

Delirium and considerations during the COVID-19 pandemic

Alistair Burns, Emma Vardy, Thomas Jackson,
Mani Krishnan, Helen Pratt, Adam Gordon

NHS England and NHS Improvement



Welcome



Host: Professor Alistair Burns
National Clinical Director for Dementia, NHS England
and Improvement

- Lines are automatically muted on entry to the webinar.
- Please use the CHAT function throughout the webinar to ask questions and provide comments/ input.
- We are unlikely to be able to answer all of the questions raised today and we will focus on the questions that get the most 'LIKES' as a way to prioritise questions during the Q&A section.
- To 'LIKE' a question, hover your mouse over the question on the feed to the right of the screen and click on the thumbs up icon.
- We are not providing CPD certificates for attendance.

Webinar recording and slides

- The webinar will be recorded. We will share the links to download the recording and the slides with those who are on our contact list and have received the invite directly from the national dementia team.
- If you have received the invite to this webinar from a colleague, rather than via the national team, you will not be on our mailing list to receive the links. In order to access them, please email ENGLAND.DomainTeam@nhs.net, putting 'dementia webinar mailing list' in the subject header.
- If you are on our mailing list but do not receive the slides or links, this is usually due to your organisation's IT not accepting attachments/ files. You will need to discuss this with your organisation.

Delirium and Considerations During the COVID-19 Pandemic

Chair: Dr Emma Vardy

Consultant Geriatrician and Honorary Senior lecturer, Clinical Dementia Lead Salford ICO, Associate CCIO for GDE pathway redesign Salford Royal NHS Foundation Trust

Presentation of delirium and detection in the context of COVID-19

Dr Thomas Jackson, Consultant Geriatrician, Queen Elizabeth Hospitals Birmingham; Clinician Scientist in Geriatric Medicine, Institute of Inflammation and Ageing, University of Birmingham

Management of delirium in COVID-19

Dr Mani Krishnan, Consultant in Old Age/Liaison Psychiatry, Senior Clinical Director TEWV NHS Foundation Trust; Academic Secretary/ Chair Elect of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, Associate Dean HEE

Delirium community pathways and care

Helen Pratt, Project Manager, Dementia United, Greater Manchester Health and Social Care Partnership

Delirium care in the community and care homes

Professor Adam Gordon, Care of Older People, University of Nottingham, Consultant Geriatrician, Derby Teaching Hospitals NHS, Vice President for Academic Affairs at the BGS

Q&A Session with the presenters

Final reflections

Professor Alistair Burns, National Clinical Director for Dementia, NHS England and Improvement

UNIVERSITY OF
BIRMINGHAM



Dr Thomas Jackson
t.jackson@bham.ac.uk
@delirious_dr @InflamAge_UoB



COVID-19 and delirium



Collective wisdom

Anecdote based medicine

Pattern recognition

Publication

Peer reviewed publications

COVID-19 infection presentations

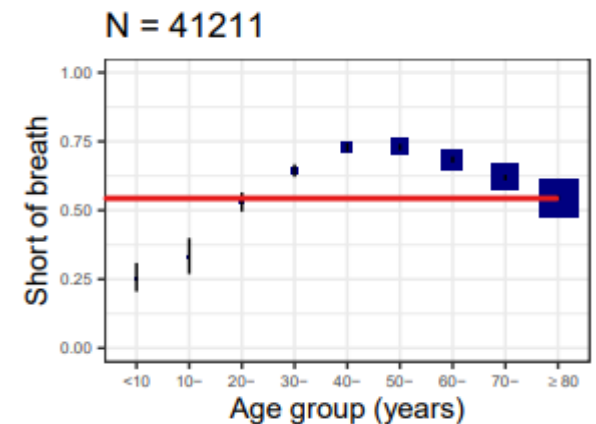
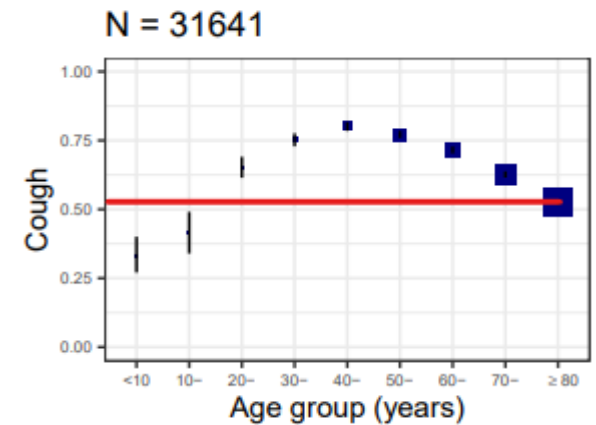
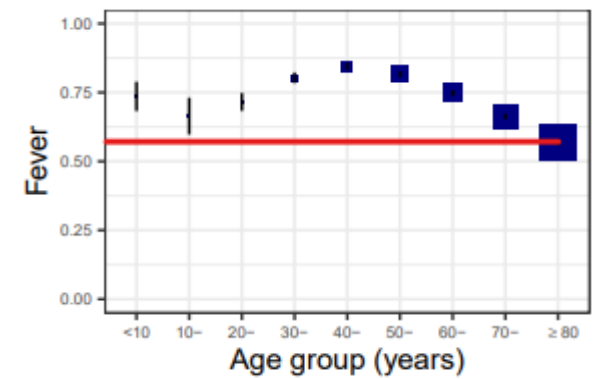
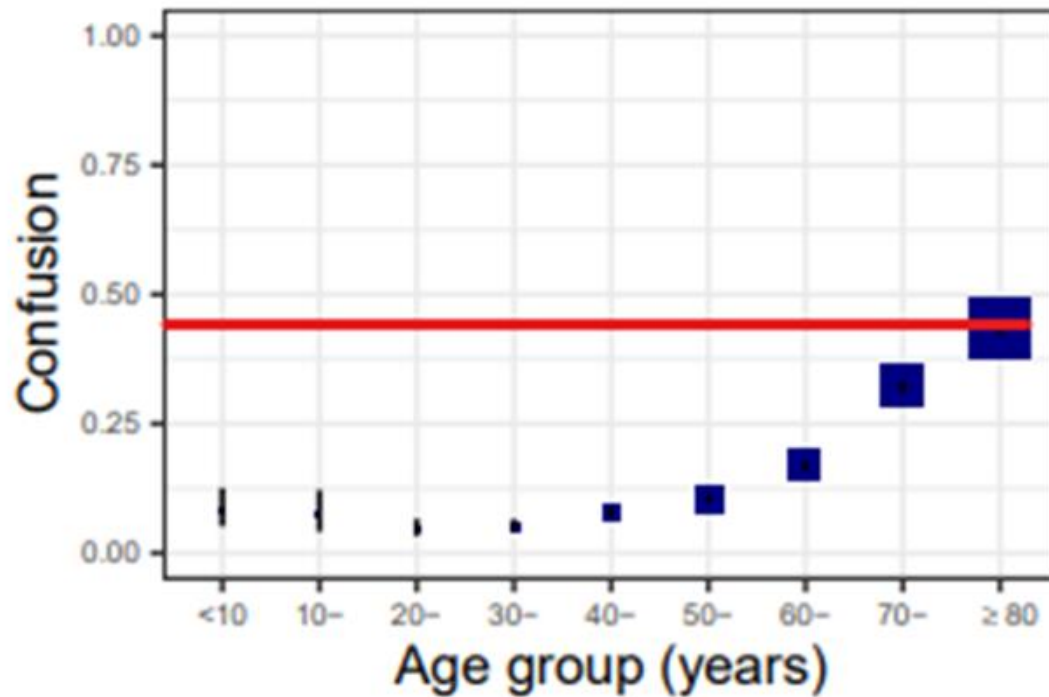
Fever and persistent cough

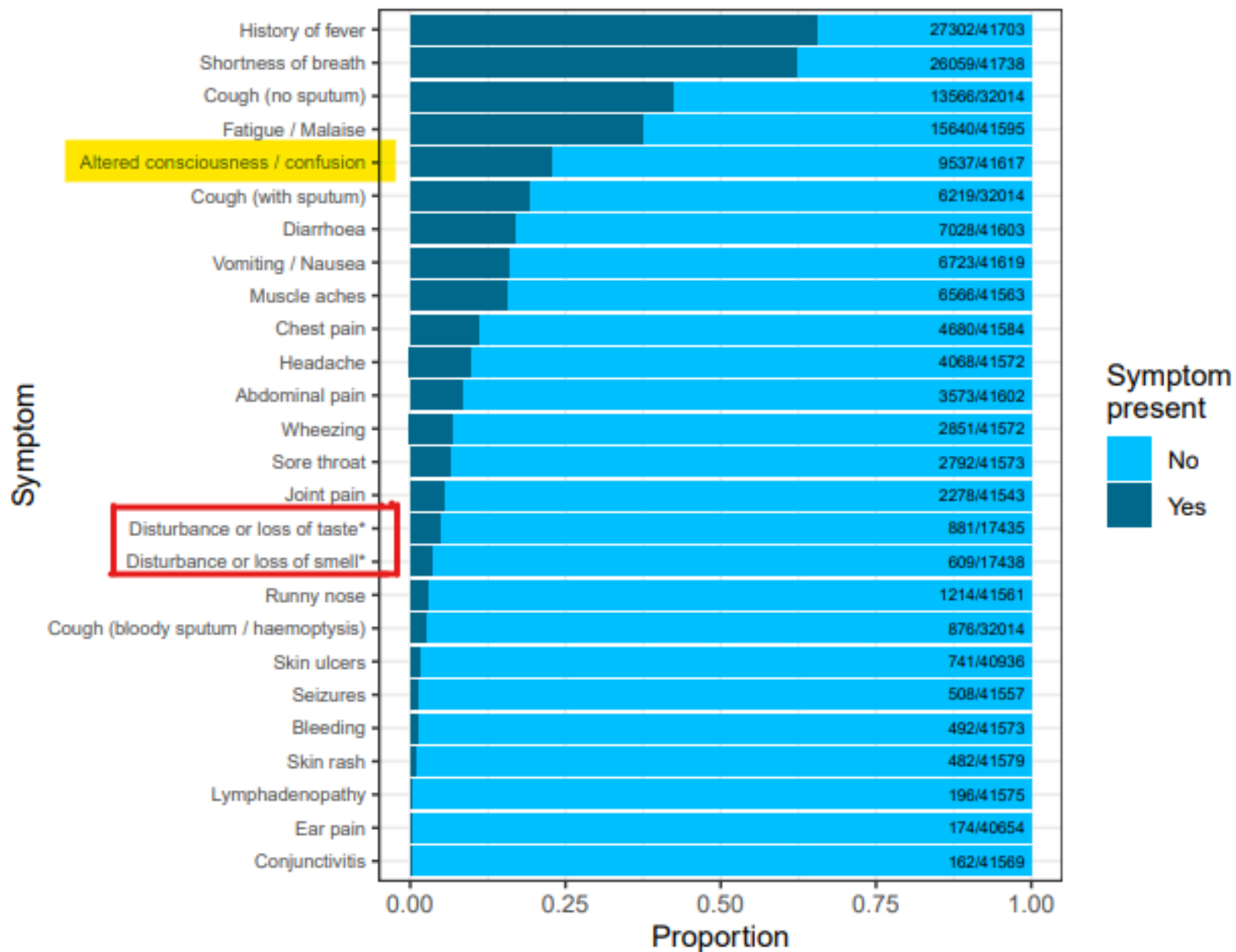


Atypical presentations

With ↑ age - ↓ 'typical symptoms - ↑ 'confusion

N = 35522





What is it?

DSM-5

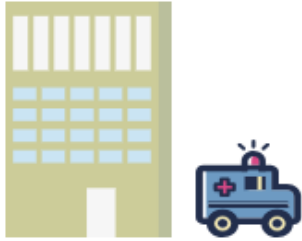
“delirium is an **acute** onset syndrome with disturbance in **attention**, **awareness**, and **cognition**”

2 engrained ageist biases

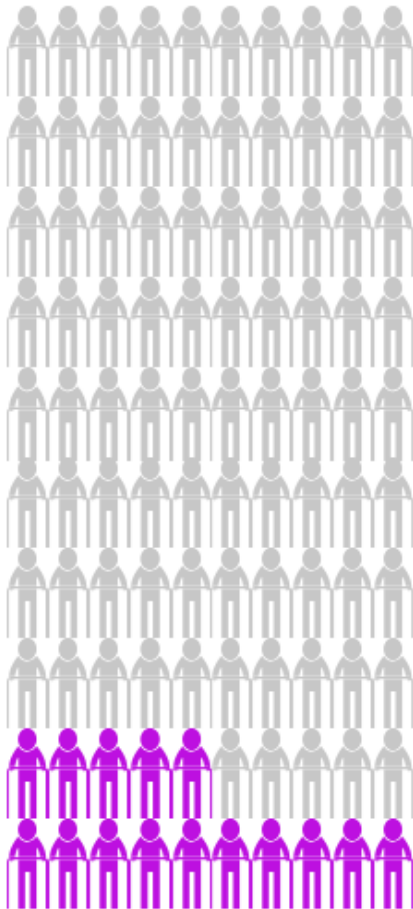
Confused old people must have a UTI

Old people are allowed to be confused



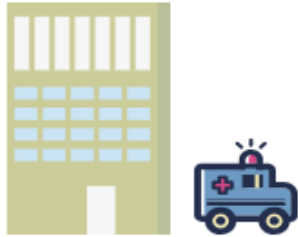


1507 UK Acute admissions >65 yrs. Assessed in first 48 hours Point prevalence - 15%



	Prevalence	Mortality at 1 month
DSM5	15%	OR 2.43 (CI 1.44-4.09)
4AT +ve	25%	OR 2.55 (CI 1.53 – 4.24)

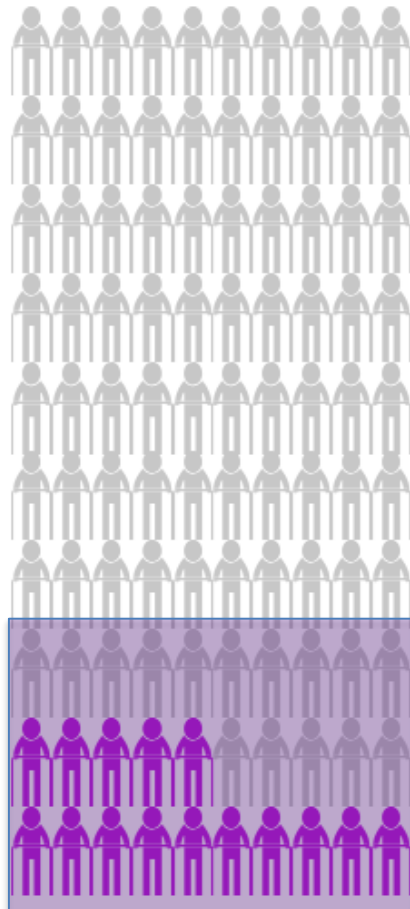
Increased length of hospital stay
Bootstrapped mean (adjusted multivariable) **+3.17 days**
(CI 1.46-4.77), p=0.001



Delirium on admission in older people with COVID-19

Pooled prevalence – 29%

De Smet (n=81)	42%	Belgium
Knopp (n=217)	29%	London - UCLH
Zazzara (n=322)	25%	London – St Thomas

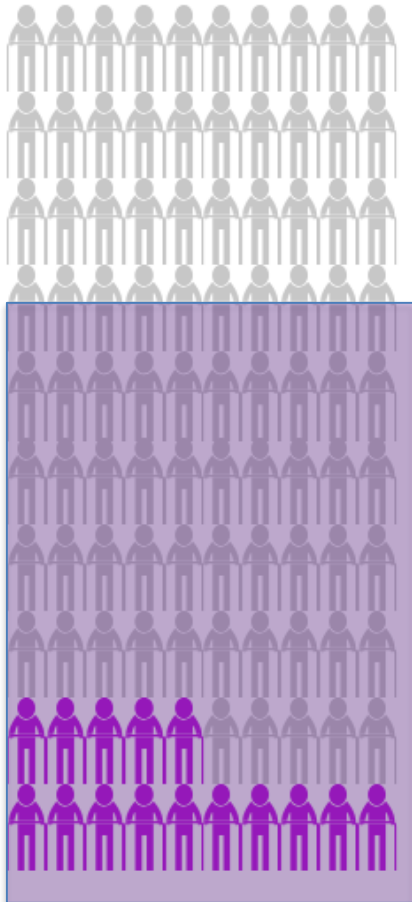
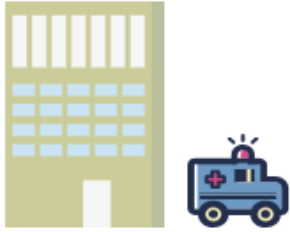


Point Prevalence – 42% (UCLH)

De Smet medRxiv 2020.05.26.20113480; doi: <https://doi.org/10.1101/2020.05.26.20113480>

Knopp medRxiv 2020.06.07.20120527; doi: <https://doi.org/10.1101/2020.06.07.20120527>

Zazzara medRxiv 2020.06.15.20131722; doi: <https://doi.org/10.1101/2020.06.15.20131722>



Delirium on admission in older people with COVID-19

**In those with dementia – 67%
Most common symptom**

**Bianchetti
(n=627)**

67% Italy



Delirium in ITU patients with COVID-19

Usually 20-80%

Pooled prevalence – 71%

Helms (n=53)	65%	USA
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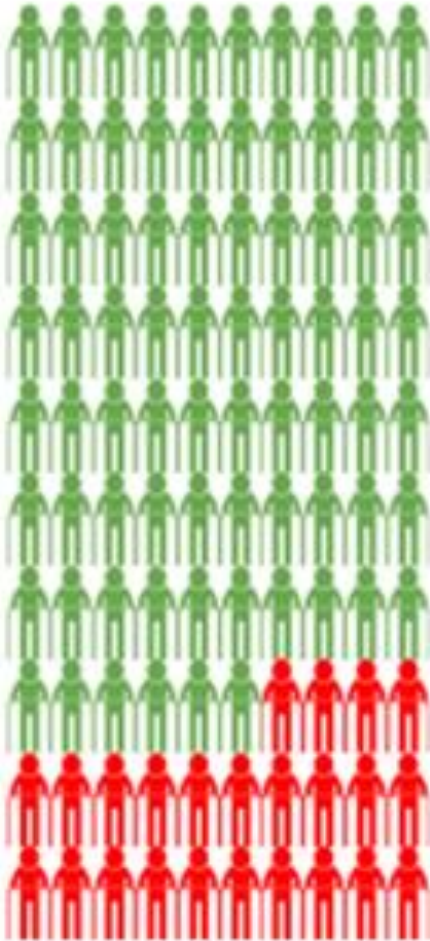
Khan (n=243)	73%	USA
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Confusion as a symptom of COVID-19 in older people with COVID-19

Prevalence – 36%

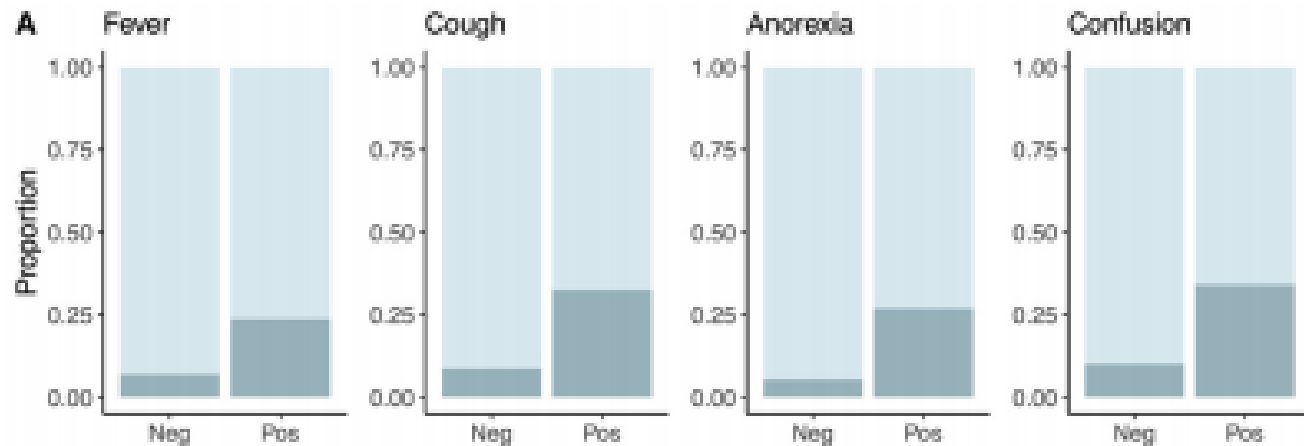
Zazzara (n=232)	36%	London (age matched to hospital study, app based)
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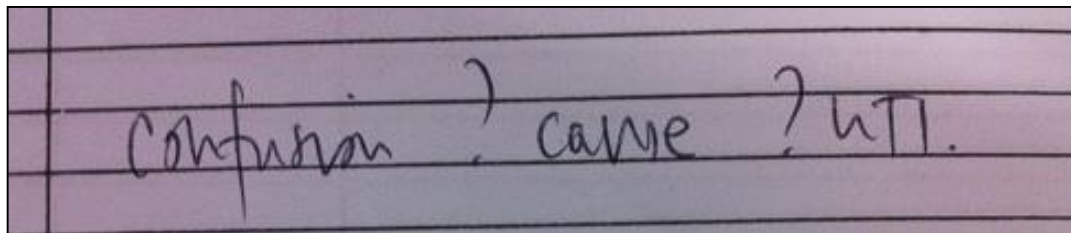
Confusion in older people with COVID-19 in UK care homes

Prevalence – 34%



Delirium is not...

“...they’re allowed to be a bit confused aren’t they? Its what you expect...”



? COVID

80yrs ♀ Mary



VS

80yrs ♀ Martha



Delirium

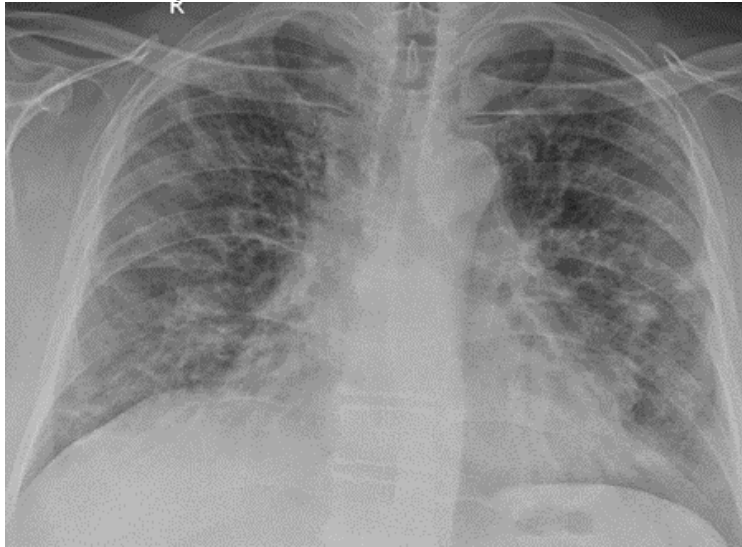
No Delirium

Pneumonia + same co-morbidity & acute illness

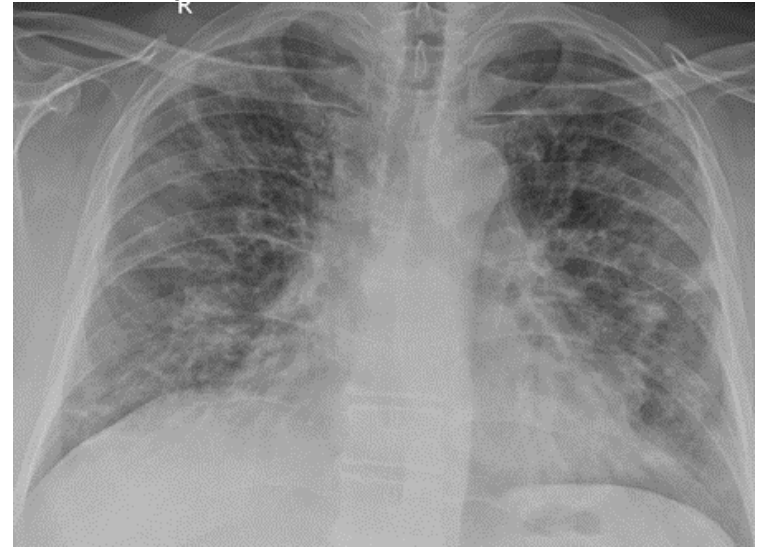
Delirium more likely to die (HR 1.95),
or develop dementia (OR 8.1)

Distressing

75yrs ♀ - Matthew



75yrs ♀ - Mark



VS

Delirium

No Delirium

COVID -19 + same co-morbidity & acute illness

Delirium more likely to die (HR 1.91, 1 study only)

But other studies with no association

Reduced physical function (2 studies)

Distressing



Severe

More severe phenotype
Agitated, hyperactive
Distressed
Across age spectrum



Harm

Risk of harm greater
Risk to others - greater



Driven by...

PPE, Isolation
Lack of care givers, family
Direct neuropathology

Delirium presentations in COVID

Initial presentation

May be only symptom
Mixed motor phenotype
Hypoxia and respiratory symptoms later in some cases
Pacing, severe attentional deficit, unable to distract
'Wool picking'

Terminal delirium

Severe agitation
Not compliant with O2, or simple management
Very distressing for patient and staff
Reluctance to manage

Delirium presentations in COVID

ITU

Predominantly hypoactive

Asso with coma

Post ITU rehab

Predominantly hypoactive and
asso with anxiety

Limits physical rehab

Bizarrely

Only **1/3**
recognised

Barrier to best care

Massive daily deficiency in
hospital practice

Lack of clarity makes it impossible to
treat

Triggers specific actions (others don't)

Impossible to offer excellent care
unless we do

Bizarrely

Only **1/3**
recognised

Barrier to best care

Massive daily deficiency in
hospital practice

**60% delirium missed in
UCL study of COVID-19**

How to diagnose it

Testing attention is key

Count backwards from 20 to 1

Can you tell me the months of the year backwards?

Can you repeat these five numbers back to me please?

Can you repeat these three numbers back to me please, but in reverse order?

Altered arousal

- Wake them up, talk to them!
- Sleepy or hyperalert?
- Not holding string of conversation together?

Disordered thinking

- What's been going on today?
- Has anything odd or strange been going on?

Change in baseline

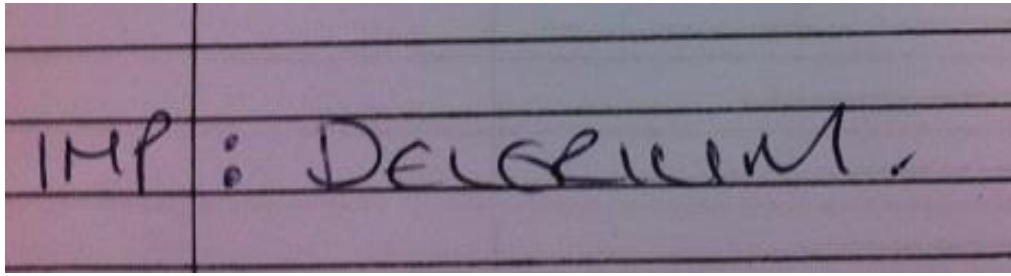
- Talk to relatives/carers/home
- Is this your mum? (SQuID)



www.the4AT.com

Alertness	Normal or abnormal
AMT4	Age, DOB, place, year
Attention	Months of the year backwards
Acute	New or fluctuating from baseline

Advanced care in COVID



Triggers certain actions that others don't
Comprehensive assessment and
treatment



Management of Delirium in COVID19

DR M SANTHANA KRISHNAN

FACULTY OF OLD AGE PSYCHIATRY



Key Points
to Discuss
today

Principles of Delirium
Management

What is different in COVID19

Challenges

Non-Pharmacological

Pharmacological

Principles of Delirium Management



Early Detection



Non-Pharmacological management



Medication carefully considered



Education



Prevention/ Risk Reduction

What is different in COVID 19



- ▶ Delirium could be the only symptom of COVID in Older Adults
- ▶ Severe hyperactive Delirium
- ▶ Hypoactive delirium - community/care homes
- ▶ Severe respiratory problems
- ▶ Lockdown effect and social isolation - delay in detection

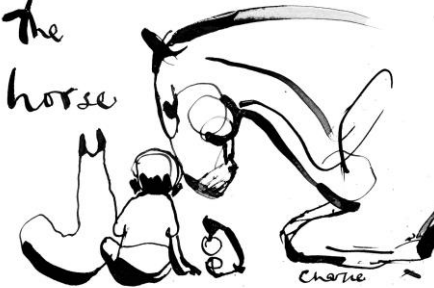
Compassion

Reassurance

Clear communication

"It's ok" said

The
horse



"Not to feel ok"

"I may forget what
you've said ~ but



I'll remember how you
made me feel."

Challenges



hospital - Nursing in isolation or with PPE



Risk of spread of infection- wandering patient - risk to other patients



Lack of consistent staff



Lack of family support/contact



Hearing aid / glasses - sensory impairment



Medication – interaction

Non-Pharmacological



Good light



Glasses and
hearing aid



Distraction



Minimise noise



Consistent
communication



Early mobilisation



**Medicine
optimisation**



**Anticholinergic
burden**



Deprescribing



**Consider drug
interaction with
antiviral**



**Avoid
Polypharmacy**

Pharmacological



Risk
Need
Side-effects
Chemical Restraint

Management of Severe Agitation in Delirium

There is no evidence for use of sedatives in routine management of delirium both benzo and antipsychotic



However

Antipsychotic medication

In COVID there may be an earlier indication along with non-pharmacological

QT prolongation - caution

Stop the medication before discharge

Benzodiazepines



No Role for Benzodiazepine in the management of Delirium, can worsen the symptoms



Some indication for management of agitation in Dementia with Lewy bodies, Parkinson's disease with Dementia



Where antipsychotic medication are contraindicated - may be a role with caution



Midazolam - End of life severe agitation

Interaction with Antiviral

(Liverpool Drug interaction Group)

● Do Not Coadminister
■ Potential Interaction
▲ Potential Weak Interaction
◆ No Interaction Expected

[Results Key](#)

	Atazanavir alone	Baricitinib	Chloroquine	Favipiravir	Nitazoxanide	Remdesivir	Ribavirin	Sarilumab	Tocilizumab
Haloperidol	●	◆	●	◆	◆	◆	◆	◆	◆
Lorazepam	◆	◆	◆	◆	◆	◆	◆	◆	◆
Midazolam (parenteral)	■	◆	◆	◆	◆	◆	◆	◆	◆
Olanzapine	◆	◆	◆	◆	◆	◆	◆	◆	◆
Quetiapine	●	◆	■	▲	◆	◆	◆	◆	◆
Risperidone	■	◆	■	◆	◆	◆	◆	◆	◆

In COVID Delirium



Cautious use of medication seem to be important to reduce distress and minimise risk of infection to others

BGS Old Age Psychiatry and EDA - Joint guidance

Hyperactive Delirium requires more aggressive management in patients with COVID 19 - Temporarily rethinking 'low and slow' Mark Lach et al May 2020

Follow up

medRxiv

THE PREPRINT SERVER FOR HEALTH SCIENCES



Cold
Spring
Harbor
Laboratory

BMJ

Yale

HOME | ABC

Search

[Comment on this paper](#)

Functional and cognitive outcomes after COVID-19 delirium

Benjamin C McLoughlin, Amy Miles, Thomas E Webb, Paul Knopp, Clodagh Eyres, Ambra Fabbri, Fiona Humphries, Daniel Davis

doi: <https://doi.org/10.1101/2020.06.07.20115188>

This article is a preprint and has not been peer-reviewed [what does this mean?]. It reports new medical research that has yet to be evaluated and so should not be used to guide clinical practice.

Follow up



**More
important now**



**Stop antipsychotic
medication**



Delirium Clinics



Education

Thank You



@psychinformatic



"Being kind to yourself is one of the greatest kindnesses," said the mole.

@charliemacksey



End of slides for Webinar - Resources

- ▶ <https://madeinheene.hee.nhs.uk/PG-Dean/Faculty-of-Patient-Safety/Delirium-Project>
- ▶ <https://madeinheene.hee.nhs.uk/PG-Dean/Faculty-of-Patient-Safety/Delirium-Project/COVID-Delirium-Resources>
- ▶ <https://madeinheene.hee.nhs.uk/PG-Dean/Faculty-of-Patient-Safety/Delirium-Project/Delirium-Resources>

HEE NE Website

General Practice Specialty Learner Support Trainee Revalidation Foundation Dentistry LET Policies PG Dean



Delirium Project

Delirium (sometimes called 'acute confusional state') is a clinical syndrome characterised by disturbance attention, awareness and cognition. Delirium has an acute onset and fluctuating course. It is a serious condition that is associated with poorer clinical outcomes including death. Delirium can be prevented and treated if it is detected and managed.

The prevalence of delirium in people on medical wards in hospital is about 20% to 30%, in addition, the number of undetected cases is thought to be as high as 30% to 67%. Reporting of delirium is poor in the UK, indicating that awareness and reporting procedures need to be improved. It can be difficult to distinguish between delirium and dementia and some people may have both conditions. (NICE website).

There is also lack of awareness among health care professionals of the importance of delirium.

HEE NE in partnership with Tees Esk and Wear Valleys have hosted a number of educational events to raise awareness of delirium among healthcare professionals, including those working in both acute and care home settings. A number of educational resources have also been developed and available below.

With the profile of delirium raised within the region and interest is high it is clear there is still an educational need especially within the community care and care home setting and that training should form part of a regular training programme with two educational training events being held annually.

On this page you will find a number of resources that can help in raising awareness and treating Delirium. Apart from developing some of the resource we have tried to compile good quality information that are available on the web to signpost for people to access those resources. We acknowledge and thank all the organizations and authors of the publication (that have been cited or linked here).

We have pulled together a number of resources to assist with managing Delirium and patients with COVID-19.



#IcanPreventDelirium - Delirium Awareness Video



Click on the picture for the video or link or scan the QR code

#DeliriumReady Video



Click on the picture for the video or link or scan the QR code

Delirium Resources



Home General Practice Specialty Learner Support Trainee Revalidation Foundation Dentistry LET Policies PG Dean Health Education England



Lancet Psychiatry 2020

Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic

[Systematic Review | Lancet Psychiatry | December 2020 | Volume 18 | Pages 1502-1512 | \[View Article\]\(#\) | \[Download Article\]\(#\)](#)

The New York Times

The Epidemic Within the Pandemic: Delirium

Delirium is leaving many older patients more vulnerable. They need caregivers, despite no visitor policy.

Journal of Geriatric Emergency Medicine

Managing delirium in older ED patients during the COVID-19 pandemic. A resource from the Geriatric Emergency Department Collaborative



Coronavirus: Managing Delirium in Confirmed and suspected cases

BGS and RCPsych Faculty of Old Age Psychiatry and European Delirium Association statement on managing Delirium in COVID



RGP Toronto paper on Management of Delirium during COVID Pandemic across care continuum



RGP Toronto paper on Communication Tips for Clinicians caring for older adults experiencing Delirium during the COVID-19 pandemic



April 1, 2020

Resources

Tees, Esk and Wear Valleys **NHS**
NHS Foundation Trust

I can prevent DELIRIUM



DELIRIUM CAN BE PREVENTED AND TREATED

SUSPECT IT
Age 75+
Cognitive impairment
Visual / hearing loss
Infection / dehydration
Pain / trauma

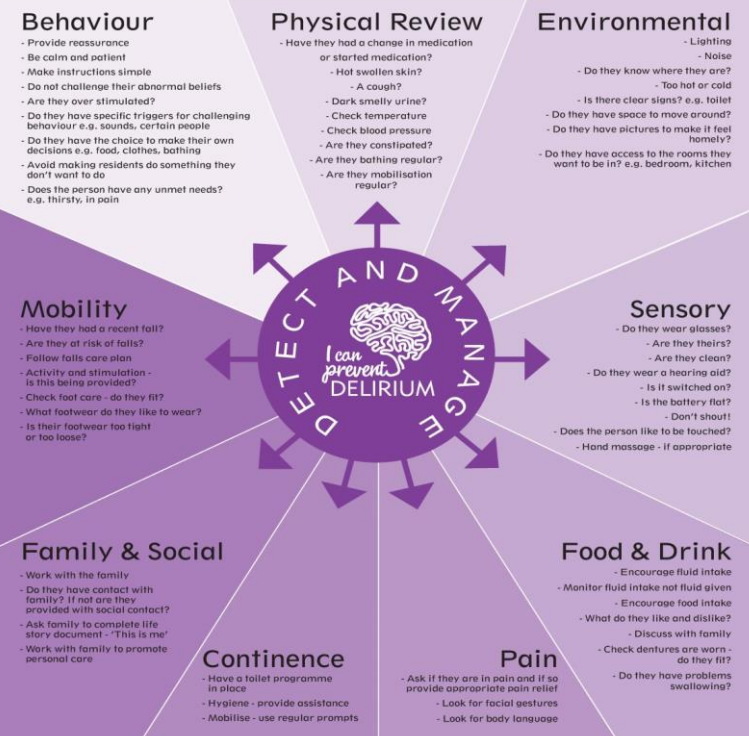
SPOT IT
Acute confusion
Poor concentration
Poor communication
Change in behaviour
Hallucinations
Fluctuations

STOP IT
Treat cause
Explain and reassure
Environment
Physical needs
Psychological needs
Social needs

Stockton-on-Tees **NHS**
Hartlepool and Stockton-on-Tees Clinical Commissioning Group

Tees, Esk and Wear Valleys **NHS**
NHS Foundation Trust

ARE THEY DIFFERENT TODAY?



Behaviour

- Provide reassurance
- Be calm and patient
- Make instructions simple
- Do not challenge their abnormal beliefs
- Are they over stimulated?
- Do they have specific triggers for challenging behaviour e.g. sounds, certain people
- Do they have the choice to make their own decisions e.g. food, clothes, bathing
- Avoid making residents do something they don't want to do
- Does the person have any unmet needs? e.g. thirsty, in pain

Physical Review

- Have they had a change in medication or started medication?
- Hot swollen skin?
- A cough?
- Dark smelly urine?
- Check temperature
- Check blood pressure
- Are they constipated?
- Are they bathing regular?
- Are they mobilisation regular?

Environmental

- Lighting
- Noise
- Do they know where they are?
- Too hot or cold
- Is there clear signs? e.g. toilet
- Do they have space to move around?
- Do they have pictures to make it feel homely?
- Do they have access to the rooms they want to be in? e.g. bedroom, kitchen

Sensory

- Do they wear glasses?
- Are they theirs?
- Are they clean?
- Do they wear a hearing aid?
- Is it switched on?
- Is the battery flat?
- Don't shout!
- Does the person like to be touched?
- Hand massage - if appropriate

Food & Drink

- Encourage fluid intake
- Monitor fluid intake not fluid given
- Encourage food intake
- What do they like and dislike?
- Discuss with family
- Check dentures are worn - do they fit?
- Do they have problems swallowing?

Pain

- Ask if they are in pain and if so provide appropriate pain relief
- Look for facial gestures
- Look for body language





Continenence

- Have a toilet programme in place
- Hygiene - provide assistance
- Mobilise - use regular prompts

Family & Social

- Work with the family
- Do they have contact with family? If not are they provided with social contact?
- Ask family to complete life story document - "This is me"
- Work with family to promote personal care

For more help and guidance go to the delirium resource box

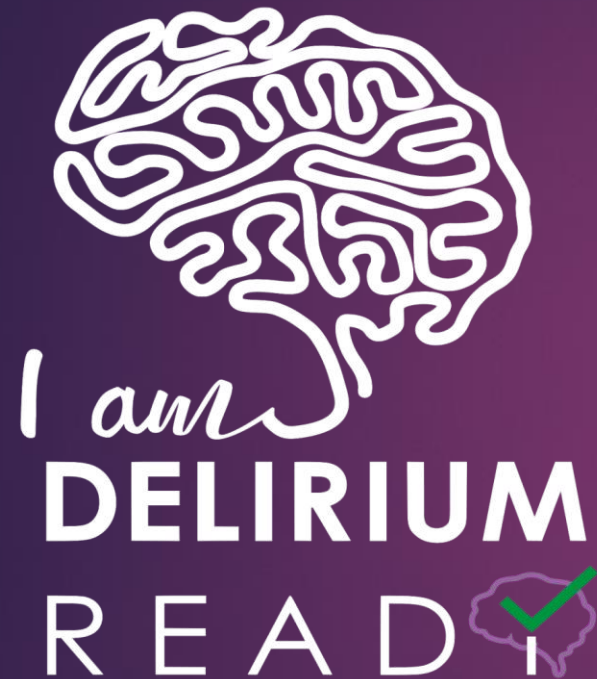
   **WATCH IT** 

Delirium Educational Videos



<https://youtu.be/2Hg1VP-Enw4>

<https://youtu.be/BPfZgBmcQB8>

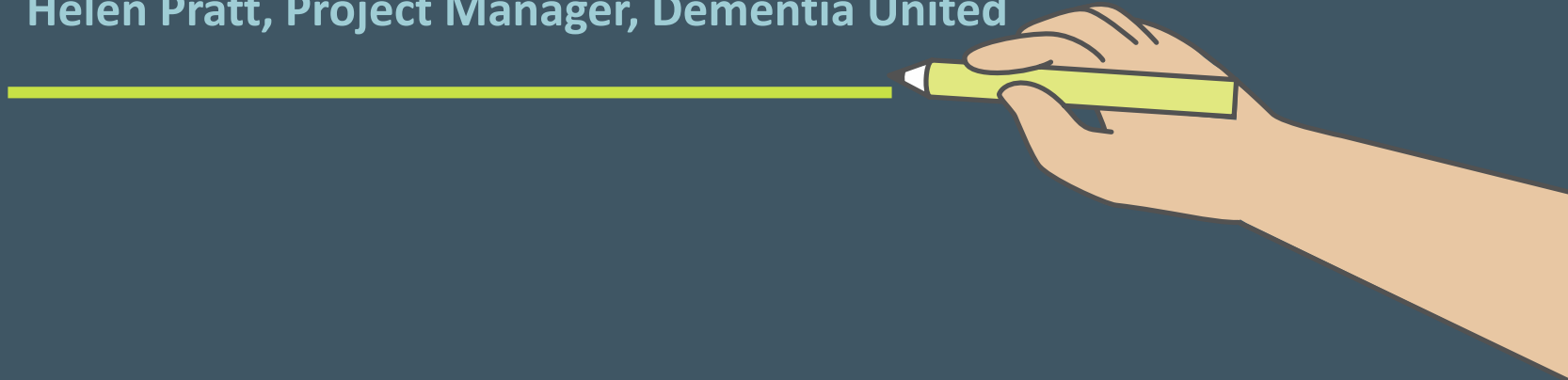


Are you?

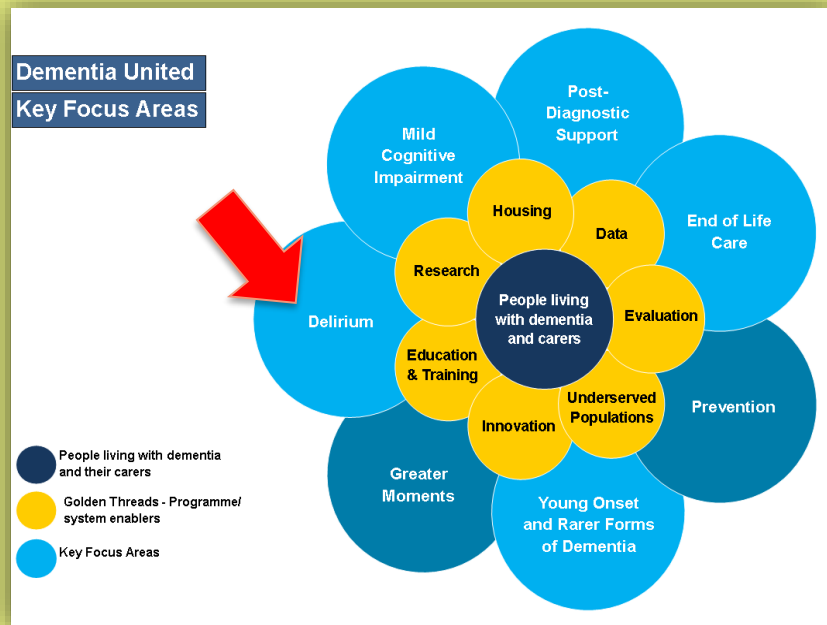
 @Psychinformatic

DELIRIUM – COMMUNITY PATHWAYS

Helen Pratt, Project Manager, Dementia United



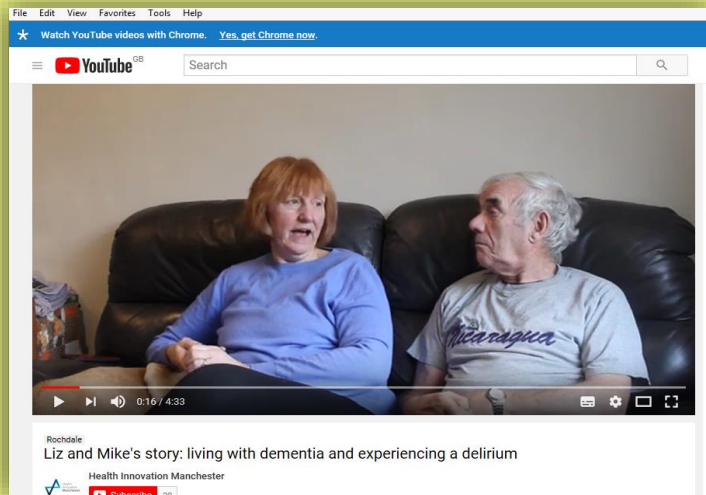
CONTEXT



Greater Manchester World Delirium Awareness events



CONTEXT



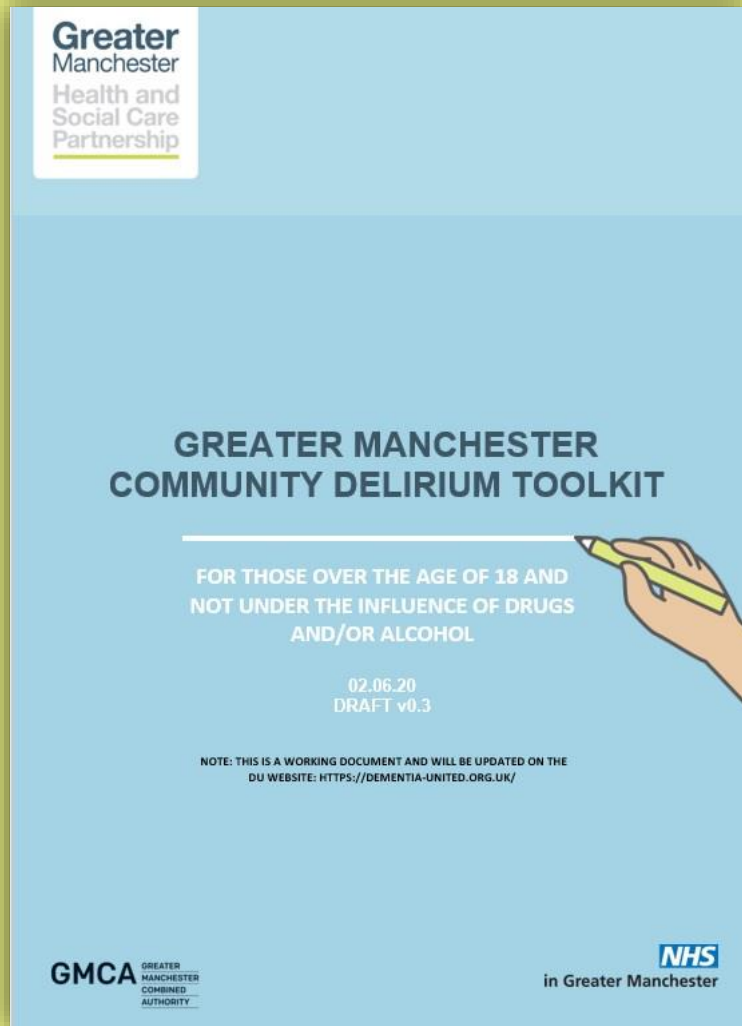
Salford Royal Hospital Global Digital Delirium Exemplar

- Cases identified risen by 650 (34% increase)
- Length of Stay of Delirium patients reduced by 11% saving estimated £1,700,000 in the first year

Liz “No sooner than we arrived at Salford Royal, the staff were on us. They looked at Mike’s age, his dementia diagnosis and the fact that he had experienced a previous episode of delirium.. they took it all on board and he was diagnosed and treated straight away.

The delirium didn’t progress, and he came home quickly and without any impact on his cognition.”

COMMUNITY TOOLKIT



Overview with time scales

Key documents e.g. 4AT, GM Management guidance, GM Delirium Leaflet

Supporting documents e.g. West Essex CCG – Anticholinergic side-effects and prescribing guidance, Alzheimer's Society – This is me

1. Complete 4AT
 - RESTORE2 (Care homes)
2. Confirm and convey diagnosis
3. Complete GM Community TIME bundle
 - Triggers, Investigations
 - Management guidance
 - Engage with families and others as needed
 - GM Delirium leaflet - complete the 'person centred care plan'.

CONSIDERATIONS AND CHALLENGES

- Early engagement and contribution
- Ownership and team structure
 - Diagnosing delirium, blood tests, equipment
- Timescales
- Red flags
- How to decide on hospital admission e.g. NEWS2, Restore2
- What's already available versus what would be recommended
- Feedback from people with lived experience
- COVID-19
 - Escalation of work
 - Links with primary care
 - Links with work in care homes

Whilst ensuring a safe 'working' version of the pathway

NEXT STEPS..



Test out with
community teams
with support from
Dementia United



Community
Delirium toolkit

Dementia United
report on findings
from testing
out/feedback



Lived experience
feedback

Further formal
evaluation -
scoping roll out



Dementia United
governance



Commissioning and
roll out across GM

ACKNOWLEDGEMENTS

- **Dr Emma Vardy** – Consultant Geriatrician, GM SCN Clinical Dementia Lead
- Health Innovation Manchester
- **Delirium Clinical Leads** (clinicians) for designated areas as follows;
 - Education and information - **Ann Collins** and **Rachel Lee Kirby**
 - Acute hospitals – **Emily Robertson** and **Seema Simon**
 - Community – **Nicola Cauldfield**
- **Delirium task and finish group members** which includes people with lived experience and carers
- **Delegates** who have attended the annual **World Delirium Awareness events** held **2018, 2019 and 2020**
- **Dementia Carers Expert Reference Group** – part of governance for Dementia United who very kindly provided initial feedback on the Delirium Leaflet



Contact us

If you have any queries about these guidelines,
contact the GMHSC communications team:
gm.hsccomms@nhs.net

www.gmhsc.org.uk
[@GM_HSC](https://twitter.com/GM_HSC)



@Dementiaunited

Dementia United website to access the
Delirium Toolkit:

<https://dementia-united.org.uk/resources/>

Dementia United email:

gmhscp.dementiaunited@nhs.net

Email:helen.pratt5@nhs.net

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www.gmhsc.org.uk

@GM_HSC



University of
Nottingham

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Delirium, COVID-19 and Care Homes

Adam Gordon,
Professor of the Care of Older
People
University of Nottingham, UK



@adamgordon1978

COMMENTARY

Commentary: COVID in care homes—challenges and dilemmas in healthcare delivery

ADAM L. GORDON^{1,2}, CLAIRE GOODMAN^{3,4}, WILCO ACHTERBERG⁵, ROBERT O. BARKER⁶, EILEEN BURNS⁷, BARBARA HANRATTY^{6,8}, FINBARR C. MARTIN⁹, JULIENNE MEYER¹⁰, DESMOND O'NEILL¹¹, JOS SCHOLS¹², KAREN SPILSBURY¹³

¹Division of Medical Sciences and Graduate Entry Medicine, University of Nottingham, Nottingham, UK

²NIHR Applied Research Collaboration East Midlands (ARC-EM), Nottingham, UK

³Centre for Research in Public Health and Community Care (CRIPACC), University of Hertfordshire, Hatfield, UK

⁴NIHR Applied Research Collaboration East of England (ARC-EoE), Cambridge, UK

⁵Leiden University Medical Center, Leiden, The Netherlands

⁶Population Health Sciences Institute, Newcastle University, Newcastle, UK

⁷Leeds Teaching Hospitals NHS Trust, Leeds, UK

⁸NIHR Applied Research Collaboration North East and North Cumbria, Newcastle, UK

⁹Kings College London, London, UK

¹⁰City, University of London, London, UK

¹¹Department of Medical Gerontology, Trinity College Dublin, Dublin, Ireland

¹²Department of Health Services Research, CAPHRI Care and Public Health Research Institute, Maastricht University, Maastricht, The Netherlands

¹³School of Healthcare, University of Leeds, Leeds, UK

Address correspondence to: Adam L. Gordon, Division of Medical Sciences and Graduate Entry Medicine, University of Nottingham, Derby Medical School, Derby DE22 3NE, UK. Tel: (+1) 01332724668; Fax: (+1) 01332724697. Email: adam.gordon@nottingham.ac.uk

COVID-19: Managing the COVID-19 pandemic in care homes for older people

GOOD PRACTICE GUIDE 

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British Geriatrics Society

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The COVID-19 pandemic raises particular challenges for care home residents, their families and the staff that look after them. This guidance has been developed to help care home staff and NHS staff who work with them to support residents through the pandemic. *This is **Version 3** of this document.*

<https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes>

[Comment on this paper](#)

SARS-CoV-2 infection, clinical features and outcome of COVID-19 in United Kingdom nursing homes

 Neil SN Graham,  Cornelia Junghans, Rawlida Downes, Catherine Sendall, Helen Lai, Annie McKirdy,  Paul Elliott, Robert Howard, David Wingfield, Miles Priestman, Marta Ciechonska, Loren Cameron, Marko Storch, Michael Crone,  Paul Freemont, Paul Randell, Robert McLaren, Nicola Lang, Shamez Ladhani, Frances Sanderson,  David J Sharp

doi: <https://doi.org/10.1101/2020.05.19.20105460>

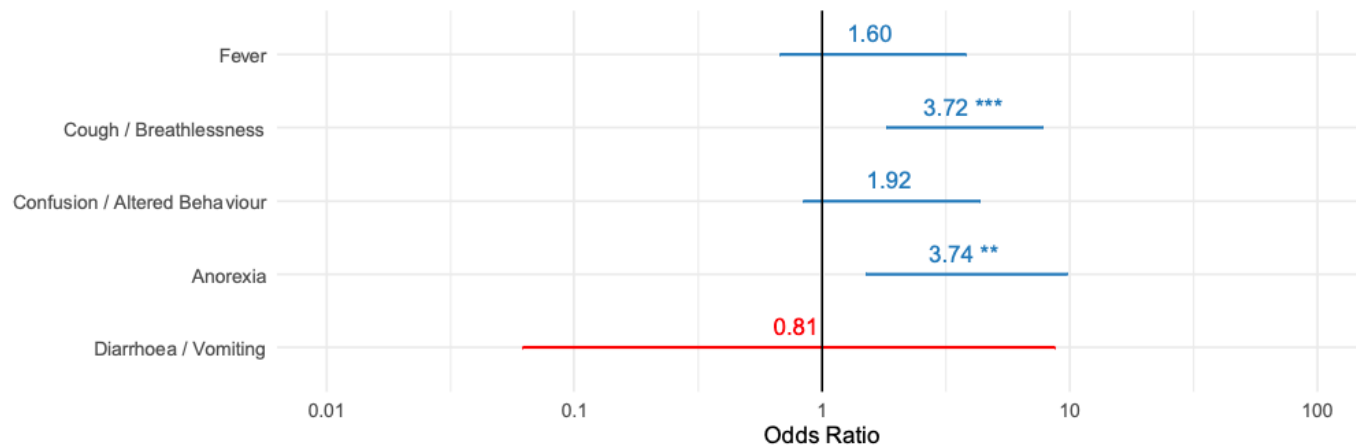
This article is a preprint and has not been certified by peer review [what does this mean?]. It reports new medical research that has yet to be evaluated and so should not be used to guide clinical practice.

[Abstract](#)[Info/History](#)[Metrics](#)[Preview PDF](#)

About this study

- 394 residents of 4 London nursing homes
- Comprehensive swabbing, detailed collection of data on symptoms.
- 40% of residents were positive (15th April)
- 3% who were negative at first swab were positive second time around.
- 33% of residents who tested positive had no symptoms.
- 71% of those with symptoms had typical symptoms
- 31% had atypical symptoms.

Figure 3. Association of symptoms with a positive SARS-CoV-2 rt-PCR result



*Figure 3. Relationship of symptom in preceding two weeks to a positive SARS-CoV-2 result in all residents tested (n=313), displayed as adjusted odds ratios with 95% confidence intervals. Significant predictors in model indicated by ** $P < 0.01$; *** $P < 0.001$.*

Palliation, supportive care, active treatment

- 17% of residents in the London study who were COVID +ve died.
- In hospital
 - about 1/3 of older patients we see with go home within a day or two.
 - about 1/3 die
 - another 1/3 get slowly better with oxygen, IV fluids (and IV antibiotics).
- So what is the role of oxygen, subcutaneous fluids (and antibiotics) for those with hypoactive delirium in care homes?

Isolation...

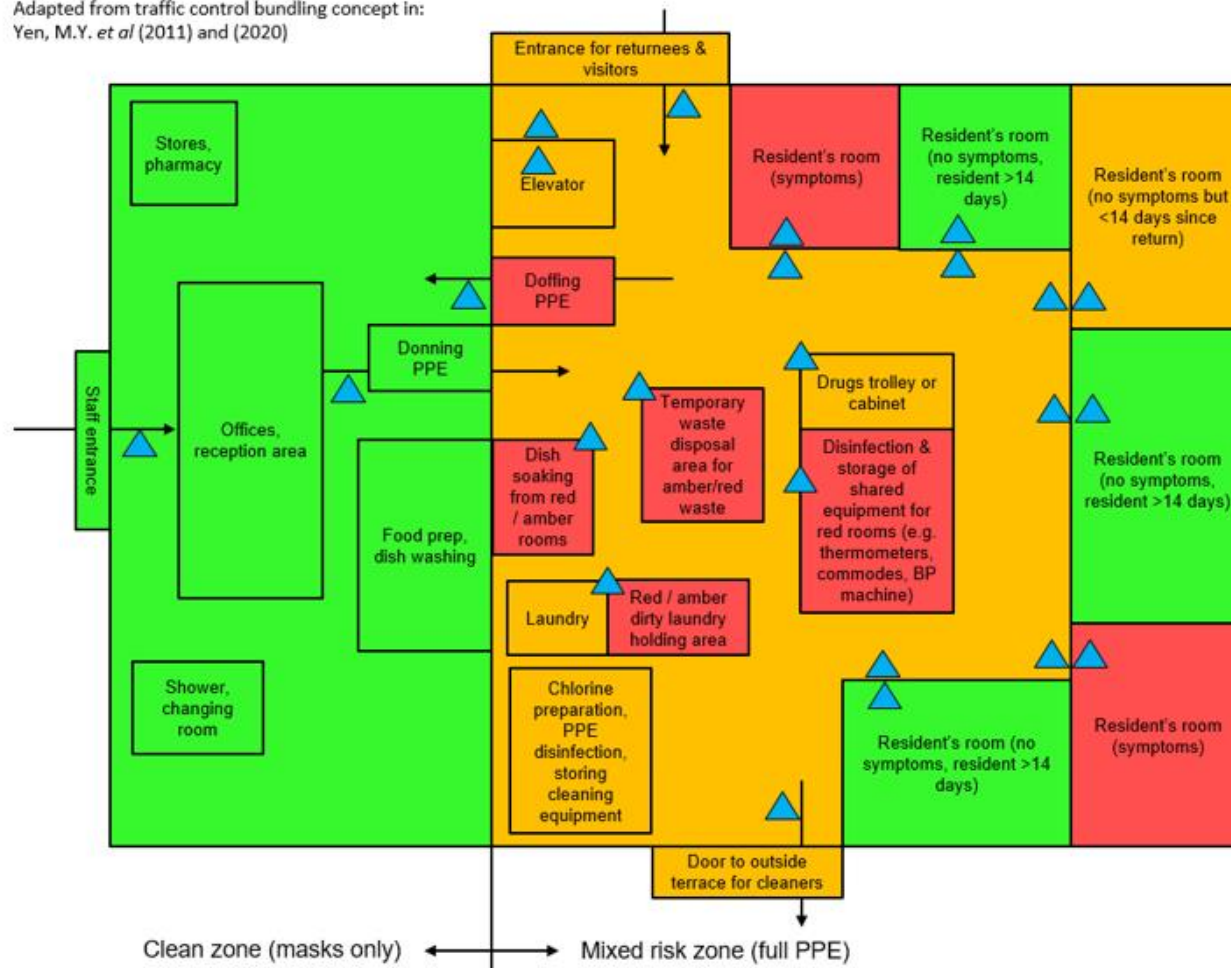
You cannot admit a COVID +ve patient to a care home in Scotland. But in England:

- 14 day isolation for symptomatic residents or COVID +ve residents on admission
- Many homes are extending this to 14 day isolation for all residents on admission.
- Same process for those already resident in the home if they become symptomatic.
- BGS Guidelines suggest homes consider managing all residents in their rooms as much as possible....but supervision, staffing, social isolation, and deconditioning are issues.
- All of this is challenged by residents who walk with purpose.

Delineation of risk zones - adapted for care homes

Adapted from traffic control bundling concept in:
Yen, M.Y. *et al* (2011) and (2020)

▲ Hand hygiene



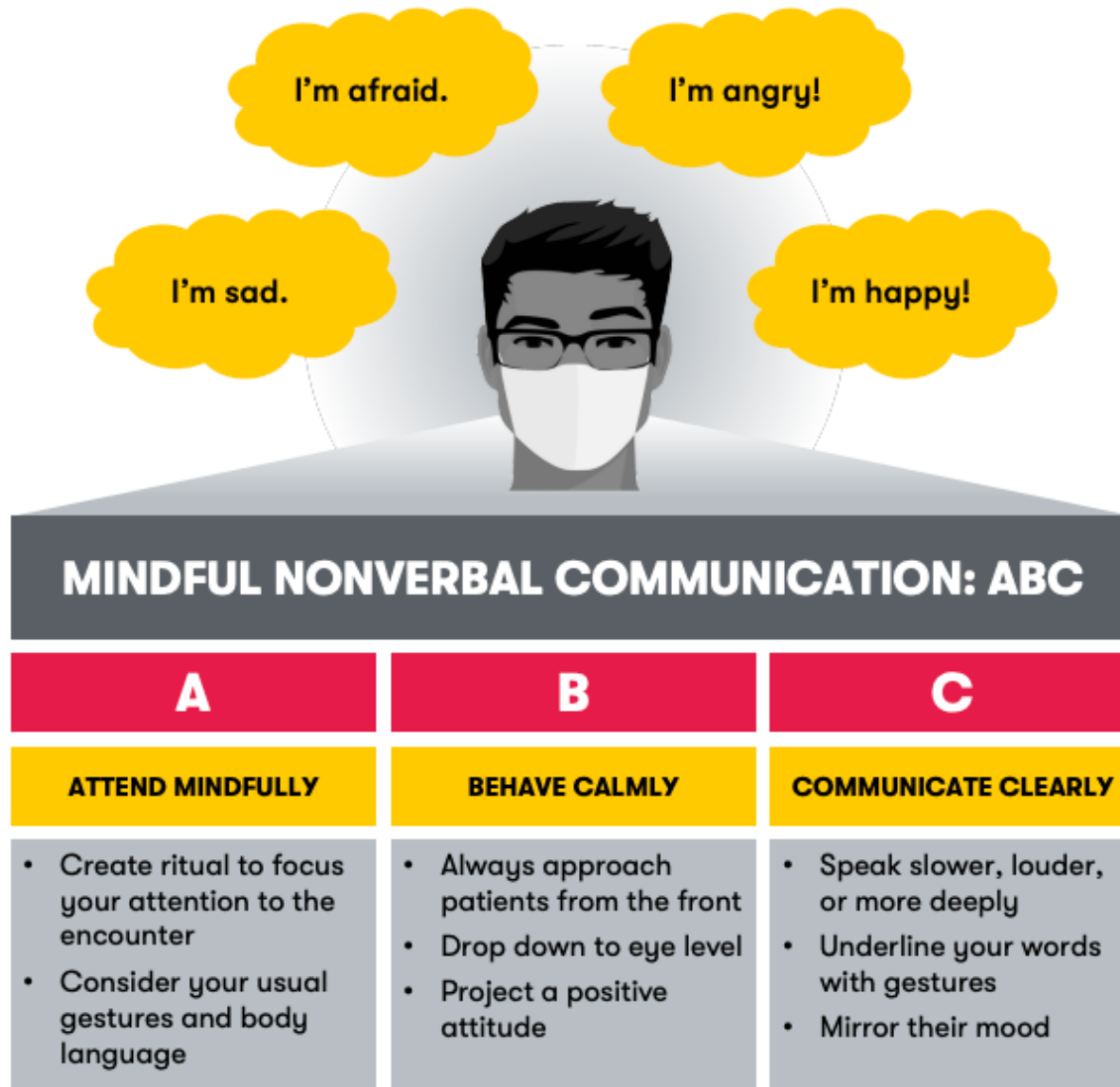
Useful tools

- About me
- Antecedent-behaviour-consequence approaches
- 4-AT or Single Question in Delirium (SQiD)
 - Has the resident been more confused in the last three days

Domain	Multi-component interventions in delirium
Sensory	Good lighting levels
	Reduced noise (pump alarms, pagers)
	Available and working sensory aids (spectacles, hearing aids, deaf aid communicators).
	Assess for verbal and non-verbal signs of pain, particularly in patients with communication difficulties.
	Commence pain relief and review appropriate management of pain.
	Attention to bowel and bladder. Avoid unnecessary catheterisation .
	Avoidance of physical restraints
Environment	Avoid movements between wards and rooms and
	Where possible ensure the continuity of care from staff that are familiar
	Regular and repeated visible and verbal reorientation (clocks, calendars and clear signs).
	Maintenance or restoration of normal sleep patterns whilst avoiding sedatives.
	Reduce noise and nursing and medical interventions during sleeping hours
	Encourage visits from family and friends.
Bodily Function	Encourage mobilisation for all patients particularly after surgery. Walking aids should be accessible at all times.
	Avoidance of dehydration. Consider sub-cutaneous or intravenous fluids if necessary. Seek advice re people with heart failure or Chronic kidney disease.
	Assess and monitor nutrition status involving the Dietitian where relevant. If the patient has <u>dentures</u> ensure they fit properly.
Medical	Assess and treat for infection.
	Assess for hypoxia and optimise oxygen saturation if necessary
Toxin	Carry out a medication review, taking into account the type and number of <u>medications</u>
	Consider Nicotine patches

Family visiting

- Minimise footfall through common areas.
- Garden spaces being used.
- Good communication challenged by:
 - PPE
 - Lack of physical contact



Links to publications

- **COVID in care homes—challenges and dilemmas in healthcare delivery:**

<https://academic.oup.com/ageing/article/doi/10.1093/ageing/afaa113/5836695>

- **COVID-19: Managing the COVID-19 pandemic in care homes for older people:**

<https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes>

- **SARS-CoV-2 infection, Clinical Features and Outcome of COVID-19 in United Kingdom nursing homes:**

[https://www.journalofinfection.com/article/S0163-4453\(20\)30348-0/pdf](https://www.journalofinfection.com/article/S0163-4453(20)30348-0/pdf)



Dr. Emma Vardy



Professor Adam Gordon



Helen Pratt



Dr. Mani Krishnan



Dr. Thomas Jackson

Panel Q&A

Final reflections

Professor Alistair Burns, National Clinical
Director for Dementia, NHS England and
Improvement