**Confusion / Agitation in Palliative Care**

### Recognition
1. Acute onset and fluctuating course
2. Inattention - easily distracted
3. Disorientated to time/ place/ person
4. Disorganised thinking - rambling or irrelevant conversation, switching topics
5. Altered level of consciousness - hyperactive or hypoactive

### Causes - often multiple
- Can the cause(s) be identified?
- Is the cause(s) reversible? What is the patient’s prognosis?
- Is investigation or treatment of the cause(s) appropriate?

#### PAST HISTORY
- Dementia, other mental illness
- Cerebrovascular disease
- Brain tumour/secondary

#### DRUGS (many including:-)
- Opioid toxicity *(see Pain Guideline)*
- Corticosteroids
- Tricyclics and other antidepressants
- Neuroleptics
- Acute withdrawal of alcohol, nicotine, antidepressants, benzodiazepines, steroids etc.

#### PHYSICAL
- Uncontrolled pain
- Urinary retention
- Bleeding

#### METABOLIC
- Infection
- Hypoxia
- Uraemia
- Liver failure
- Hypercalcaemia
- Glucose (high or low)
- Low sodium, low magnesium
- Dehydration

#### PSYCHOLOGICAL DISTRESS
→ explore concerns of patient / family, if possible

### General Care
- **Maintain hydration** – use SC fluids if appropriate
- Try to nurse in a quiet, well lit environment and limit staff changes if possible
- Involve key family members and offer support and information
- Use lucid intervals to establish rapport and address fears/concerns
- Gentle, repeated reorientation where possible - use clock, calendar, schedule of daily routines
- Don’t confront deficits and communicate in a simple, clear, concise manner.
- Try to maintain a normal sleep-wake cycle
- Correct hypoxia, if possible

### Medication for treatment of confusion
- Review all medication and discontinue any non-essential drugs
- Use the minimum sedative medication necessary and regularly review the prescription
- Use the oral route if possible
- Withdraw sedative medication as the episode of confusion settles
- Use prophylactic treatment with a benzodiazepine in acute alcohol withdrawal
**Lothian Palliative Care Guidelines**

**NB** If the patient is very disturbed or fails to settle → seek advice

Do not assume the patient’s agitation is due to pain. Consider other causes.
Assess carefully – if evidence of opioid toxicity (see pain guideline) → reduce opioid dose by 1/3 + consider adjuvant therapies, if patient is in pain. Seek advice.

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**A Emergency sedation of an acutely agitated/disturbed patient**

- sedate with haloperidol 2.5-5mg IM
  +/- benzodiazepine eg. midazolam 2.5mg IM or diazepam (rectal solution) 5-10mg, PR
- repeat after 30 –60 minutes if needed
- maintenance treatment may be needed based on stat doses used
  (Patients who are larger and physically fit may need higher doses)

**B Delirium - may be hyperactive, hypoactive or mixed state**

(Benzodiazepines alone do not improve cognition in delirium, and may worsen it)

- use haloperidol: stat + prn ; 1.25-5mg, SC or 0.5-5mg, oral
  maintenance ; 2.5-10mg/ 24hrs, SC via a syringe driver or 0.5-3mg b.d, oral

**C Acute on chronic confusion eg in dementia, cerebrovascular disease**

- delirium – haloperidol as above
- chronic confusion - risperidone 0.25-1mg nocte, increasing gradually to 1mg bd, oral
- insomnia – trazodone 50-100mg nocte. (should be withdrawn gradually)

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**D Distressing restless/ agitation in the last days of life**

Sedation may be the most appropriate management
Opioid analgesics should not be used to sedate patients in the last days of life.

![Flowchart](chart.png)

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