Terminal restlessness in the aged care setting - it's all about having a plan

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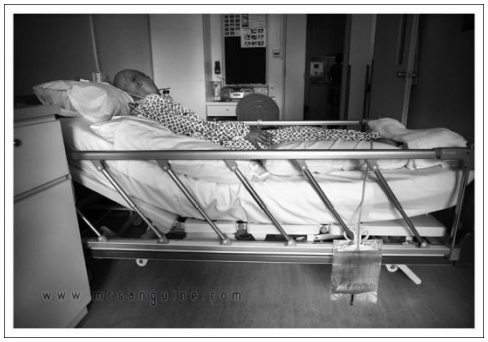
Restlessness and Agitation at the End of Life

Terminal delirium

- one third of patients admitted to a palliative care unit will have a delirium & up to 90% of those in terminal phase
- confusion & altered consciousness
  - disorientation
  - reduced attention and concentration
  - disorganised thinking and behaviour
  - memory deficits
  - perceptual disturbance (eg hallucinations)



- may fluctuate throughout the day and night
- may be expressed in the less conscious patient as groaning, motor restlessness, grimacing…

Multifactorial Causation

- no precise, potentially reversible cause found in ~50% cases
- contributing factors may include:
  - medications
    - those with CNS actions (opioids, benzodiazepines, tricyclic antidepressants, anticholinergics…)
    - corticosteroids
    - metabolites of morphine accumulate in renal failure
  - drug withdrawal (alcohol, opioids, benzodiazepines, nicotine)
  - uncontrolled pain
  - anxiety and anguish
  - organ failure, commonly renal or hepatic
  - metabolic causes: dehydration, hypercalcaemia & hypoglycaemia
  - urinary retention or constipation
  - infection
  - hypoxaemia
  - brain radiotherapy
  - pre-existing dementia or brain injury

Why address terminal restlessness and agitation?

Unrelieved restlessness and agitation:

- distresses the patient, their family & staff
- exacerbates other symptoms, esp pain
- may result in injury to the patient, family or staff
- is undignified
- ‘steals’ precious time

Approach to Restlessness and Agitation at the End of Life

- Recognise (especially if quiet) and act promptly
- Educate the patient (if possible), family and staff
- Address simply reversible contributors
  - pain, dyspnoea, rectal loading (PR), urinary retention (IDC)
- Consider contributing factors – investigate & treat if appropriate, but consider:
  - goals of care, stage of illness, burden to patient, patient's wishes, likelihood of reversibility & improved QOL

Approach to Restlessness and Agitation at the End of Life

Use pharmacological and non-pharmacological measures simultaneously:

- reassurance, reorientation, presence of familiar people or objects, peaceful room, music, avoid dark, avoid bright lights…
- cease or reduce non-essential medications
- use a neuroleptic (haloperidol, levomepromazine…) for delirium

Responding to Unusual Behaviour

- Do not dismiss, collude, react strongly or ridicule
- Gently & briefly acknowledge:
  - what the patient is likely to be experiencing
  - emotion or distress observed in the patient
- Reassure with brief re-orientating information
  - identify yourself (every time!)
  - what is happening
  - why you are here
  - what you are doing or about to do
- Allow time to process information
  - use simple & brief sentences
  - patient's response may be delayed

Approach to Restlessness and Agitation at the End of Life

- Unrelieved distress = palliative care emergency!
- However, sedation is not routinely a part of terminal care
- In the setting of pain or dyspnoea, it is never appropriate only to
  sedate the patient:

  - use opioids & anxiolytics to treat distress & panic due to dyspnoea
  - use regular opioids & other analgesics to treat pain
  - titrate with care, aiming for ‘comfortable but still rousable’
  - high doses may be needed

- Seek Palliative Care specialist advice if symptoms are difficult to control

Treatment of Restlessness and Agitation at the End of Life

- During terminal phase pharmacological therapy needs to be effective, quickly titrated & available subcutaneously
- Benzodiazepines have sedative, anxiolytic & anticonvulsant properties
- Midazolam is the local drug of choice
- Less prominent role for anti-psychotics when patient is unconscious

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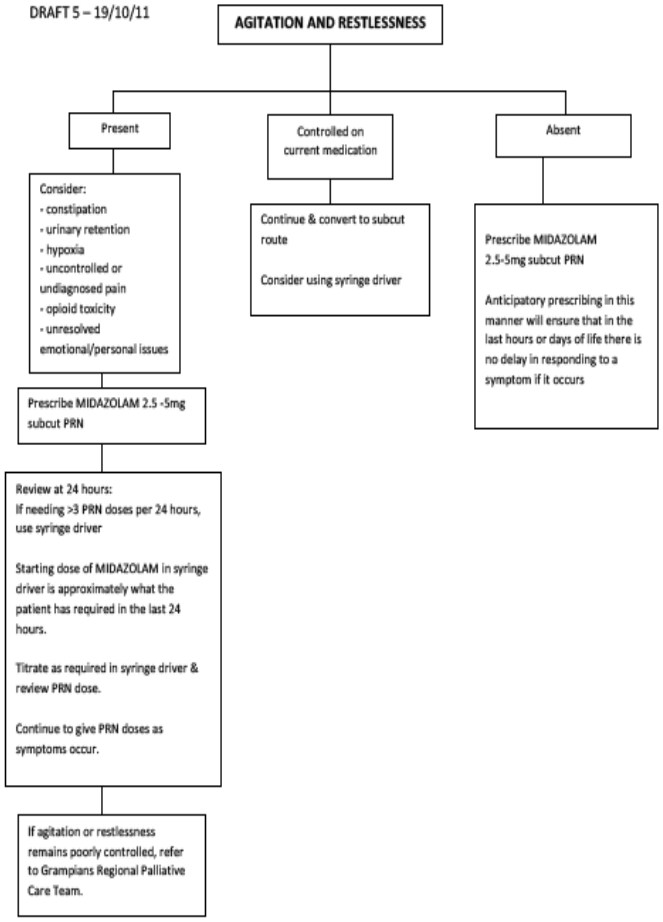

SUPPORTING INFORMATION

- When administering subcut medications use a Saf-t-intima at all times.
- For severe agitation use significantly higher doses of midazolam & use PRN until settled.
- Do not place a time limit on frequency of PRN drug administration.
- Review drug & dose for patients who are very elderly, frail or have renal failure.
- Provide a calm environment for the agitated patient, explain to family/carers that small amounts of visitors at a time is needed to help manage this symptom.
- Continue to monitor for other causes – eg pain, urinary retention, constipation.
- Regular attendance by nursing staff will provide reassurance to the agitated and restless patient.

Agitation & Restlessness Algorithm

If agitation & restlessness are present consider:

- constipation
  - manually evacuate rectum +/- suppository
  - aperients may not be appropriate (even methylnaltrexone!)
- urinary retention
  - insert catheter
- hypoxia
  - trial oxygen therapy (watch for nasal irritation)
  - trial more upright position
  - transfusion unlikely to be appropriate

Agitation & Restlessness Algorithm

- Uncontrolled or undiagnosed pain
  - titrate analgesics
- Opioid toxicity
  - reduce or rotate opioid
  - consider gentle hydration
- Unresolved emotional or personal issues
  - talking therapy (if conscious)

Agitation & Restlessness Algorithm

- Prescribe midazolam 2.5-5mg s/c PRN
- Review every 24 hours & if needing >3 PRN doses per 24 hours, use syringe driver:
  - starting dose of midazolam in syringe driver is approximately what the patient has required in the last 24 hours
  - titrate as required in syringe driver & review PRN dose
  - continue to give PRN doses as symptoms occur
- Request Palliative Care specialist advice if agitation or restlessness remains poorly controlled

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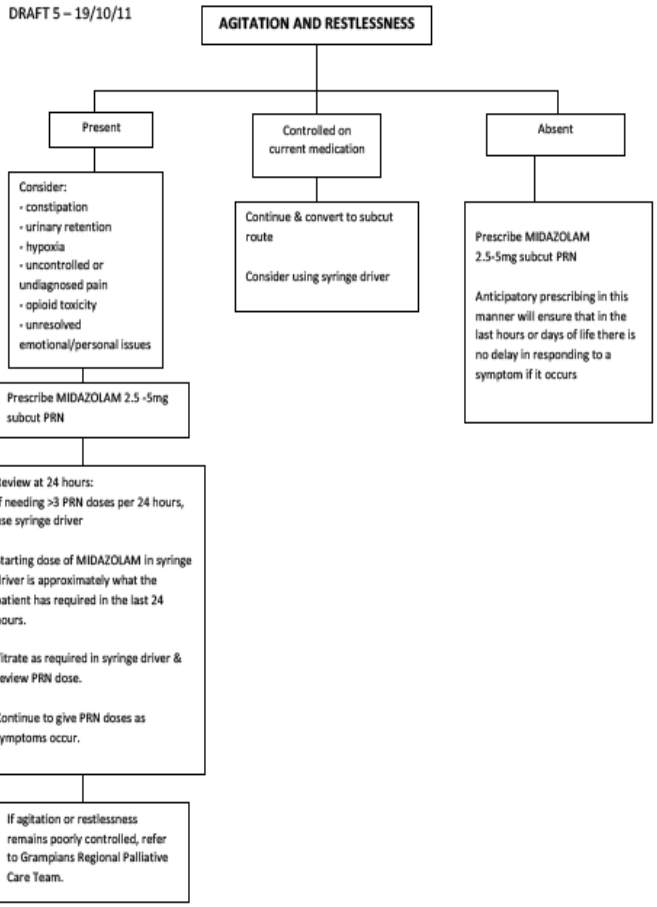

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Agitation & Restlessness Algorithm

f agitation & restlessness are controlled on current regime:

- continue and convert to subcutaneous route
- consider using a syringe driver
- If agitation & restlessness are absent:
- prescribe midazolam 2.5-5mg s/c PRN
- anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay in responding to a symptom if it occurs

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AGITATION AND RESTLESSNESS

Present

Consider:
- constipation
- urinary retention
- hypoxia
- uncontrolled or undiagnosed pain
- opioid toxicity
- unresolved emotional/personal issues

Prescribe MIDAZOLAM 2.5 -5mg subcut PRN

Review at 24 hours:
If needing >3 PRN doses per 24 hours, use syringe driver

Starting dose of MIDAZOLAM in syringe driver is approximately what the patient has required in the last 24 hours.

Titrate as required in syringe driver & review PRN dose.

Continue to give PRN doses as symptoms occur.

If agitation or restlessness remains poorly controlled, refer to Grampians Regional Palliative Care Team.

Controlled on current medication

Continue & convert to subcut route

Consider using syringe driver

Absent

Prescribe MIDAZOLAM 2.5-5mg subcut PRN

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay in responding to a symptom if it occurs

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