End of life management of delirium and agitation

Kirkwood
The Hospice for Kirklees

This guidance is for management of delirium and agitation in those people who are **in the last days of life**, for whom treatment of reversible causes has either failed to control symptoms or is inappropriate. It may be for severe agitation that these drugs are used in combination.

Initial management

See MD170 Early management of delirium and agitation in palliative care (in the Kirkwood Toolkit) for advice on early assessment and management

Step 1: BENZODIAZEPINE

First choice: MIDAZOLAM SC

- If benzodiazepine naïve – use 2.5mg SC initial PRN dose and assess response
- If background midazolam dose ≥ 30mg/24hrs – use 5mg initial SC PRN dose
- If background midazolam dose ≥ 60mg/24hrs – use 10mg initial SC PRN dose
- Start a syringe driver based on PRN requirements and response. Max dose 100mg/24hrs

If midazolam unavailable: Consider use of second line antipsychotic if solely treating agitation. If benzodiazepine required for multiple symptoms, see below options

IF SYRINGE DRIVER UNAVAILABLE (or midazolam unavailable but use of a benzodiazepine is required) options include:

- **BUCCAL MIDAZOLAM** 2.5-10mg buccal dose PRN. Dosing as per SC midazolam. Maximum 100mg/24hrs
- **SUBLINGUAL LORAZEPAM** 0.5-1MG PRN. Maximum 4mg/24hrs in divided doses. Please note not all brands are for sublingual use
- **RECTAL DIAZEPAM** 2-5mg PRN, maximum 30mg/24hrs in 3 divided doses

Please speak to Kirkwood Hospice for further advice at any time or if symptoms persist

Step 2: Add in ANTIPSYCHOTIC

First choice: LEVOMEPROMAZINE OR HALOPERIDOL in addition to first line drug

If hallucinations predominate: Haloperidol SC

- For terminal agitation, dose 3-5mg SC
- Can be administered as OD dose or via a syringe driver given its long half- life and duration of action
- Maximum dose 10mg/24hrs. Will accumulate in renal failure and doses should be reduced

If agitation is severe or sedation is required: Levomepromazine SC

- For terminal agitation, dose 25-50mg SC (lower doses in renal failure)
- Can be administered via a syringe driver or as OD-BD daily dosing if syringe driver unavailable, given its long half- life and duration of action
- Maximum dose 300mg/24hrs

If injectable antipsychotics unavailable – see MD175 COVID-19: Care of the dying patient when unable to obtain a syringe driver – non-injectable alternatives in the Kirkwood Toolkit.

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Step 3 – Add in BARBITUATE

Phenobarbitone (Phenobarbital) 120-200mg IM can be administered in some cases of intractable distress at the end of life. Please MD172 and 174 COVID-19:Care of the dying patient when unable/able to obtain a syringe driver in the Kirkwood Toolkit for dose and administration guidance.

In the case of any doubt or for further advice please speak to Kirkwood Hospice.

At all stages in this process, please consider the person's mental capacity to make decisions regarding their care and act within the guidance of the Mental Capacity Act.

Further national guidance and information on the assessment of delirium and mental capacity is included in the links on the Sources of Information page on the Kirkwood Toolkit.

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