FACTSHEET: DELIRIUM & AGITATION

THE KIRKWOOD SUPPORT LIFE.

This guidance is for management of delirium in palliative care patients who have persistent symptoms despite assessment and treatment of any reversible causes.

INITIAL MANAGEMENT (ALL PATIENTS)

ENVIRONMENTAL – Familiar environment, regular orientation, optimise vision, hearing & communication

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

CAPACITY ASSESSMENT – Consider how decisions are being made and document accordingly

PHARMACOLOGICAL MANAGEMENT – NOT AT END OF LIFE

For those patients with delirium or agitation who are not anticipated to be at the end of life, and in whom reversible causes are being managed/excluded – the aim is to **manage symptoms, not to sedate.**

FIRST LINE: ANTIPSYCHOTIC

- **Haloperidol** 0.5-3mg PO or SC, once daily initially. Maximum dose 5mg/24hrs in the elderly and in renal failure. May reduce seizure threshold. **Contraindicated in Parkinson's disease.** Available as tablets, oral solution, or 5mg/ml solution for injection
- 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 tablets
    - **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 1mg tablets.
- If lorazepam unavailable: **Diazepam** 2-5mg PRN PO. Maximum dose 15mg/24hrs in 3 divided doses. Available as tablets, oral solution/suspension, rectal solution
- Benzodiazepines can have an amnesic effect and in some people can exacerbate confusion

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PHARMACOLOGICAL MANAGEMENT – LAST DAYS OF LIFE

THE KIRKWOOD SUPPORT LIFE.

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

STEP 1: START 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

STEP 2: ADD ANTIPSYCHOTIC

First choice: LEVOMEPROMAZINE or HALOPERIDOL (in addition to benzodiazepine)

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
- Dilute with WFI
- Maximum dose 10mg/24hrs (or 5mg/24hrs in renal failure)
- Will accumulate in renal failure and doses should be reduced
- May reduce seizure threshold, and is contraindicated in Parkinson's Disease

If agitation is severe or sedation is required: Levomepromazine SC

- For terminal agitation, initial 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
- Dilute with WFI
- Maximum dose 300mg/24hrs
- Has sedative side effects and can cause some SC irritation at higher doses

STEP 3: GET ADVICE

Please call **The Kirkwood 24 Hour Advice Line (01484 557910)** for specialist advice regarding further management options

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