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ACEP Geriatric Emergency Department Accreditation

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Preventing and managing delirium in older emergency department (ED) patients during the COVID-19 pandemic

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1. **Delirium is an emergency!** The mortality for persistent delirium is higher than 1-year mortality rates for acute conditions like heart disease.[1] See the ADEPT tool for tips on delirium care: https://acep.org/patient-care/adept/
2. In older adults, **systemic illness (viral infection like COVID-19), fever, and hypoxemia may trigger delirium**. Acute confusion may be a sign of COVID-19 in older adults (even before fever and cough).
3. Although visitors in hospitals and EDs are now becoming restricted, and use of personal protective equipment (PPE) during the COVID-19 pandemic will protect and limit spread, it will be important to **maintain calm, clear, and comforting communication** whenever possible with our older patients.
4. Confusion is **NOT** normal… it can be baseline, but it is not normal. Do not treat it as such.
   - "*Mom's not usually like this*" should be an alarm!
   - Assess baseline: Is the patient typically like this? Is this a change from their normal behavior? When did the change occur? Is there someone to provide information of what they are normally like?
5. **Delirium is an acute change from baseline**, highlighted by altered level of awareness and inability to maintain attention. In older adults, **hypoactive delirium** (sleepy, withdrawn, "pleasantly confused") **is more common** than hyperactive delirium (agitation and anxiety).
6. Risk factors for delirium are:[2]
   - **Sensory impairment (vision and hearing)**
   - **65+ years in age**
   - **History of dementia**
   - **Nursing home patients**
   - **SERIOUS INFECTION**
7. Other exacerbating factors in the context of COVID-19:
   a. Decreased availability of caregivers to orient and provide meaningful interactions.
   b. Trouble hearing (sensory impairment) worsened by use of PPE. Older adults with sensory or cognitive limitations (dementia), will no longer be able to read lips or hear communication obscured by masks, and may become disoriented, frightened, and agitated by gowned and masked caregivers.
   c. Being placed into isolation. Closing of the exam room door, curtailing ambulation and mobility in the ED, and how the patient sees people in protective gear doing invasive tests (nasopharyngeal swabs, blood draws) is stressful for all. For confused patients, it can only be worse.
   d. Polypharmacy and use of new anticholinergic or psychoactive medications.
8. Identify and treat **reversible causes of delirium – immobility, dehydration, fever, pain, hypoxia, nausea, constipation, psychoactive medications**.
9. **Prevention** is the best management for delirium. **Stop it before it happens**. Here are things that work: mobilize the patient, personal contact with orientation, ensure physiological needs are met (food, drink, warmth, bowel and bladder emptying). These may be hard with isolated older COVID-19 patients, but will be easier than managing agitated delirium once it develops.
10. Use of antipsychotics for management of delirium is **NOT** supported as best practice.[3] These medications may worsen delirium. If severe agitation develops, then use reduced doses of antipsychotics: Risperidone ≤1mg PO, Olanzapine 2.5-5mg PO, Quetiapine 25-50mg PO, Olanzapine 2.5-5mg IM, Haloperidol 1-2.5mg IM/0.25-1mg IV

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