Early management of delirium and agitation in palliative care

Kirkwood
The Hospice for Kirklees

Delirium is a broad neuropsychiatric syndrome which is defined as *disturbed consciousness, cognitive function or perception, which is acute in onset and follows a fluctuating course*. There are numerous potentially reversible causes of delirium. This guidance is for **early management** of delirium in palliative care patients who have **persistent symptoms despite assessment and treatment of any reversible causes**. For further information on the management of delirium and agitation at the end of life, please see MD171 End of Life Management of Delirium and Terminal Agitation in the Kirkwood Toolkit. Guidance on assessment of delirium has been produced by the British Geriatric Society (link on Sources of Information page). Please consider the person's capacity to make decisions regarding their care and treat in accordance with the Mental Capacity Act when necessary.

Initial management

ENVIRONMENTAL – Familiar environment, regular orientation, optimise vision & hearing, use communication aids where necessary

CONTRIBUTING FACTORS – treat urinary retention, constipation & pain. Optimise pressure area management. Try to maintain normal sleep-wake cycle where possible

EXPLANATION – Explain likely contributing factors and course to the affected person and their family

Pharmacological management

If the person is not in the terminal phase of their illness, the aim is to manage symptoms, **not to sedate**. The risk/benefit balance for each drug should be considered.

FIRST LINE: Antipsychotic

- Haloperidol 0.5-3mg PO or SC, once daily initially. Maximum dose 5mg/24hrs in the elderly and in renal failure. **Contraindicated in Parkinson's disease**
- If haloperidol unavailable:
    - In the elderly (or known dementia) – Risperidone 0.5mg PO ON. Maximum dose 1.5mg/24hrs. Available as tablet, orodispersible tablets or oral solution
    - In younger adults:
        - Olanzapine 2.5mg PO ON. Maximum dose 10mg/24hrs. Available as tablets or orodispersible
        - Quetiapine 12.5mg PO BD, increased as necessary in 12.5-25mg increments. Maximum dose 300mg/24hrs. Available as tablets or oral solution

SECOND LINE: Benzodiazepine

- Lorazepam 0.5-1mg sublingually PRN. Maximum dose 4mg/24hrs. Available as tablets (some forms can be used sublingually, check with pharmacy)
- If lorazepam unavailable: Diazepam 2-5mg PRN PO. Maximum dose 15mg/24hrs in 3 divided doses. Available as tablets, oral solution/suspension, rectal solution
- Please note benzodiazepines can exacerbate memory impairment.
- Use lower doses in hepatic impairment, neuromuscular conditions and obstructive sleep apneoa