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Interim guidance for health-care professionals and administrators providing hospital care to adult patients with cognitive impairment, in the context of COVID-19 pandemic

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Abstract

Objective: We developed interim guidance for the care of patients with cognitive impairment in hospital during the COVID-19 pandemic.

Methods: A Guidance Committee and Readers Group were recruited. The content was identified by the Committee and content-specific subgroups, resulting in a draft document, which was sent to the Readers for review. People with dementia and care partners were involved in all aspects of the process.

Results: Infection control measures can lead to an escalation of distress. In an environment where visiting bans are applied to care partners/advocates, hospitals need to ensure care partners can continue to provide decision-making support. Health-care professionals can proactively engage care partners using videoconferencing technologies. Developing models of care that proactively support best practice can minimise the risk of delirium, mitigate escalating symptoms and guide the use of non-pharmacological, pharmacological (start low, go slow) or physical restraint in managing behavioural and psychological symptoms.

KEYWORDS
cognitive impairment, COVID-19, Hospital, physical and pharmacological restraints, delirium

1 | PATIENTS WITH COGNITIVE IMPAIRMENT IN HOSPITAL DURING COVID-19 PANDEMIC

Interim guidance for health-care professionals and administrators providing hospital care to adult patients with cognitive impairment, in the context of COVID-19 pandemic. More information at https://chsr.centre.uq.edu.au/interim-guidance-care-adult-patients-cognitive-impairment-requiring-hospital-care-during-covid-19-pandemic-australia

2 | COGNITIVE IMPAIRMENT MAY INCREASE DURING COVID-19

- COVID-19 can cause delirium

Cognitive Impairment and COVID-19, Hospital Care Guidance Committee Members are present in Appendix 1.

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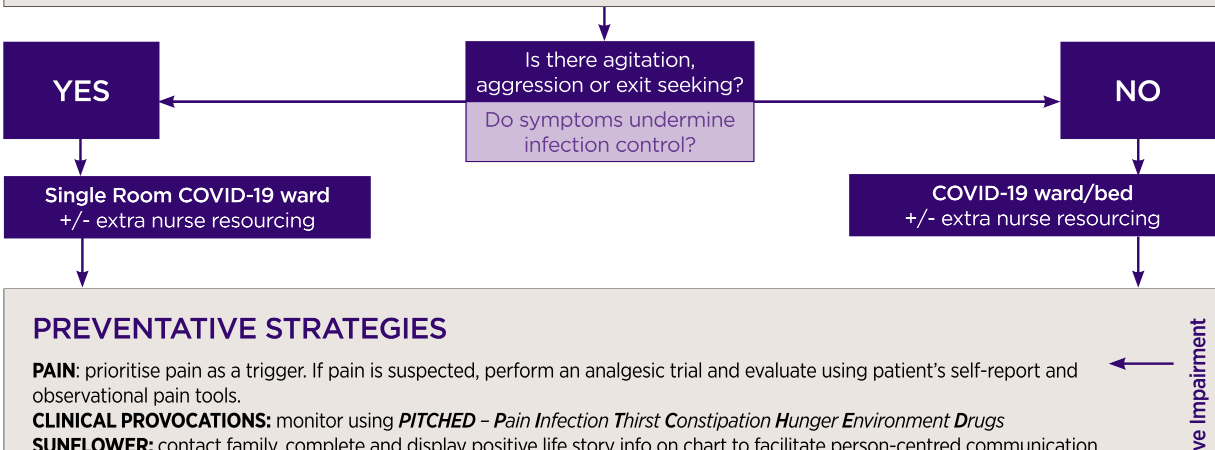
SCREEN TO IDENTIFY COGNITIVE IMPAIRMENT (including delirium)

- Use your facility (low contact) cognitive/delirium screen (e.g. 4AT, CAM)
- Determine any dementia, delirium, brain injury, intellectual disability (identify established diagnosis, history, concerns)
- Ensure all health care professionals are aware of the person's cognitive impairment



PREVENTATIVE STRATEGIES

PAIN: prioritise pain as a trigger. If pain is suspected, perform an analgesic trial and evaluate using patient's self-report and observational pain tools.
CLINICAL PROVOCATIONS: monitor using ***PITCHED*** – ***P****ain* ***I****nfection* ***T****hirst* ***C****onstipation* ***H****unger* ***E****nvironment* ***D****rugs*
SUNFLOWER: contact family, complete and display positive life story info on chart to facilitate person-centred communication
TOP 5: contact family and document in progress notes "Tell me 5 things I need to know about caring for (X)?
NORMALISE: attempt to normalise PPE context with regular calm orienting conversations. Wear name and photo on PPE
HEALTH LITERACY: where appropriate, individualise education about the situation
SOCIAL: plan for staff to spend periods of social time with patient, spaced out regularly across a shift (PPE limited)
ACTIVITY: encourage recreational activity. Ask families to provide an activity box (life story book & resources)
FAMILIARITY: use iPad to play video messages that family/friends have been encouraged to prerecord (1-2 minute message)

BEHAVIOURAL PLAN for acute, severe behaviour with immediate risk of harm

When symptom severity threatens safety for person or others and has not reduced with preventative strategies

Prescribe (in advance) PRN analgesia for possible pain related behaviour
Non-pharmacological strategies should be used first and medications used as the last option.

RESPONSE TO ACUTE, SEVERE BEHAVIOUR

Request extra assistance (if required)

Administer analgesia first, if any suspected reasons for pain (patients often unable to self-report)
Psychotropic medications may paradoxically worsen symptoms in some patients. (Use existing prescribed medications; Note cautions for Lewy Body Disease and Parkinson's Disease - Quetiapine has the lowest risk of causing significant extrapyramidal side effects in patients with Lewy body dementia and Parkinson's disease dementia).

Sedating agents carry considerable risk in acutely unwell patients, have limited evidence base and should be avoided
Studies have shown that older adults with dementia who take antipsychotics have an increased chance of death during treatment. Write cessation plan. Explain use and risks to person with cognitive impairment if feasible, and to care partner/advocate.

Some examples of medication doses (based on COVID-19 guidance from the British Geriatric Society and UK Royal College of Psychiatry, and using existing guidelines for delirium and dementia by the Royal Australian and New Zealand College of Psychiatrists, NPS Medicinewise, and the Australian Clinical Practice Guidelines) have been provided to highlight the importance of starting low and going slow when using medication in situations of acute deterioration.

1st line: **Haloperidol (IM or O) or risperidone 0.25 to 0.5 mg every 4 hours** up to a maximum of 2mg over 24 hours.
2nd line: If ineffective then small doses such as olanzapine (2.5 mg prn four hourly up to a maximum of 10mg over 24 hours) or quetiapine (12.5 mg to 25 mg prn four hourly up to a maximum of 100mg over 24 hours).

Benzodiazepines e.g. midazolam and lorazepam are best avoided considering respiratory depression in patients with COVID-19. If used, senior staff should be consulted and clear goals of care regarding ventilation and palliation established.

Adhere to organisation policies and legislative requirements National Guidelines:
Clinical practice guidelines and principles of care for people with dementia, Delirium Clinical Care Standard

FIGURE 1 Flow chart of COVID-19–related care decisions for people with cognitive impairment. The full 2-page version of this poster can be viewed in the article's Online Supporting Information.

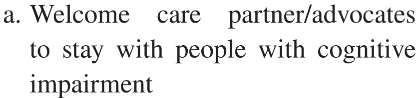
- Admissions may increase for patients with dementia or intellectual disability due to COVID-19 spatial isolation and reduced community resources
- Patients with any kind of cognitive impairment are at higher risk of complications and distress, for example adverse events, long length of stay, behavioural and psychological symptoms and death
- Higher risk warrants increased preventative strategies to reduce the risk of harm

3 | PEOPLE WITH COGNITIVE IMPAIRMENT MAY REQUIRE INNOVATIVE APPROACHES TO CARE BECAUSE OF:

- Inconsistent historians, comprehension of care requirements and remembering/following instructions
- Challenges in maintaining infection control principles (eg keeping mask on) due to the person experiencing anxiety, restlessness, breathlessness, exit-seeking behaviours/wandering, fear, agitation or aggression
- Limited access to their usual care partner/advocate (eg due to COVID-19 control measures or illness)
- Fear of people wearing PPE, which can be frightening and unfamiliar

4 | CLINICAL STRATEGIES TO MAINTAIN EFFICIENT, EFFECTIVE AND ETHICAL CARE

- Assess patients to identify contributing factors to delirium and factors that are treatable
  a. Manage hypoxia, pain, infection, dehydration, constipation, hunger and strange environments
  b. Reduce polypharmacy and tethers where possible (IVC, IDC and bed rails)
- Normalise infection control practices
  a. Use regular calm reorienting conversations, maintain calm demeanour, prioritise dignity and respect
  b. Provide sample packs of personal protective equipment (PPE) to enable patients' familiarisation
  c. Consider humanisation of staff by placing large print name labels and photographs on staff wearing PPE
  d. Consider the best environment for individual patients based on their acceptance of PPE
  e. Provide education on PPE and infection control to care partner/advocate who will be present in hospital



- Orient people with cognitive impairment t social reinforcement
  a. Welcome care partner/advocates to stay with people with cognitive impairment
  b. Document the 'Top 5' strategies that were requested by the person (or care partner/advocate) for help with their care in their medical record
  c. Place items in view (family photographs, music, phone and personal items)
  d. Encourage activity (life storybook/app, puzzles, fidget boards, towel folding and toolbox)
  e. Use human solutions (hearing and visual aids, music, pictures, TV and video)
  f. Support time orientation: day/night lighting; bedside clock/calendar; and assist with meals
  g. Promote the use of staff familiar to the patient; social and mobilising time
  h. Write down information and instructions for patients, use visible whiteboard
- Discuss and document goals of care

  a. Identify the lawful decision-maker if substitute decision-making is occurring
  b. Support shared decision-making, informed consent and advance care planning
  c. Plan comprehensive care based on the patient's goals of care, and in line with their values and preferences, ensure regular communication
  d. Focus on reablement, palliative care or end-of-life care as relevant
- Respond to any behavioural crisis (breach of infection control and aggressive behaviour) (Figure 1)

  a. Implement non-pharmacological strategies (as above)
  b. Medications should be avoided and used only in extreme circumstances in a timely manner with consent policies and procedures implemented, and cessation plan written

5 | GOVERNANCE STRATEGIES TO MAINTAIN EFFICIENT, EFFECTIVE AND ETHICAL CARE

- Review whole-of-hospital policy, procedures and guidelines, risk management systems, clinical and support staff training (Figure 1)
- Separate wards and staff with health-care workers skilled in managing cognitive impairment challenges
- Enable hospital avoidance strategies if safe to do so
- Enable hospital stay to include recovery, restorative care and rehabilitation

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CONFLICTS OF INTEREST

No conflicts of interest declared.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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APPENDIX 1

Cognitive Impairment and COVID-19, Hospital Care Guidance Committee Membership

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