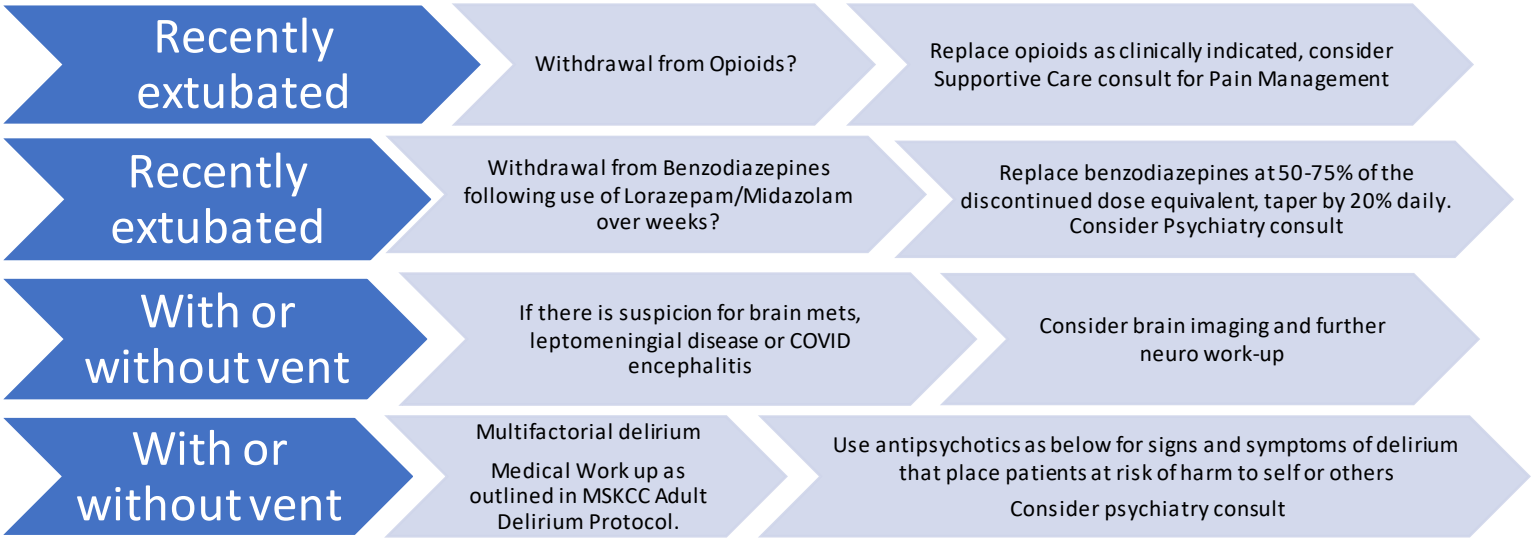
Adult COVID-19 Delirium Management Guidelines

(Outside of Critical Care Settings)

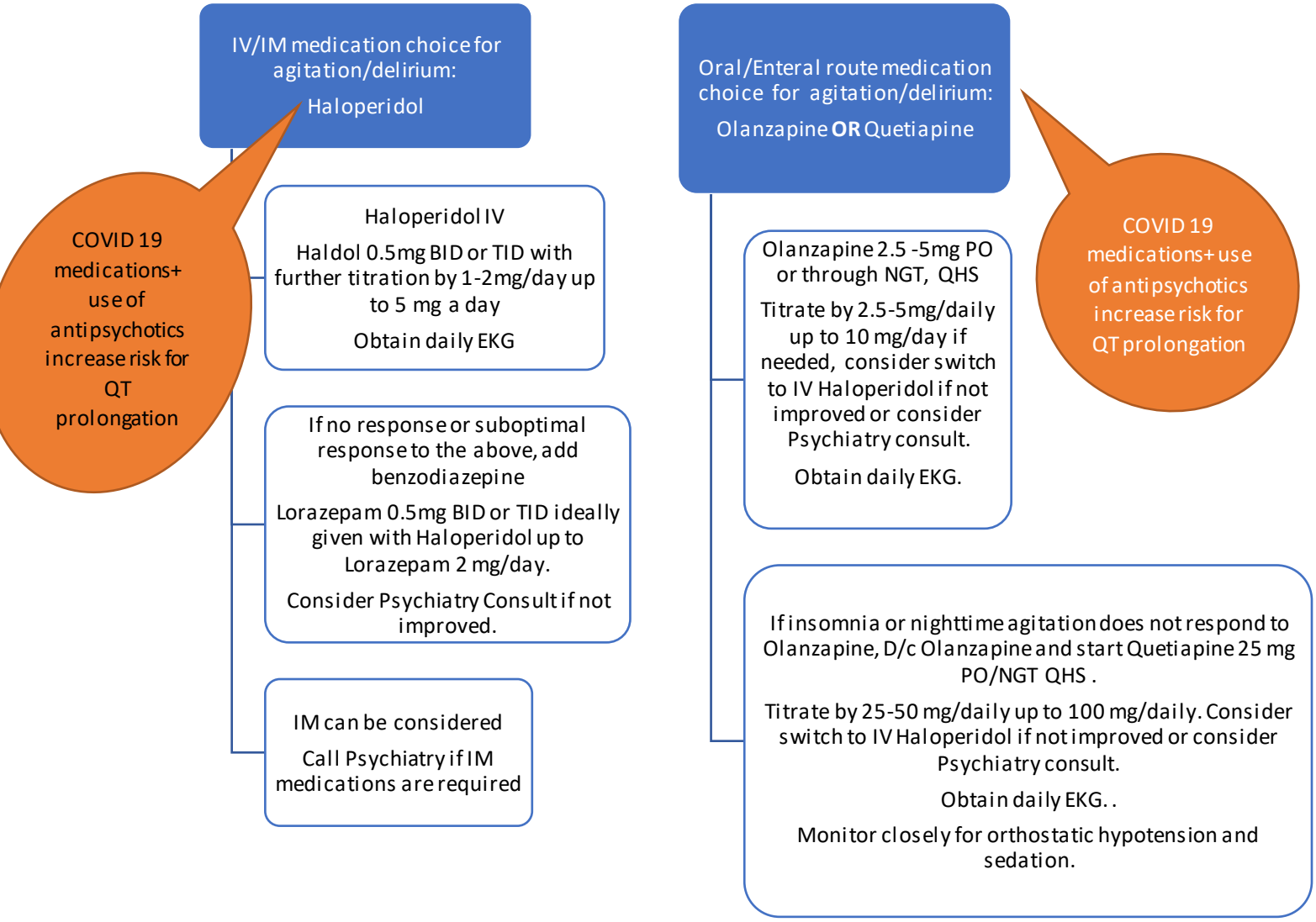
DELIRIUM IS A NEUROPSYCHIATRIC SYNDROME THAT OCCURS SECONDARY TO MEDICAL ETIOLOGIES, MEDICATIONS, AND/OR WITHDRAWAL STATES.

Refer to MSKCC Adult Delirium Protocol at https://one.mskcc.org/sites/pub/qa/Policies/Delirium%20Adult.pdf for information on screening, assessment, and non-pharmacological management of delirium.



Pharmacological Management of Delirium in Adult COVID-19 Patients Outside of Critical Care Settings

- **Obtain K^+, Mg^+, Ca^+, Vitamin B12, TSH, maintain K>4, and Mg>2** while on antipsychotics
- **Administer Thiamine 500 mg IV q8 for 3 days**
- **Obtain baseline and daily EKG**
- **If patients can take PO or have enteral route otherwise -> Start Ramelteon 8 mg PO QHS**
- **For all patients with history of Parkinson's disease, parkinsonism, dementia, schizophrenia, intellectual disability, or bipolar disorder, consult Psychiatry for management of delirium.**
- **Please review all medication interactions and side effects on Lexicomp or FDA webpage before use**
- **When starting medications from the chart below, use combination of standing and 'PRN for agitation' orders to optimize management. Start low, go slow.**



Special Considerations

- Sedatives such as benzodiazepines are added to antipsychotics to assist with rapid sedation in a severely agitated patient and must be used judiciously as **benzodiazepines may increase risk of delirium.**
- Use of benzodiazepines is appropriate and required in patients with **alcohol and/or benzodiazepine withdrawal delirium.**
- **Antipsychotics are used for patients with delirium who are at risk of harm to self (e.g., pulling out oxygen mask) or others, or those patients who experience significant distress due to symptoms of delirium (e.g., disturbing hallucinations, paranoid delusions)**
- **For geriatric patients, use antipsychotics sparingly and start lower, go slower due to increased risk of antipsychotic side effects.**
- If using Hydroxychloroquine/Azithromycin: **The risk of QT prolongation** is further increased, especially with use of IV Haloperidol.
- **If using IV benzodiazepines for over a week during mechanical ventilation:** During the post-extubation stage, reduce standing benzodiazepine dose by 25 to 50%, and continue taper by 20% daily until discontinuation (**consider slower taper and using prn benzodiazepines if withdrawal is a concern).**
- Check daily for **extrapyramidal symptoms** (EPS) including **parkinsonism, dystonia, akathisia, and neuroleptic malignant syndrome daily** while on antipsychotics medications.
- For patients who **require prn IV haloperidol for episodes of severe agitation, consider standing oral haloperidol instead of oral olanzapine or oral quetiapine**, with the goal to use one antipsychotic medication.
- **Consider Psychiatry** consultation if agitation/delirium could not be managed despite **Olanzapine 10 mg daily, Quetiapine 100 mg/daily or Haldol 5 mg daily,** if there are concerns for antipsychotic side effects (e.g. EPS, QT prolongation), and if needed.

Taper and Discontinuation of Antipsychotics

- **If patient is not agitated for 24 hours,** reduce **Olanzapine** by 2.5-5 mg/ daily down to 2.5 mg/day. **The goal is to discontinue Olanzapine before discharge or shortly after.**
- **If patient is not agitated for 24 hours, reduce Quetiapine by 12.5-50 mg/ daily down to 25 mg/day. The goal is to discontinue Quetiapine before discharge or shortly after.**
- **If patient is not agitated for 24 hours**, reduce **Haloperidol** by 0.5-2 mg/daily down to 0.5 mg/day. **The goal is to discontinue Haloperidol before discharge or shortly after.**