St Vincent’s Palliative Care Services  
CCH DELIRIUM MANAGEMENT GUIDELINES

A palliative care supplement for the Caritas Christi Inpatient Units for the STV Delirium Management Guidelines, which are currently under review.

**Scope**
This guideline is for use within the Palliative Care Inpatient Units (Caritas Christi, Kew & Fitzroy Campuses) and the Palliative Care Consultation Service.

**Contents:**

1. Non pharmacological issues
   - Introduction
   - Communication with family/carers
   - Communication between staff
   - Patient needs

2. Pharmacological management of delirium
   - General considerations
   - Medication for mild delirium
   - Medication for moderate delirium
   - Medication for severe delirium
   - Medication for terminal delirium

3. Appendix 1: Delirium in the palliative care setting
1. Non Pharmacological issues to be considered together with Pharmacological Management

1.1 Introduction
Delirium is the acute or recent development of confusion and altered consciousness occurring in a fluctuating manner. Malignant disease, organ failure, patient comorbidities, pre-existing dementia, symptom issues such as pain, constipation & urine retention, as well as the process of dying makes delirium a very common diagnosis in a palliative care setting. It is a distressing experience for the individual, for carers and for staff and should be recognised and treated early. The delirium may persist even with appropriate management. Inadequately treated delirium at end-of-life leads to considerable bereavement issues for carers and staff. Investigation and treatment should always be considered, but if it is clear that death is occurring, a focus on easily reversible causes is a better approach and to use appropriate sedation. Medication management and the doses required may be in excess of those usually required or guided for in other hospital settings with non palliative care patients.

1.2 Communication with family/carers

- Engage the family, explain the issue(s) and encourage family members to sit with the patient as much as possible.
- The Palliative Care Victoria brochure “About: Confusion & terminal restlessness”, available at both CCH units, may be useful to provide

1.3 Communication between staff

- If agitated delirium is identified by staff member as an issue that needs addressing urgently a PCOC change of phase to “unstable-phase 2” should occur
  This means that:
  - The reporting staff member should initiate a documented PCOC assessment at the time
  - The patient history should reflect from the nursing staff what pharmacological and non pharmacological processes were tried and results of the actions
  - Handover the change of phase so the medical team is required to action the change as soon as practical
  - The medical personnel should communicate directly with the patient’s allocated nursing staff member in discussions formulating the actioned treatment plan.

1.4 Patient needs

- Move patient to a single room if possible
- Ensure patient is hydrated if possible
- Correct reversible factors
- Medical review of patient at least morning and afternoon when unstable
- Assessment of the patient, the recent history & their expected disease trajectory may determine if we are dealing with an acute delirium that requires stabilisation or a delirium of the terminal phase (terminal delirium) – this changes emphasis from correction & stabilisation of the delirium to provision of comfort and minimization of distress.
2. Pharmacological Management of Delirium, including terminal delirium and use of prn medication.

General considerations:

- The patient with an acute, severe delirium and an agitated delirium whilst dying should be considered a "medical emergency" and managed urgently.
- The quiet “pleasantly confused” or hypoactive delirious patient can change status rapidly, especially at night to become an acute, severe delirium and an agitated delirium.
- It is important to distinguish differing goals of care between patients who have a delirium, with some time to live and the goal of modifying the delirium and those who have a terminal delirium where the goal is only for rapid symptom management. This may need discussion with nursing staff & senior medical staff. The management plans are different for each type of delirium.
- Review and reverse opioid neurotoxicity, and review the other medications including Digoxin.
- Anticipate the need to escalate medication, both regular and prn doses if agitation persists.
- A patient with a persistent agitated delirium will have a baseline antipsychotic prescribed with regular prn doses of the same antipsychotic to stabilise mild to moderate acute exacerbations.
- The patient may also have “medical emergency” orders as well to assist if the acute exacerbations are severe. Medical staff, with advice from nursing staff should make sure there is provision of adequate and appropriate prn medications to allow staff to prevent a “medical emergency”.
- If the patient is known to have a history of delirium with proven episodes of severe agitation, appropriate prn need to be prescribed to cover this potential occurrence and appropriately identified as “medical emergency for severe delirium”.
- Benzodiazepines would not normally be prescribed for a new acute agitated delirium, unless there is a rationale for their use such as newly diagnosed terminal delirium. Benzodiazepine augmentation for severely agitated or terminal delirium – acts as a sedative and can minimise the extra-pyramidal side-effect of akathisia. Only use then in conjunction with neuroleptics after discussion with a senior doctor. Remember that benzodiazepines can cause a paradoxical excitation and worsening of the delirium.
- A patient may also have baseline and prn benzodiazepines prescribed for anxiety, sedation, poor sleep, seizure activity, myoclonus, symptomatic neuropathic pain, symptomatic dyspnoea or terminal delirium (restlessness).

Practical considerations:

- Prescribe medication so that it is obvious that one drug at xx dose is to be used for y doses, at z intervals until a particular dose is reached.
- Medical staff need to distinguish between the different uses for the same medication or 2 or more antipsychotics that may have different uses on the drug chart (both regular and prn) & have a separate order for each use i.e:
Example 1:

NOT ACCEPTABLE: haloperidol 0.5mg (for agitation/nausea)

ACCEPTABLE:
order 1: Haloperidol 0.5mg (for nausea)
order 2: Haloperidol 1mg (for agitation of delirium)
order 3: Haloperidol 5mg (for medical emergency of severe delirium)

Example 2:

NOT ACCEPTABLE: Midazolam 0.5mg (for anxiety/seizures)

ACCEPTABLE:
order 1: Mizazolam 0.5mg (for anxiety)
order 2: Mizazolam 2.5mg (for seizures)

Example 3:

NOT ACCEPTABLE: Haloperidol (agitation/nausea), Olanzapine (agitation)

ACCEPTABLE:
Order 1: Haloperidol (for nausea)
Order 2: Olanzapine (for agitation of delirium)

- The prn doses per 24 hours presented below in the tables for each drug are not meant to be ceiling doses, i.e. 4 doses per 24 hour or doses till a maximum amount should be interpreted as giving the doses until appropriate symptomatic response and not spacing them out over 24 hrs, once a maximum is reached move onto the next medication or contact the medical officer.

NOTE:

- Communication and review should be a priority each day between nursing & medical staff.

- The plan for the delirium management should be made by medical staff in the patient record.

- Nursing staff need to continue to provide a running record of responses to medication, patient’s ongoing mental state and behaviour, their assessment details, carer issues and nursing advice in the patient’s history.

Medication guidance for Mild Delirium –
Characterised by mild restlessness & confusion; e.g. patient calling out occasionally, possibly disturbing other patients, or removing bed clothes, or causing distress to family because the patient does not recognise the family member, or wants them to go away.

- Suggest using Haloperidol as first line, up to 5 mg total prn doses then get help.
- If using Olanzapine, up to 15 mg total prn doses and then get help.
- Benzodiazepines, no prn dose should be used for the delirium management, unless symptom issues arise for conditions when they have been previously prescribed (see above) or a new diagnosis of terminal delirium (restlessness) is made.

### Table 1: FOR MILD DELIRIUM

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indicative daily doses</th>
<th>“Regularly charted” prn doses</th>
<th>Prns for “Medical emergency for severe delirium”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>0.5-1.0mg BD-TDS, Oral or S/C</td>
<td>1.0 to 2.5mg, S/C every half hour, maximum 5mg per 24hrs</td>
<td>See Table 3 If severe episodes expected or occur, orders can also be written in addition but need to be clearly identified on medication chart.</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>2.5mg-5mg TDS-QID, S/L, Oral or S/C</td>
<td>2.5-5mg S/L, Oral or S/C every half hour, max 15mg per 24 hrs.</td>
<td>Once a total of 15mg has been given in prn form contact medical officer</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>None –see above notes &amp; Table 4: Terminal Delirium</td>
<td>None –see above notes &amp; Table 4: Terminal Delirium</td>
<td>None –see above notes &amp; Table 4: Terminal Delirium</td>
</tr>
<tr>
<td>Temazepam</td>
<td>Lorazepam</td>
<td>OXAZEPAM</td>
<td>Midazolam</td>
</tr>
<tr>
<td>Clonazepam</td>
<td>Temazepam</td>
<td>Lorazepam</td>
<td>Oxazepam</td>
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<tr>
<td></td>
<td></td>
<td>Midazolam</td>
<td>Clonazepam</td>
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Characterised by increasing agitation & restlessness, confused - can still be co-operative unpredictable: e.g. patient trying to get out of bed, quite noisy in longish bursts, incoherent, taking all clothes off, very disordered sleep wake cycle.

- Suggest use Haloperidol as first line, up to 10 mg dose then get help
- If Olanzapine then up to 30 mg and get help
- If Levomepromazine then up to 100 mg total prn doses and get help
- Benzodiazepines, no prn dose should be used for the delirium management, unless symptom issues arise for conditions when they have been previously prescribed (see above) or a newly diagnosed terminal delirium (restlessness) made.

### Table 2: FOR MODERATE DELIRIUM

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indicative daily doses</th>
<th>“Regularly charted” prn doses</th>
<th>Prns for “Medical emergency for severe delirium”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol</td>
<td>1.0 to 2.5mg BD-TDS Oral or S/C</td>
<td>2.5-7.5mg, S/C every half hour, maximum 20mg every 24 hrs</td>
<td>See Table 3</td>
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<tr>
<td></td>
<td></td>
<td>Once a total of 20mg has been given in prn form contact medical officer</td>
<td>If severe episodes expected or occur, orders can also be written in addition but need to be clearly identified on medication chart.</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>5.0mg-10mg TDS-QID Oral or S/C</td>
<td>5.0-10mg S/L, Oral or S/C every half hour, max 30mg per 24 hrs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Once a total of 30mg has been given in prn form contact medical officer</td>
<td></td>
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<tr>
<td>Levomepromazine</td>
<td>12.5mg-25mg BD-QID intermittent S/C or continuous infusion</td>
<td>12.5-25mg S/C every half hour, maximum 100mg per 24 hrs</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Once a total of 100mg has been given in prn form contact medical officer</td>
<td></td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td>None – see above notes &amp; Table 4: Terminal Delirium</td>
<td>None – see above notes &amp; Table 4: Terminal Delirium</td>
<td></td>
</tr>
<tr>
<td>Temazepam</td>
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<tr>
<td>Lorazepam</td>
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<td>Oxazepam</td>
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<td>Midazolam</td>
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<tr>
<td>Clonazepam</td>
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### Medication for severe delirium
Characterised by severe agitation with major aggression, not cooperative or able to be reasoned with: e.g. if mobile, patient constantly pacing around unit & patient may try to abscond from unit, if less mobile or normally bed dependent: patient trying to mobilise and falling on floor, or crawling on floor; risk of harm to themselves, other patients, relatives or staff.

- “Medical emergency of severe delirium” situation, prn use main focus and discussion with medical team, may require senior medical officer contact as soon as possible to confer.
- Assess if patient is in Terminal phase or not.
- Continue background antipsychotics previously used, assess need for cessation or continuation of background anxiolytics.
- Suggest start with Levomepromazine and move to Phenobarbitone reasonably quickly. Benzodiazepines can be introduced for delirium management at this stage if patient is actively dying, doses will be dependent of previous use and recent medication history.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indicative daily doses (Following medical emergency stabilisation)</th>
<th>“Regularly charted” prn doses</th>
<th>Prns for “Medical emergency for severe delirium”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levomepromazine</td>
<td>50 to 200mg every 24 hours</td>
<td>25mg</td>
<td>25 to 50mg initial dose then, every 30 minutes, maximum of 200mg per 24 hrs.</td>
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<tr>
<td>Phenobarbitone</td>
<td>600 to 1,200mg every 24 hours</td>
<td>100 to 200 mg</td>
<td>100 to 200mg initial dose, then 100-200mg every 60 mins, maximum of 2,400mg per 24 hrs</td>
</tr>
<tr>
<td>Benzodiazepine</td>
<td></td>
<td></td>
<td>Indicative doses only for severe terminal delirium.</td>
</tr>
<tr>
<td>Temazepam</td>
<td></td>
<td></td>
<td>Midazolam: 5-10mg initially S/C, every 30 minutes, maximum of 30mg per 24 hrs or</td>
</tr>
<tr>
<td>Lorazepam</td>
<td></td>
<td></td>
<td>Clonazepam: 0.5-1mg S/L or S/C every 30 minutes, maximum of 3mg per 24 hrs</td>
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<tr>
<td>Oxazepam</td>
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<td></td>
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<tr>
<td>Midazolam</td>
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<tr>
<td>Clonazepam</td>
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**Medication for TERMINAL delirium**
May be characterised by mild, moderate or severe symptomatology of delirium & may be a predictable transition or may occur unexpectedly and acutely. The severity of the delirium symptoms cannot be predicted & if severe should be stabilised as a “medical emergency of severe delirium” as soon as possible.

- The delirium needs to be assessed in context of patient’s current phase of care, recent history, predicted disease trajectory and symptoms developing associated with dying.
- Reassessment for new precipitating causes needs to occur i.e. full bladder, incontinence of urine or faeces into the bed sheets.
- Cessation of background oral/sublingual antipsychotics and anxiolytics may need to be considered as swallowing may have ceased but doses will need to be accounted for in consideration of dosing regimen prescribed for terminal delirium.
- For continuous S/C infusion may require:
  - Antipsychotics: haloperidol, levomepromazine or phenobarbitone
  - Anxiolytic: midazolam or clonazepam
- For prn medication: this will need to be guided by assessed level of delirium: Mild, Moderate or Severe and guide prescribing accordingly. Achieving both stabilisation of delirium and ongoing sedation in the last hours of life should be the priority.

3. Appendix 1 - Delirium in the palliative care setting

Clinical features

- altered conscious state
- attention deficit
- short-term memory disturbance
- impaired thought & judgement
- altered perception – visual illusions/hallucinations
- disturbed sleep-wake cycle - reversal
- incoherent or rambling speech
- affect disturbances – patient looks fearful or reports frightening dreams/visions
- abnormal behaviour
- abnormal psychomotor activity - hyper- or hypo-active or mixed
- acute/sub-acute onset, fluctuating course, nocturnal exacerbation

Common causes of delirium (almost always multifactorial)
- Medications – opioids, anticholinergic drugs, benzodiazepines, antidepressants, steroids, frusemide, TCAs, digoxin, antiparkinsonians, H2 antagonists, chemotherapy, anticonvulsants
- Infection
- Metabolic disturbances (Na, Ca, glucose, SIADH)
- Organ failure
- Hypoxia
- Anaemia
- Cerebral tumour – 1° or 2°
- Paraneoplastic syndromes
- Leptomeningeal infiltration
- Drug withdrawal (alcohol, benzodiazepines, opioids, steroids)

Types of delirium
- Not all the same – usually described in terms of activity level
- Prodromal - anxiety, irritability, dysphoria, sleep disturbance
- Hyperactive

Differential Diagnosis
- Dementia (NB co-existence 22-89%) (Lewy Body dementia can be similar)
- Psychosis
- Depression (hypoactive)
- Severe anxiety
- Dissociation
- Mania
- Terminal restlessness (a particular form of delirium)
- Dying (hypoactive)

References
1. Therapeutic Guidelines in Palliative Care, 3rd Edition, Melbourne 2010

Authorship Details

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
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<tr>
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<td><strong>Head of Department Responsible for policy:</strong></td>
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