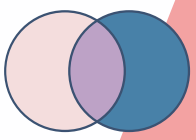
MANAGING AGITATION/ RESTLESSNESS/DELIRIUM

"Disorder of global cerebral dysfunction characterized by disturbances in attention, awareness, orientation, and cognition that develop of a short period of time and fluctuate in intensity and presentation over hours and days"

Adapted Assessment Acronym: OPQRSTUV (adapted from Fraser Health)	
Onset	When did it begin? Has it happened before?
Provoking/Palliating	Are there things that worsen the agitation? What makes it better? What makes it worse? How are you sleeping?
Quality	What does it feel like? Do you feel confused? Are you seeing or hearing anything unusual?
Region/Radiation	Do you know what day/month/year it is? Do you know where you are right now? Can you tell me your full name?
Severity	What is the intensity of the symptom (On a scale from 0 to 10 with 0 being none and 10 being worst possible)? Right now? At best? At worst? On average? How bothered are you by this symptom? Are there any other symptom(s) that accompany this symptom?
Treatment	What medications or treatments are you currently using? How effective are these? Do you have any side effects from the medications/treatments? What medications/treatments have you used in the past?
Understanding	What do you believe is causing this symptom? How is this symptom affecting you and/or your family?
Values	What is your goal for this symptom? What is your comfort goal or acceptable level for this symptom (On a scale from 0 to 10 with 0 being none and 10 being worst possible)? Are there any other views or feelings about this symptom that are important to you or your family?

SUBTYPES

- Hyperactive (30%): overactive
  - confusion, restlessness , agitation +/- hallucinations
- Hypoactive (48%): underactive
  - confusion, somnolence, withdrawn
  - underrecognized, often mistaken for depression/ EOL fatigue
- Mixed (22%): fluctuates between hyper/hypo



Decision to Investigate to look for underlying causes depends on several factors:
- stage of illness and disease burden
- reversibility of the cause
- availability and burden of investigations and treatments
- goals of care and individual's wishes and values

PHYSICAL ASSESSMENT

- vital signs
- hydration status, colour, fever
- breathing pattern, rate
- chest, abdomen
- myoclonus
- urinary retention, constipation, bowel obstruction

INVESTIGATIONS

- Bloodwork: Full blood count, electrolytes, Mg, Creatinine, Urea, Calcium, Albumin, Liver Function Tests
- Urinalysis and urine culture
- Head CT / MRI (for brain mass/disease)
- Chest XRAY (for pneumonia)

CONFUSION ASSESSMENT METHOD (CAM)

Feature 1: Acute Onset and Fluctuating Course
- Acute change in mental status from baseline?
- Behaviour fluctuate during the day? (Come and go; increase and decrease in severity)

Feature 2: Inattention
- Difficulty focusing attention? (easily distractible, difficulty keeping track of what is being said, can they count backwards from 20)

Feature 3: Disorganized Thinking
- Incoherent or disorganized thinking? (rambling, irrelevant conversation, unclear/illogical flow, unpredictable switching of topics)

Feature 4: Altered Level of Consciousness
- Vigilant (hyperalert); Lethargic (drowsy, easily aroused); Stupor (difficult to arouse); Coma (unarousable)

Positive CAM if YES to Feature 1 + 2 and either 3 or 4. Suggestive of delirium

MANAGING AGITATION/ RESTLESSNESS/DELIRIUM

CAUSES

D	Drugs, dehydration, depression
E	Electrolyte, endocrine, alcohol and/or drug use, abuse or withdrawal
L	Liver failure
I	Infection (UTI, pneumonia, sepsis)
R	Respiratory problems (hypoxia), retention of urine and/or stool
I	Increased ICP
U	Uremia, undertreated pain
M	Metabolic disease, mets to brain, med errors/omissions, malnutrition

Assess for and treat reversible causes (according to goals of care)

NON-PHARMOCOLOICAL MANAGEMENT

- Gentle, repeated reassurance. Avoid arguing
- Calm, quiet, well lit environment
- Frequent reorientation
- Engaging activities
- Use hearing aids / eyeglasses as needed
- Adequate oral hydration
- Good sleep hygiene
- Prevent over-stimulation
- Relaxation strategies
- Avoid physical restraints
- Correct reversible causes

MANAGEMENT CONSIDERATIONS

- Individualize decisions - Identify and treat underlying cause as appropriate and aligned with goals of care
- Manage symptoms
- Consider non-pharmacological management with all cases
- Provide education and reassurance to individual, family and care partners
- Don't only blame the opioids, look for other possible causes
- Remember to consider urinary retention and constipation as these are often missed
- Once symptom is controlled, try to find and maintain lowest effective dose

Pharmacological Management

Mild Delirium

- Non-pharmacological interventions are preferred
- Low dose Haloperidol PO/SC
- Low dose Methotrimeprazine (Nozinan) PO/SC
  - sedating
- Atypical antipsychotics
  - Risperidone, Quetiapine, Olanzapine

Moderate Delirium

- Use with non-pharmacological interventions
- Control quickly with PRN doses, may need regularly scheduled as well
- Haloperidol PO/SC
- Methotrimeprazine (Nozinan) PO/SC
- Atypical antipsychotics
  - Less options if SC needed
  - Quetiapine
  - Olanzapine appears less effective for severe delirium or in elderly

Severe Delirium

**Emergent Situation*

- Use with non-pharmacological interventions
- Control quickly with PRN doses, once under control add regularly scheduled
- Midazolam SC
  - For fast acting calming effects
  - consider antipsychotic medication at the same time
- Methotrimeprazine (Nozinan) PO/SC

References:
BC Centre for Palliative Care (2019). Inter-professional Palliative Symptom Management Guidelines
Cancer Care Ontario (2019). Symptom Management Algorithm
Pallium Palliative Pocketbook (2016)

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