A GUIDE TO DELIRIUM CARE FOR CRITICAL CARE AND ITU STEPDOWN IN THE TIME OF COVID

With the rise in critically unwell people and a change in how and where patients are being stepped down, you are likely to find you are managing more people with delirium during the coronavirus pandemic. Delirium in critical care areas can feel challenging, but the principles are the same as with delirium elsewhere in the hospital. Risk reduction and treatment with good fundamental care, screening and identification, and a multidisciplinary and person centred approach are your keys to excellent delirium care.

In NHSGGC we use the TIME checklist in high dependency care as well as downstream wards to prompt this process. Look at the GGC Acute Sector Guidelines on Risk Reduction, Diagnosis and Management and the Delirium Education video, available on the Delirium Webpage, to update your knowledge. It's all about getting the basics right.

Here are a few specific tips for critical care and stepdown areas – use in conjunction with TIME.

Risk Reduction - just as important if not more so than management. All people in HDU or ITU stepdown need a multicomponent risk reduction strategy as prompted by part T of TIME. Assess and put in place on transfer to your unit.

Assessment – for all patients in HDU or ITU stepdown. Use 4AT on transfer to the unit, if 4 or more they need a medical decision as to whether the cause is delirium. If so then also use parts I, M and E of TIME to guide management. Monitor mental state with SQID at all care rounds – if +ve then repeat the 4AT, part T of TIME and let medical staff know.

Person Centred care – is key to risk reduction and management of delirium. Getting To Know Me forms can be completed over the phone if needed and can give the individualised information we need. Families can be asked to drop off items via the volunteer team, who can also print off photographs or messages which can be laminated for the bedside. Would the person like to listen to music, or audio books - use your activities boxes. Utilise every episode of care to have a meaningful conversation or interaction.

Pain – Often undertreated in delirium as people may not be able report their pain well and it may present as behavioural disturbance. People coming out of ITU may have significant pain after being proned. If you aren't sure consider using Abbey pain scale, or give a trial dose of strong analgesia and assess response.

Constipation – not glamorous but absolutely key to both critical care and delirium care. Be obsessive about preventing, treating and recording on bowel charts. This needs medical as well as nursing input.

Oral intake – needs prompted frequently in delirium. Loss of smell may affect the wish of people to eat and drink – try sweet fluids. Lots of attention to mouth care is required. Assess daily for oral thrush which is very common when people are so unwell. If they have dentures put them in.

Sensory impairment – it's vital to use hearing aids and glasses to help patients make sense of their environment. Are hearing aid batteries working? Are their ears full of wax?

Mobility – promoting this will aid delirium risk reduction and management as well as general recovery. People coming out of ITU may have significant weakness. Can they do active range of movement in bed, sit on the side of the bed, stand and sit in a chair or walk? Physio and occupational therapists will help assess but all

team members can promote encouraging the highest level the patient can achieve. If someone is keen to walk support them to do so as much as possible, even if this requires assistance.

Communication – even more challenging with the restrictions in visiting but promoting this will help reduce and manage delirium. Can FaceTime, either on the patient's own phone or with a device via the virtual patient centred visiting scheme be used? Or a phone call? Relatives may be very anxious about their loved one, especially if they have picked up on delirium symptoms. Ensuring they are kept up to date and have a diagnosis of delirium explained to them will help. You can signpost them to the Scottish Delirium Association website which has a patient and carer information leaflet. http://www.scottishdeliriumassociation.com/for-patients--carers.html

Lines – catheters, PVCs, other indwelling devices, monitors – all can cause or prolong delirium. They should be removed as soon as it is safe to do so. Challenge the team on the ward round – are they still needed? Does the risk now outweigh the benefits?

Sleep – sleep wake cycle is so important in delirium care. It can be a challenge to promote sleep hygiene in critical care areas but considering eyemasks and ear plugs if possible, being thoughtful about checking obs and administering IV medications overnight, dimming lights and quieting alarms overnight where safe can all help. Also aim to keep the person awake and stimulated during the day to avoid day night reversal.

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Orientation - remind people where they are and what is happening at every opportunity. Let them know they are in hospital and that you are the healthcare provider before carrying out any care so as not to frighten them. Have clocks clearly visible. Remind them why you are wearing PPE and why their relatives are not able to visit – it will be very strange for them.

Management of Stress and Distress – non pharmacological strategies are the mainstay of this. All the above can help. Look at the guide produced by our psychology service http://www.staffnet.ggc.scot.nhs.uk/Info%20Centre/PoliciesProcedures/GGCClinicalGuidelines/GGC%20Clinical%20Guidelines%20Electronic%20Resource%20Direct/Covid-19%20and%20Cognitive%20Impairment.pdf Pharmacological approach is only used when these fail and the person is severely distressed, unable to accept necessary care or a danger to themselves or others.

Drugs for stress and distress – If on antipsychotic meds review these daily. If PRNs are used frequently can they be changed to regular to prevent rather than react to distressed behaviours ? If the person has hypoactive delirium, or is not distressed or paranoid they should be reduced and stopped – you can wean down over a few days or stop regular and change to PRN depending on the circumstances. Remember that older people require much smaller doses. Benzodiazepines have a clear role in substance withdrawal but can promote or prolong delirium so we mostly try to avoid unless there are other reasons why antipsychotics aren't suitable. The therapeutics handbook section on Delirium has a useful section on meds for distressed behaviours but if you need more advice contact Liaison Psychiatry/critical care outreach or geriatric medicine as appropriate.

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NHS Greater Glasgow and Clyde

COVID-19 APPROVED GUIDANCE

OFFICIAL SENSITIVE

Note: This guidance has been fast-tracked for approval for use within NHSGGC

Covid-19 Delirium Care for Critical Care and ITU Stepdown in the time of Covid-19

This guidance is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guidance, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following guidance, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

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Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.