary
- ensure adequate lighting

Pharmacological measures: mild to moderate to severe

Haloperidol is generally the drug of choice for both hyper- and hypo-active delirium. Avoid in Parkinson's Disease.

- start with 500 micrograms / 24h CSCI or PO/SC at bedtime and q2h prn
- if necessary, increase in 0.5−1mg increments
- median effective dose 2.5mg/24h (range 250 microgram - 10mg / 24h
- consider a higher starting dose (1.5-3mg PO/SC) when a patient's distress is severe and / or immediate danger to self or others

If the patient remains agitated, it may become necessary to add a benzodiazepine, e.g.

- lorazepam 500 micrograms-1mg PO bd and prn

  or
- midazolam 2.5-5mg SC prn 1-2 hourly

Pharmacological measures: end of life (last days / hours)

Use a combination of levomepromazine and midazolam in a syringe driver

Levomepromazine (helpful for delirium)

- Can start 6.25mg SC stat and q1h prn (3.125mg SC in the elderly)
- if necessary, titrate dose according to response
- maintain with 25mg or higher doses / 24h CSCI
- alternatively, doses given as a SC bolus at bedtime, bd and prn

Midazolam (helpful for anxiety)

- start with 2.5-5mg SC/IV stat and q1h prn
- if necessary, increase progressively to 10mg SC/IV q1h prn
- maintain with 10-60mg / 24h CSCI

If the above is ineffective, seek specialist palliative care advice

Management of this symptom, which is distressing for both relatives and staff (patients are usually unaware of what they are doing at this time) can be troublesome. Through use of suggested medications, titrated appropriately, this can usually be managed effectively.

- Prevention of delirium better than cure, so meticulous adherence to delirium prevention strategies (orientation, prevention of constipation, management of hypoxia, etc) is essential
- Adoption of daily screening, using Single Question in Delirium (SQiD) and / or 4AT rapid test for delirium (https://www.the4at.com/) to detect early and treat cause