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

INSTITUTE OF INFLAMMATION AND AGEING

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

NHS
University Hospitals Birmingham
NHS Foundation Trust

COVID-19 and delirium

Collective wisdom

Anecdote based medicine

Pattern recognition

Publication

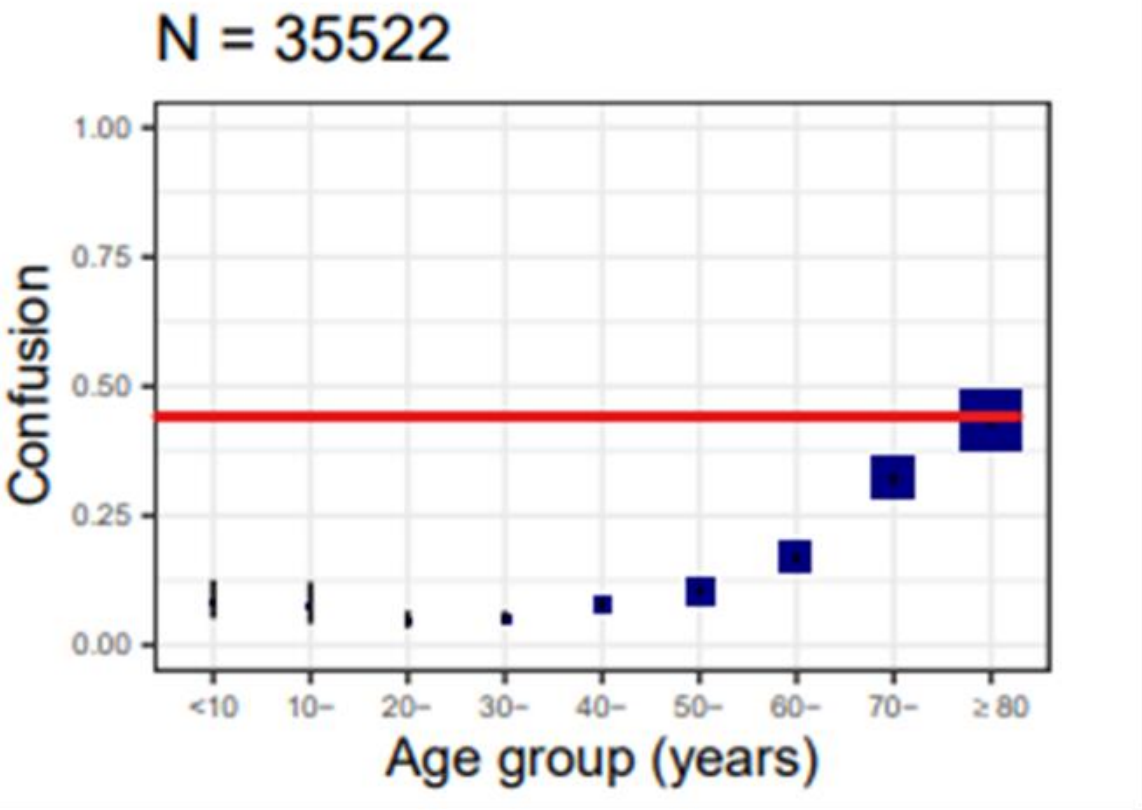
Peer reviewed publications

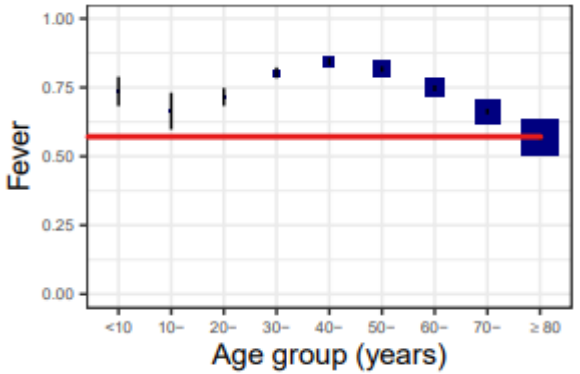
COVID-19 infection presentations

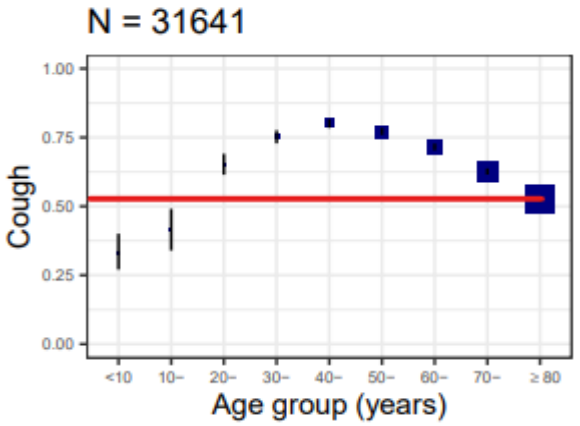
Fever and persistent cough

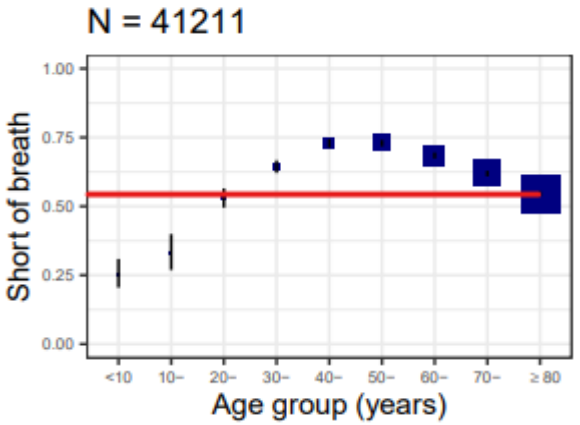
Atypical presentations

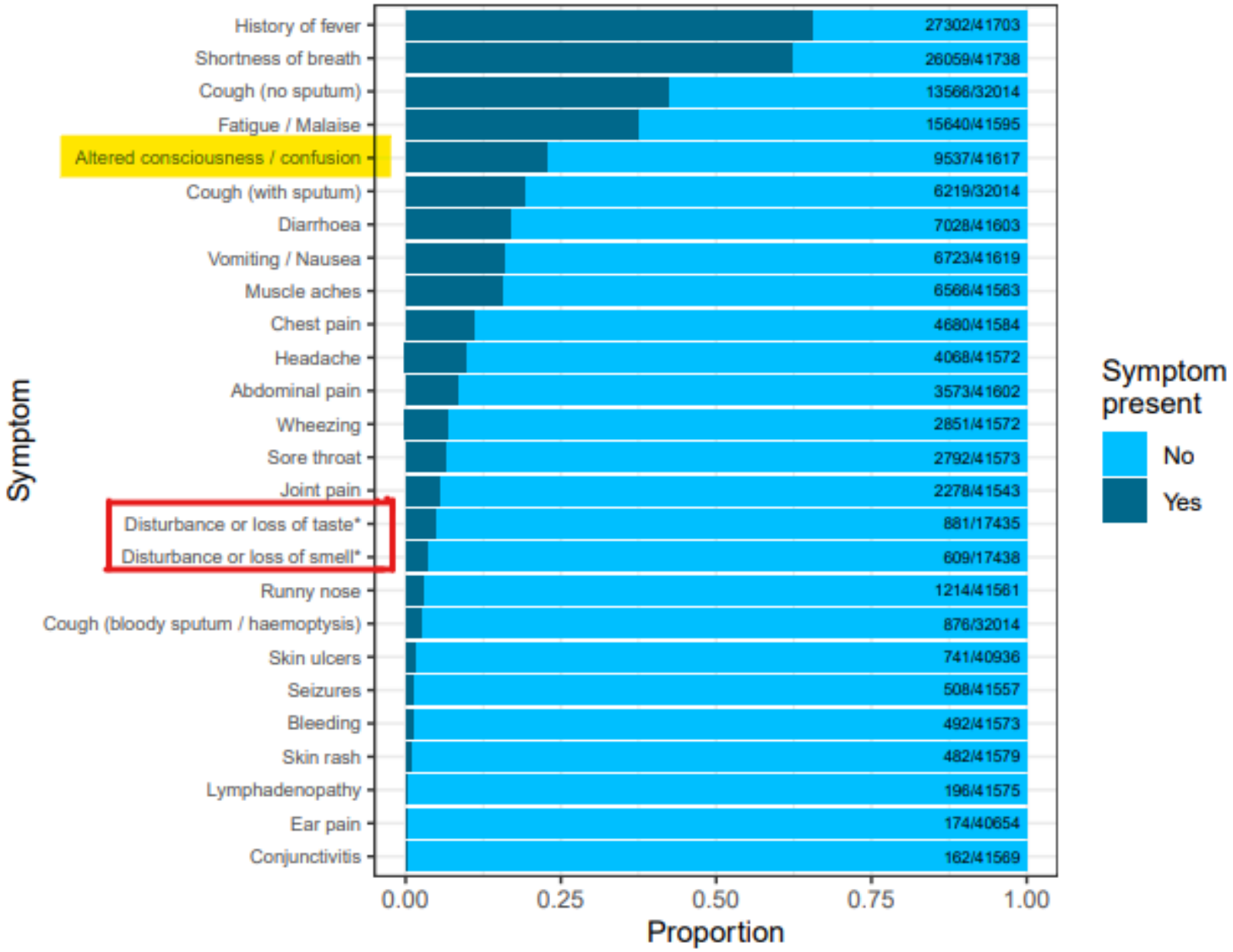
With ↑ age - ↓ ‘typical symptoms - ↑ ‘confusion


N = 35522
Confusion
1.00
0.75
0.50
0.25
0.00
<10
10–
20–
30–
40–
50–
60–
70–
≥ 80
Age group (years)


Fever
1.00
0.75
0.50
0.25
0.00
<10
10–
20–
30–
40–
50–
60–
70–
≥ 80
Age group (years)


N = 31641
Cough
1.00
0.75
0.50
0.25
0.00
<10
10–
20–
30–
40–
50–
60–
70–
≥ 80
Age group (years)


N = 41211
Short of breath
1.00
0.75
0.50
0.25
0.00
<10
10–
20–
30–
40–
50–
60–
70–
≥ 80
Age group (years)


History of fever
Shortness of breath
Cough (no sputum)
Fatigue / Malaise
Altered consciousness / confusion
Cough (with sputum)
Diarrhoea
Vomiting / Nausea
Muscle aches
Chest pain
Headache
Abdominal pain
Wheezing
Sore throat
Joint pain
Disturbance or loss of taste*
Disturbance or loss of smell*
Runny nose
Cough (bloody sputum / haemoptysis)
Skin ulcers
Seizures
Bleeding
Skin rash
Lymphadenopathy
Ear pain
Conjunctivitis
27302/41703
26059/41738
13566/32014
15640/41595
9537/41617
6219/32014
7028/41603
6723/41619
6566/41563
4680/41584
4068/41572
3573/41602
2851/41572
2792/41573
2278/41543
881/17435
609/17438
1214/41561
876/32014
741/40936
508/41557
492/41573
482/41579
196/41575
174/40654
162/41569
Symptom
0.00
0.25
0.50
0.75
1.00
Proportion
Symptom present
No
Yes

What is it?

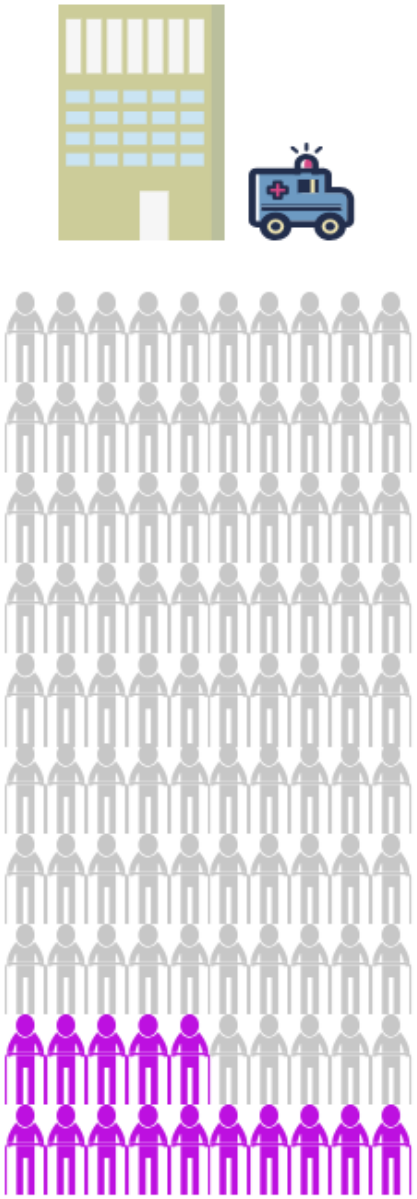
DSM-5

“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

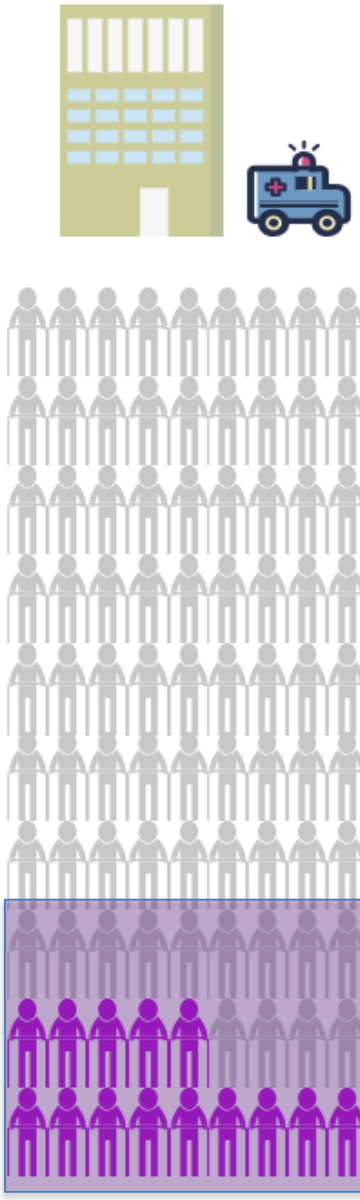


1507 UK Acute admissions >65 yrs.
Assessed in first 48 hours
Point prevalence - 15%

	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

Geriatric Medicine Research Collaborative 2019
BMC Medicine volume 17, Article number: 229 (2019)



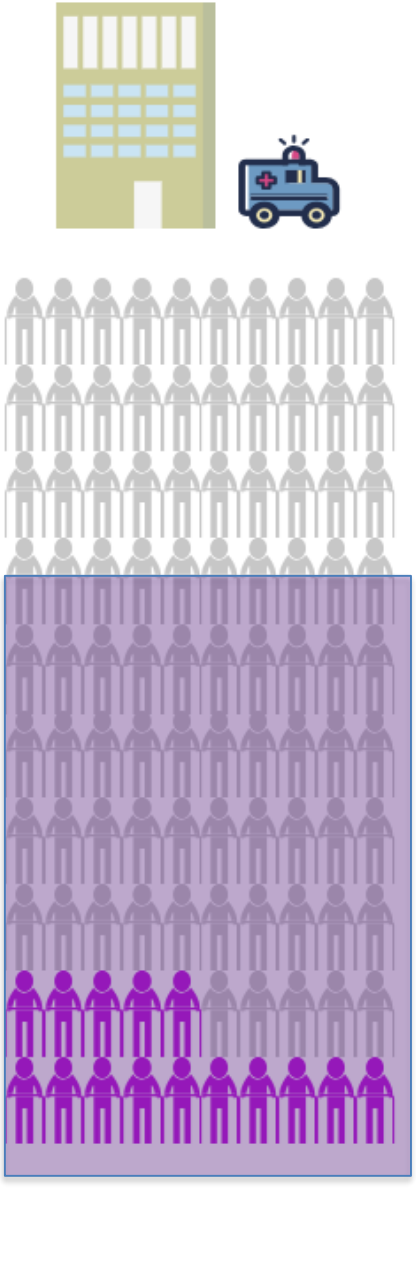
Delirium on admission in older people with COVID-19

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

J Nutr Health Aging. 2020 May 15 : 1–3.doi: 10.1007/s12603-020-1389-1

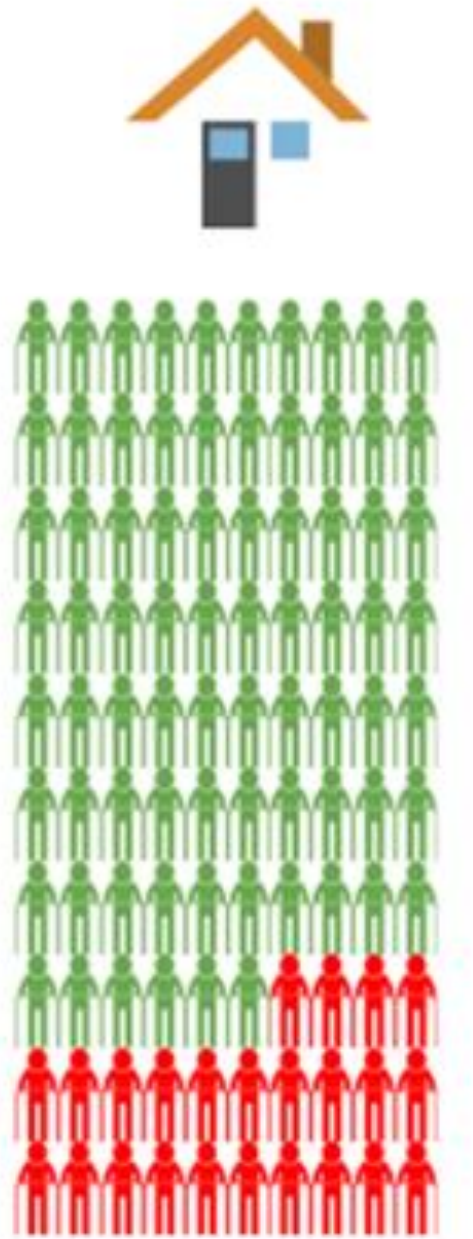
Delirium in ITU patients with COVID-19

Usually 20-80%

Pooled prevalence – 71%

Helms (n=53)	65%	USA
Khan (n=243)	73%	USA

Khan medRxiv 2020.05.31.20118679; doi: https://doi.org/10.1101/2020.05.31.20118679

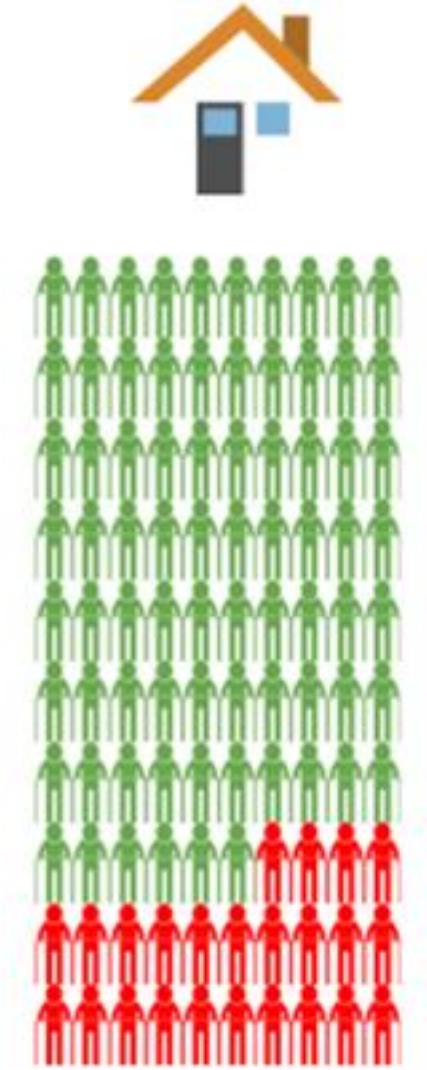


Confusion as a symptom of COVID-19 in older people with COVID-19

Prevalence – 36%

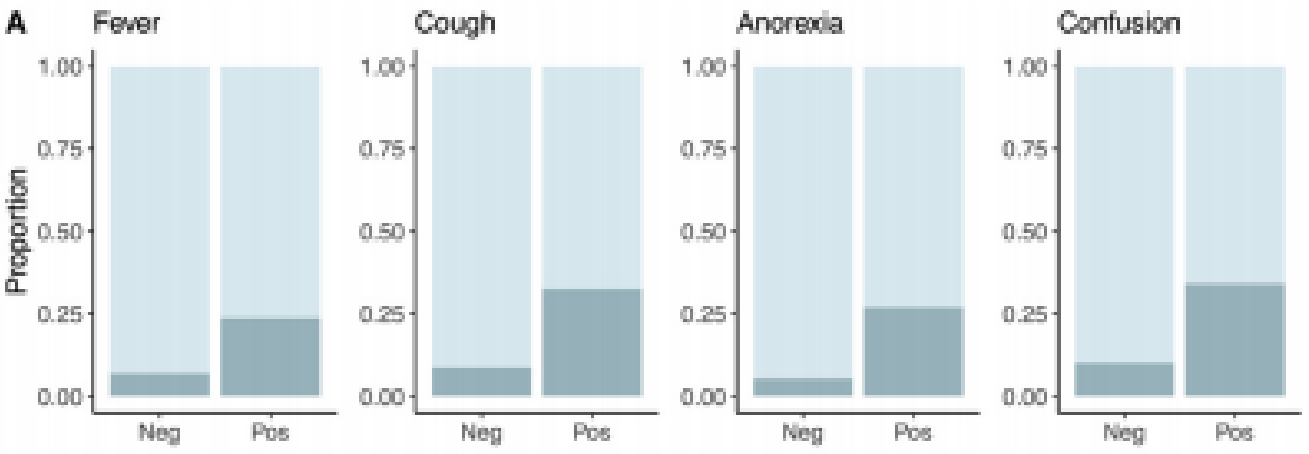
Zazzara (n=232)	**36%**	London (age matched to hospital study, app based)

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



Confusion in older people with COVID-19 in UK care homes

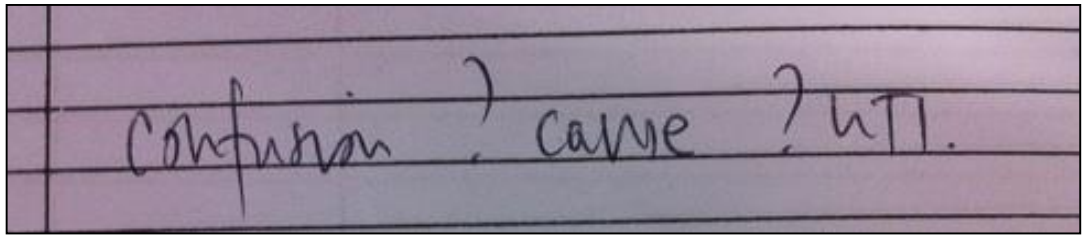
Prevalence – 34%



N.S.N. Graham, C. Junghans and R. Downes et al., SARS-CoV-2 infection, clinical features and outcome of COVID-19 in United Kingdom nursing homes, Journal of Infection, https://doi.org/10.1016/j.jinf.2020.05.073

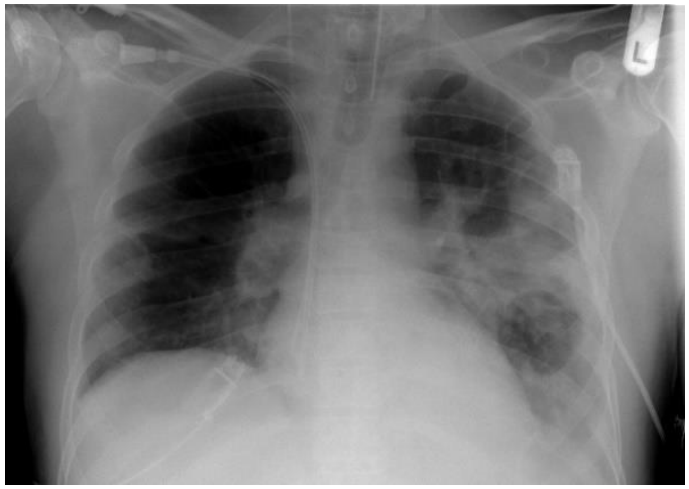
Delirium is not…

"…they're allowed to be a bit confused aren't they? Its what you expect…"



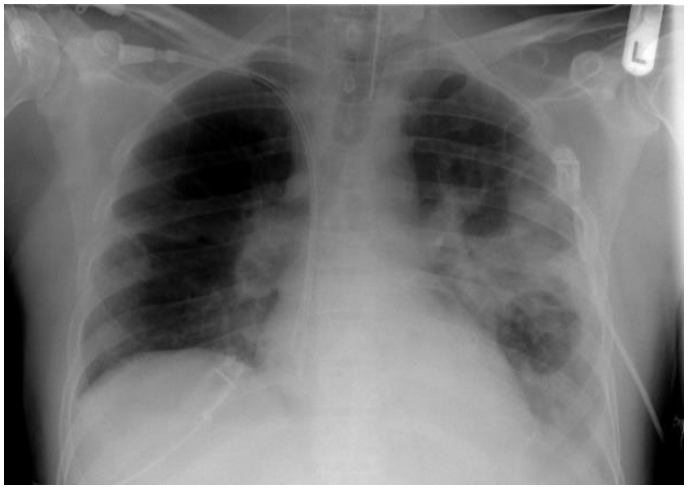
? COVID

80yrs♀ Mary



VS

80yrs♀ Martha



Delirium

No Delirium

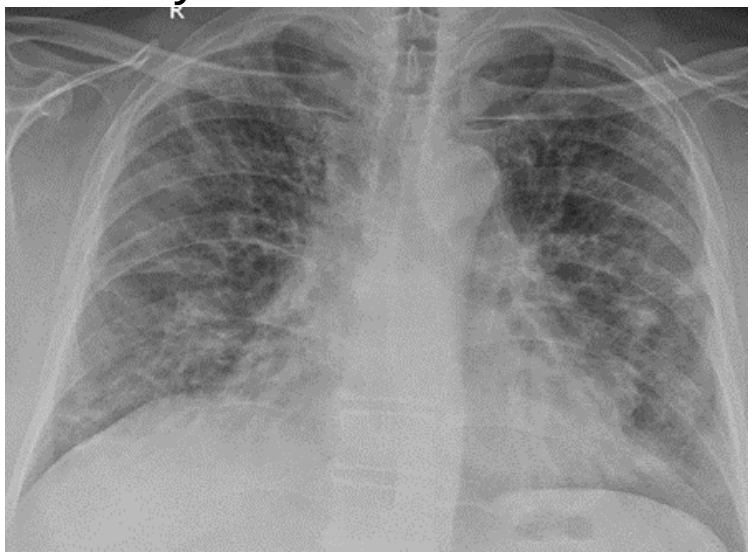
Pneumonia + same co-morbidity & acute illness

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

Distressing

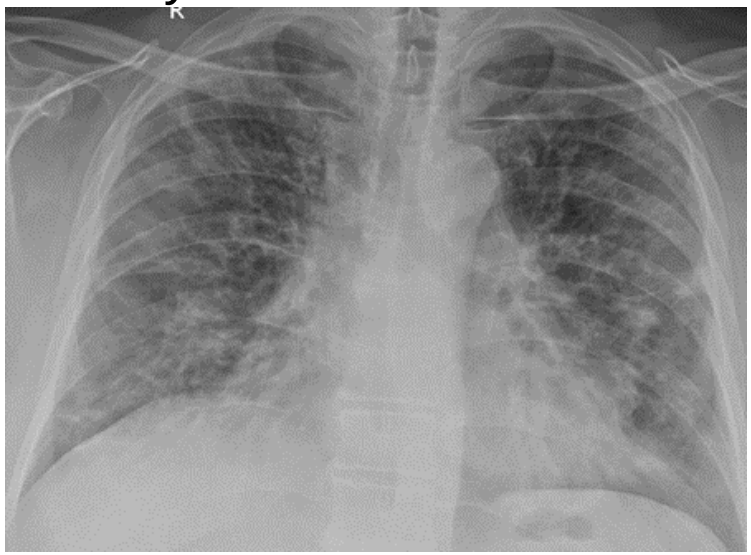
JAMA Psychiatry. 2017;74(3):244-251.
JAMA. 2010;304(4):443-51.

75yrs ♀ - Matthew



VS

75yrs ♀ - Mark



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

Knopp medRxiv 2020.06.07.20120527; doi: https://doi.org/10.1101/2020.06.07.20120527
Mcloughlin medRxiv 2020.06.07.20115188; doi: https://doi.org/10.1101/2020.06.07.20115188

More severe phenotype
Agitated, hyperactive
Distressed
Across age spectrum

Risk of harm greater
Risk to others - greater

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?

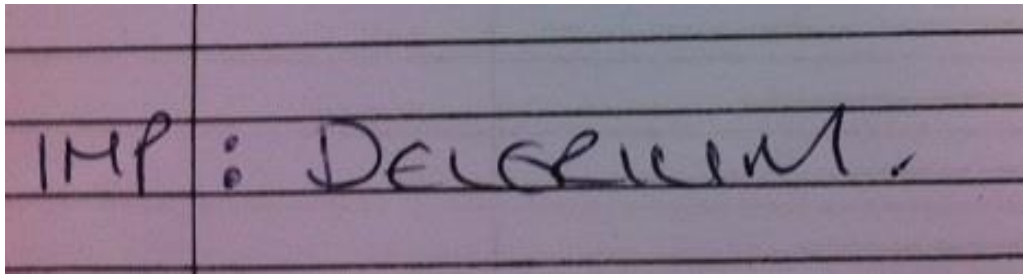
Change in baseline

- 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

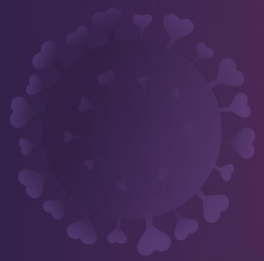
- Principles of Delirium Management
- What is different in COVID19
- Challenges
- Non-Pharmacological
- Pharmacological

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

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

Pharmacological

Medicine optimisation

Anticholinergic burden

Deprescribing

Consider drug interaction with antiviral

Avoid Polypharmacy

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

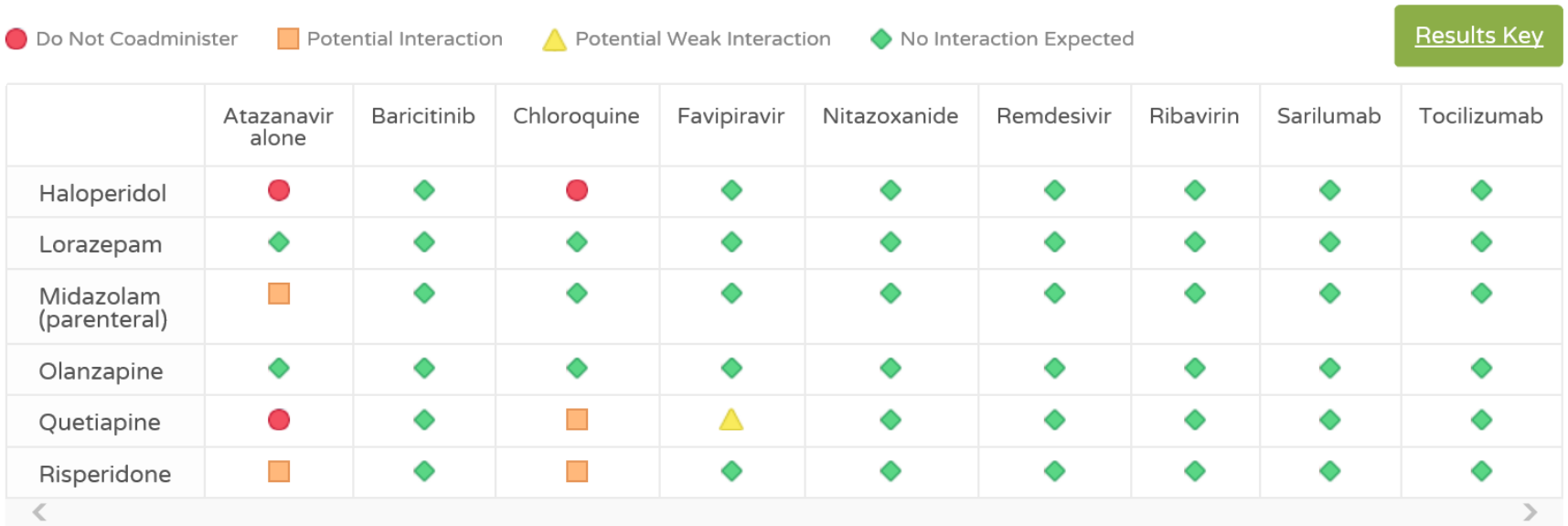
Stop the medication before discharge

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)



	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

CSH 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.

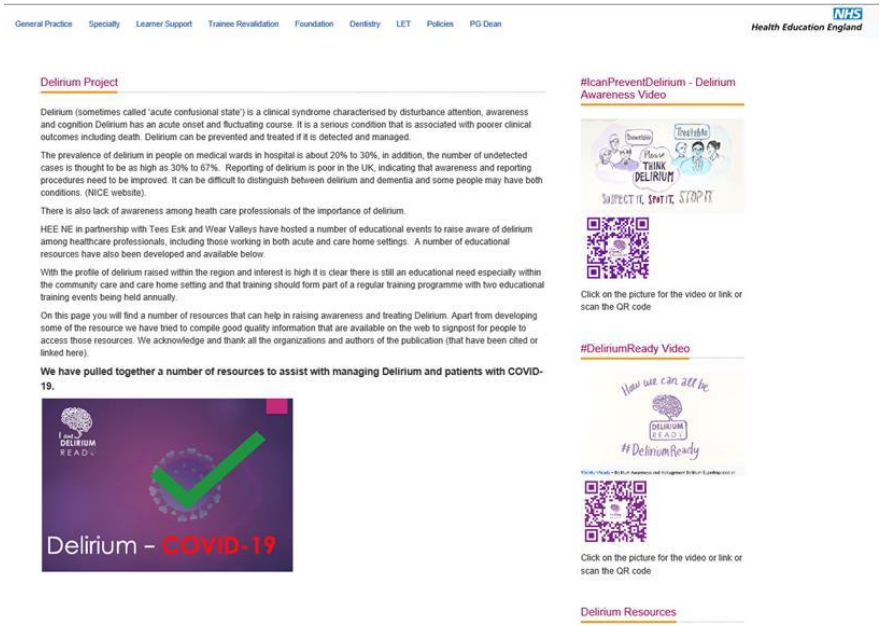
@charliemacksey

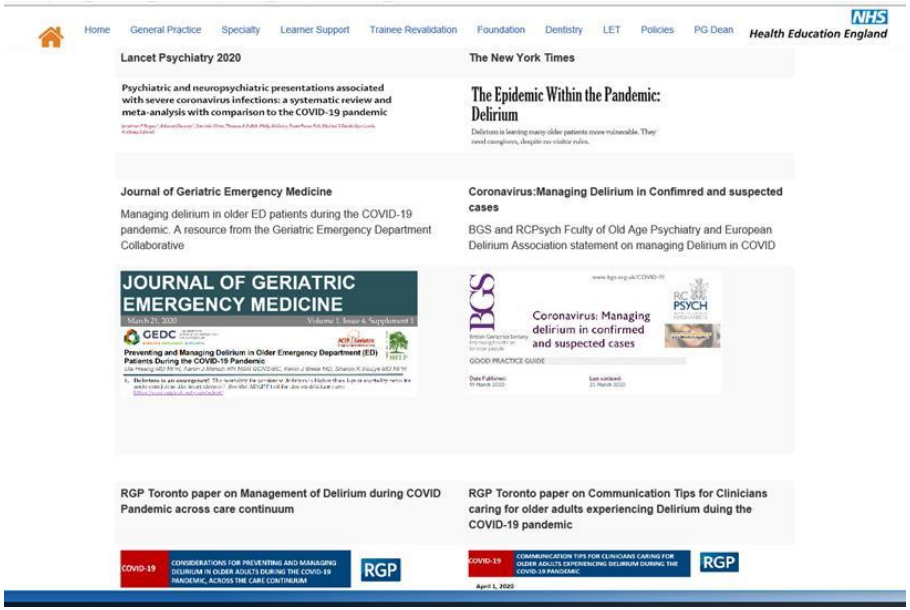
I CAN PREVENT DELIRIUM
DELIRIUM READY

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

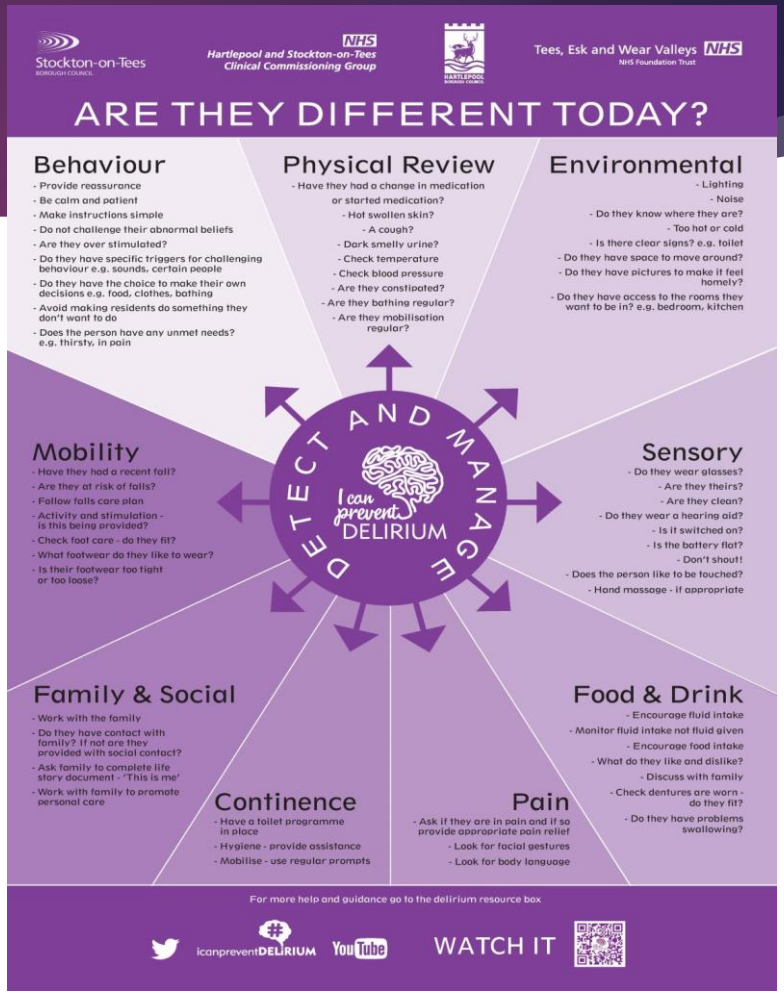
HEE NE Website





Resources

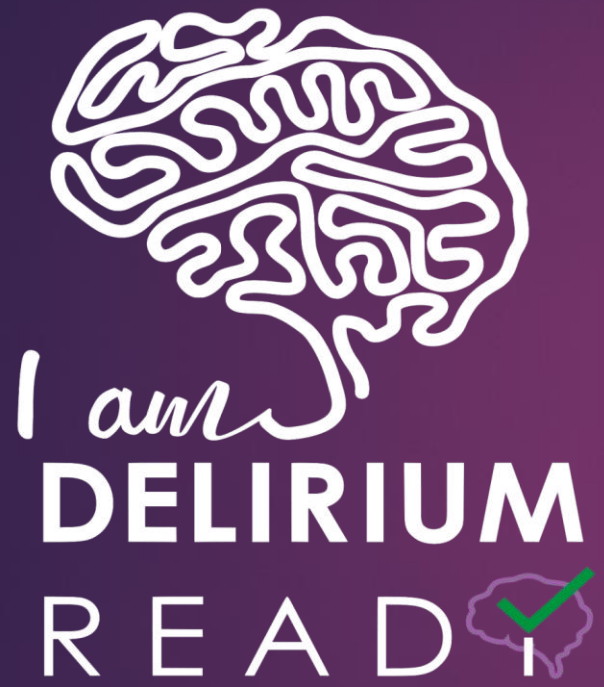

Tees, Esk and Wear Valleys NHS
NHS Foundation Trust
I can prevent DELIRIUM
DELIRIUM CAN BE PREVENTED AND TREATED
icanpreventDELIRIUM
SUSPECT IT
Age 75+
Cognitive impairment
Visual / hearing loss
Infection / dehydration
Pain / trauma
SPOT IT
Acute confusion
Poor concentration
Poor communication
Change in behaviour
Hallucinations
Fluctuations
STOP IT
Treat cause
Explain and reassure
Environment
Physical needs
Psychological needs
Social needs


Stockton-on-Tees
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
DETECT AND MANAGE
I can prevent DELIRIUM
Mobility
- Have they had a recent fall?
- Are they at risk of falls?
- Follow falls care plan
- Activity and stimulation - is this being provided?
- Check foot care - do they fit?
- What footwear do they like to wear?
- Is their footwear too tight or too loose?
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
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
Continence
- Have a toilet programme in place
- Hygiene - provide assistance
- Mobilise - use regular prompts
Pain
- Ask if they are in pain and if so provide appropriate pain relief
- Look for facial gestures
- Look for body language
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?
For more help and guidance go to the delirium resource box
icanpreventDELIRIUM
YouTube
WATCH IT

Delirium Educational Videos

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

https://youtu.be/BPfZgBmcQB8



Are you?

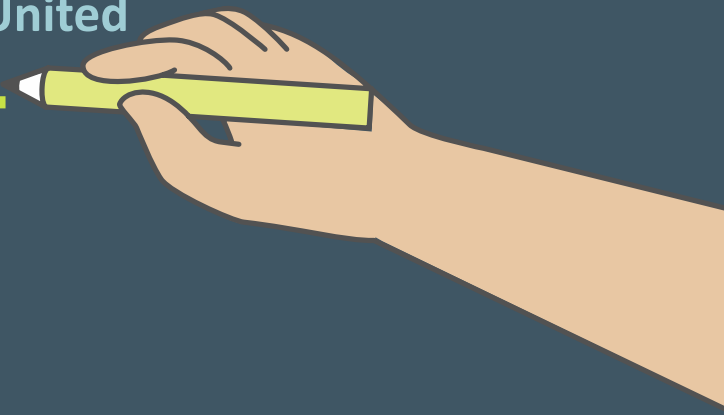
@Psychinformatic

Greater Manchester Health and Social Care Partnership

Dementia United

DELIRIUM – COMMUNITY PATHWAYS

Helen Pratt, Project Manager, Dementia United

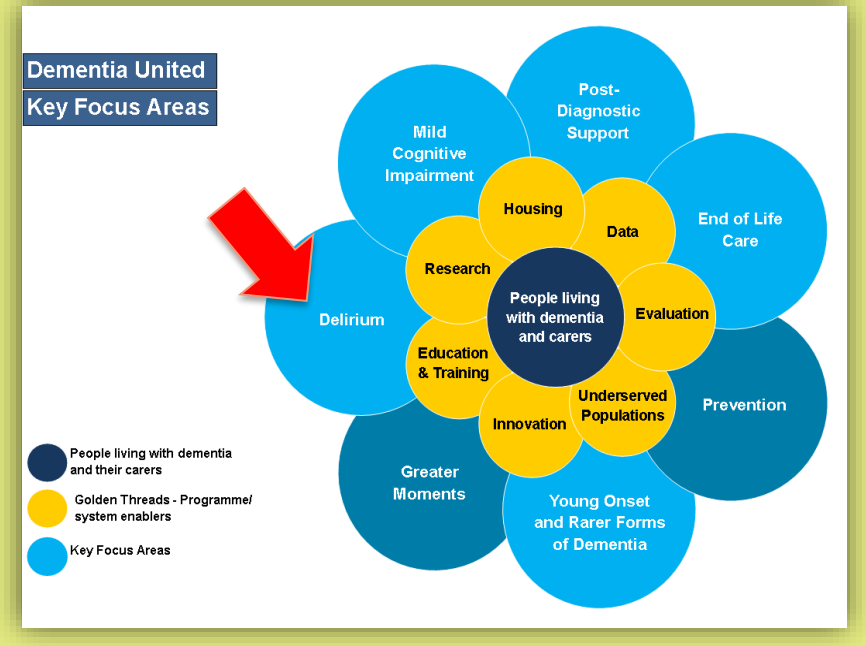


GMCA GREATER MANCHESTER COMBINED AUTHORITY

Tweet: @Dementiaunited

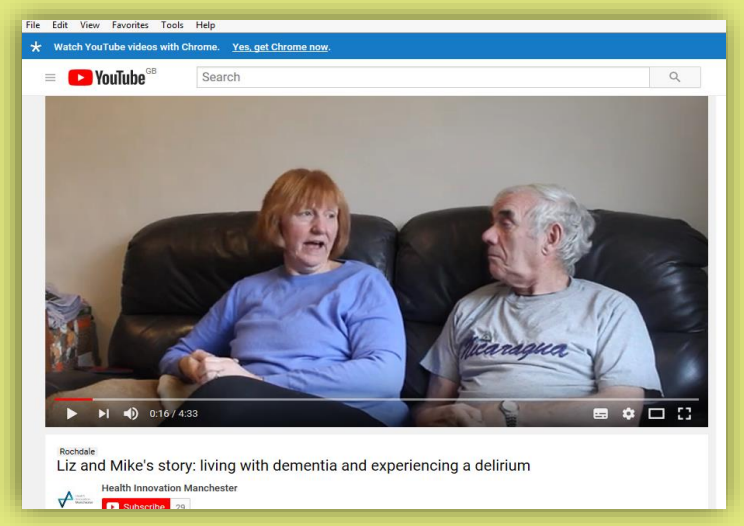
NHS in Greater Manchester

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.”

AIMS

Greater Manchester standardised pathway and approach

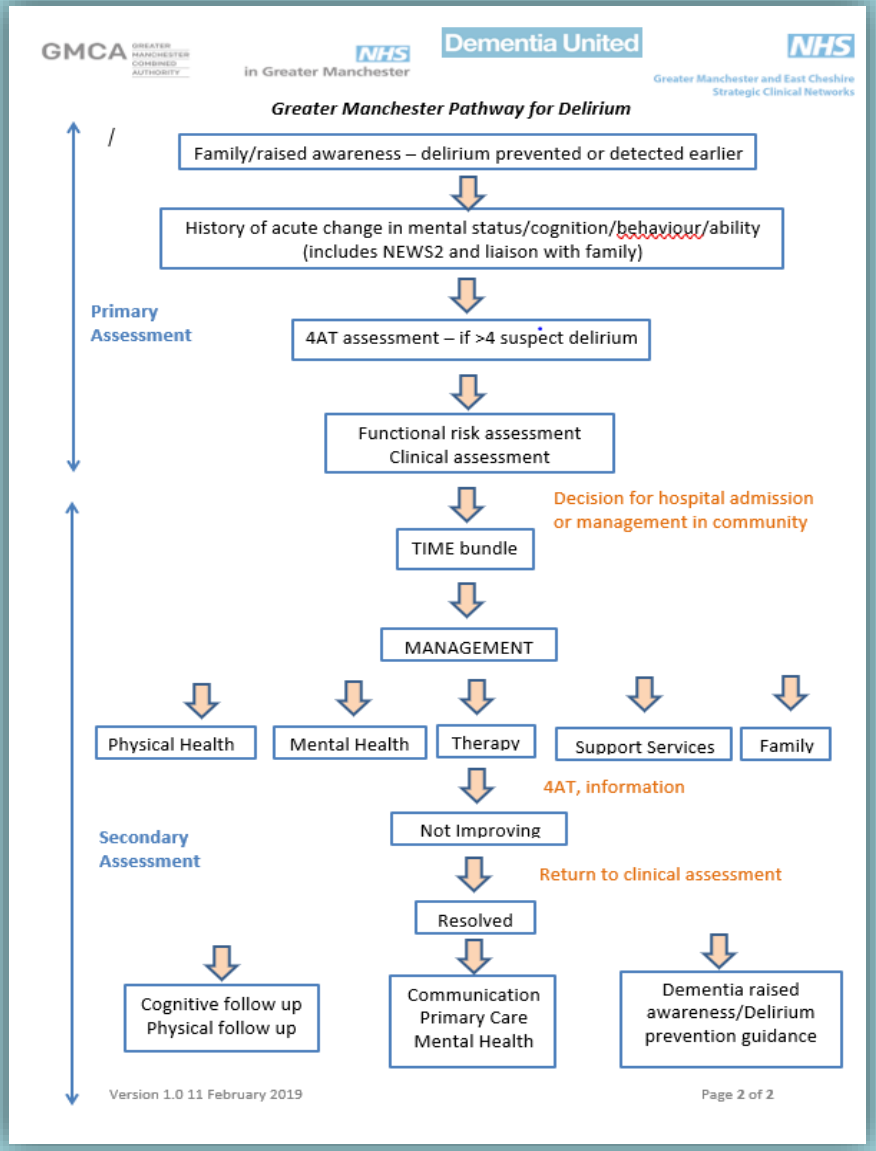
- Prevention
- Early identification and diagnosis
- Proactive management and follow-up
- Education and information

Transforming 'out of hospital care' with fully integrated community based care to support people with complex needs. [NHSE/I Ageing Well, Long Term Plan]

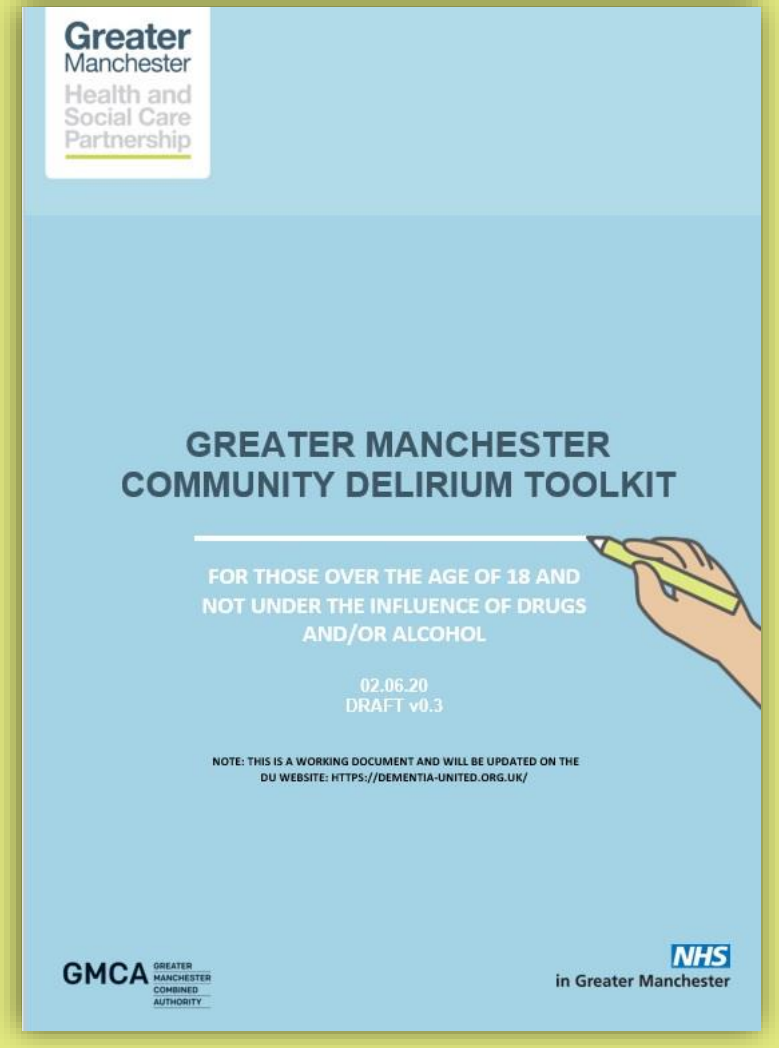
- Reduce unnecessary hospital admissions
- Improve prognosis with early detection

What we learnt from others

- With thanks to NHS Ayrshire and Arran for their Community Pathway, Healthcare Improvement/Scottish Delirium Association for Delirium Toolkit and TIME bundle



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..

Community Delirium toolkit

Test out with community teams with support from Dementia United

Dementia United report on findings from testing out/feedback

Lived experience feedback

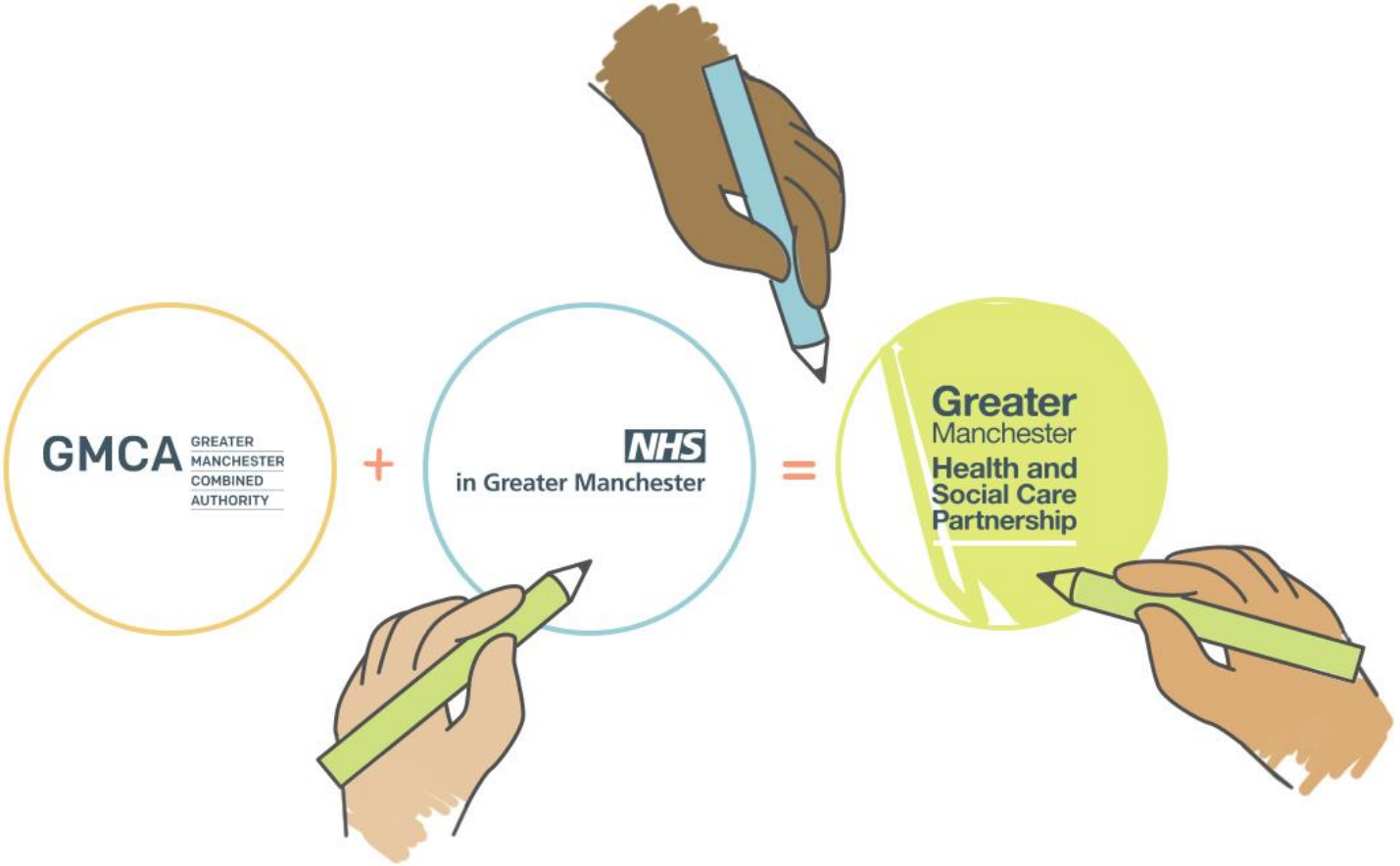
Further formal evaluation - scoping roll out

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

@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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Delirium, COVID-19 and Care Homes

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Age and Ageing 2020; 1–5
doi: 10.1093/ageing/afaa113

COMMENTARY

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

Adam L. Gordon[1,2], Claire Goodman[3,4], Wilco Achterberg[5], Robert O. Barker[6], Eileen Burns[7], Barbara Hanratty[6,8], Finbarr C. Martin[9], Julienne Meyer[10], Desmond O'Neill[11], Jos Schols[12], Karen Spilsbury[13]

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

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

GOOD PRACTICE GUIDE

Authors:

British Geriatrics Society

Date Published:

30 March 2020

Last updated:

02 June 2020

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

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

Neil SN Graham, Cornelia Junghans, Rawlda 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

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

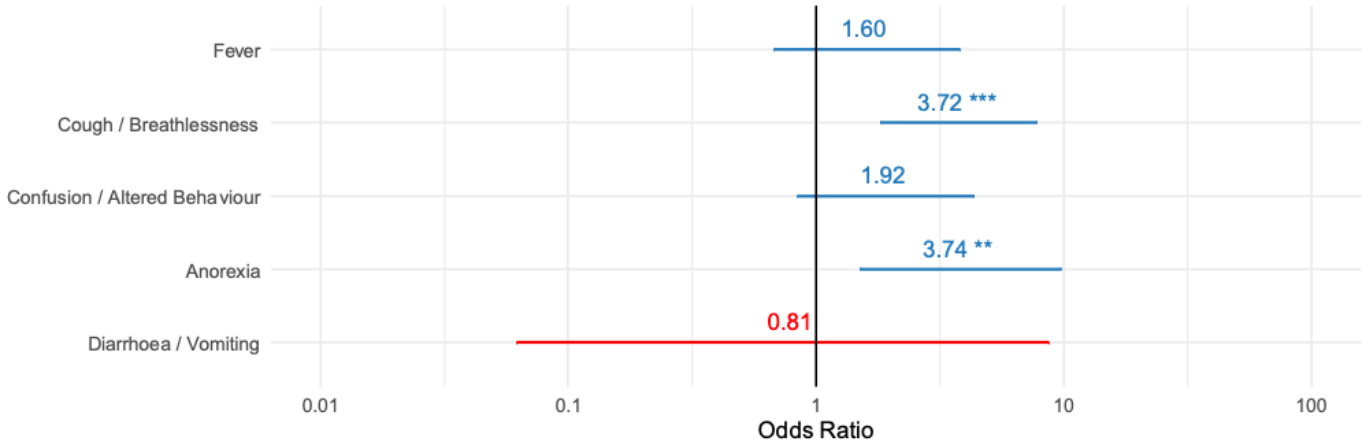


*Figure 3. Relationship of symptom in preceding two weeks to a positive SARS-CoV-2 result in all residents tested (n=313), displayed as adjusted odds ratios with 95% confidence intervals. Significant predictors in model indicated by ** P<0·01; *** P<0·001.*

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?

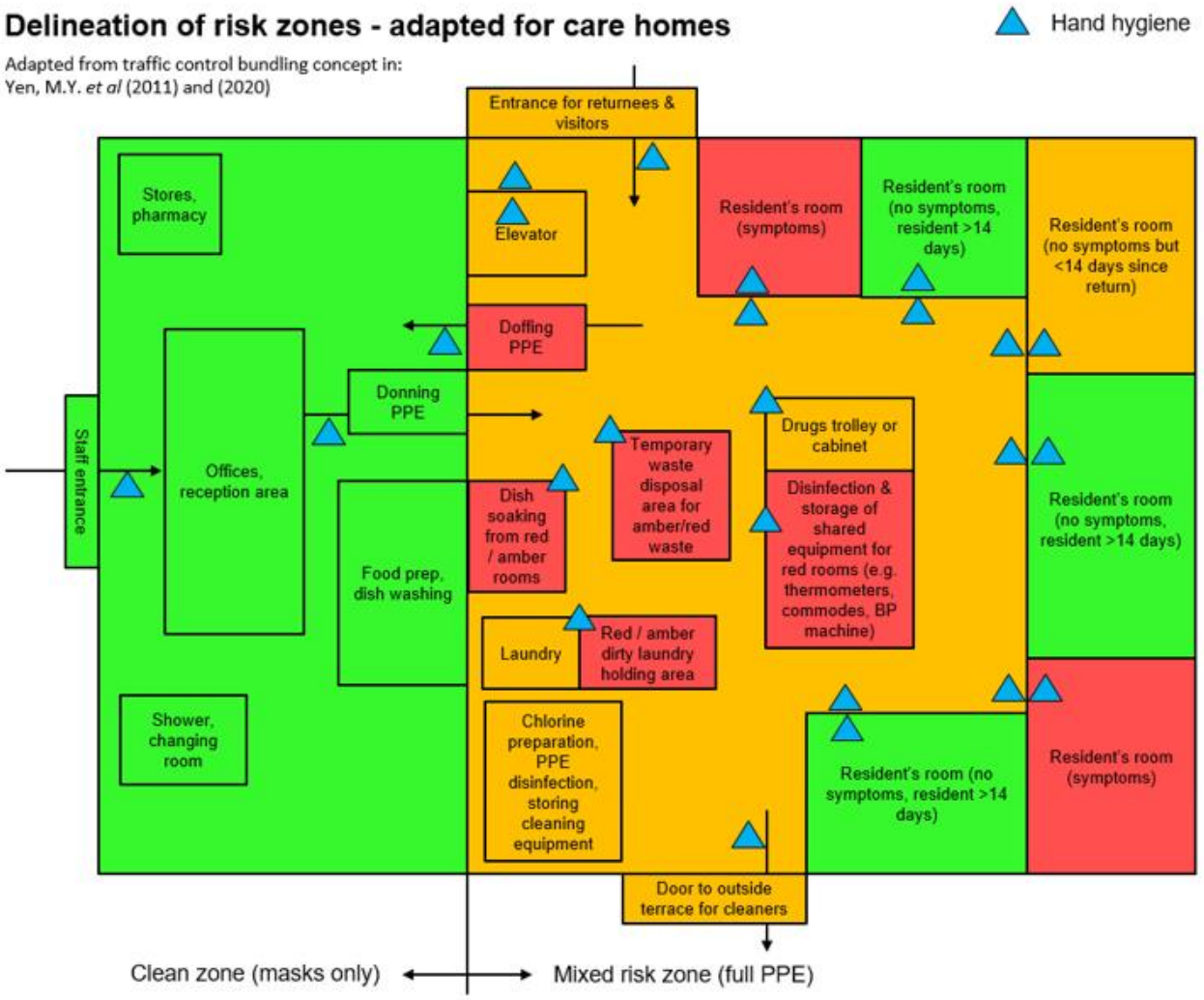
Isolation…

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.

BushProof

www.bushproof.com



https://ltccovid.org/2020/04/18/resource-care-homes-strategy-for-infection-prevention-control-of-covid-19-based-on-clear-delineation-of-risk-zones/

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 dentures 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 medications
	Consider Nicotine patches

Family visiting

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

MINDFUL NONVERBAL COMMUNICATION: ABC

A	B	C
ATTEND MINDFULLY	**BEHAVE CALMLY**	**COMMUNICATE CLEARLY**
• Create ritual to focus your attention to the encounter • Consider your usual gestures and body language	• Always approach patients from the front • Drop down to eye level • Project a positive attitude	• Speak slower, louder, or more deeply • Underline your words with gestures • Mirror their mood

Infographic by florianmueck.com

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

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