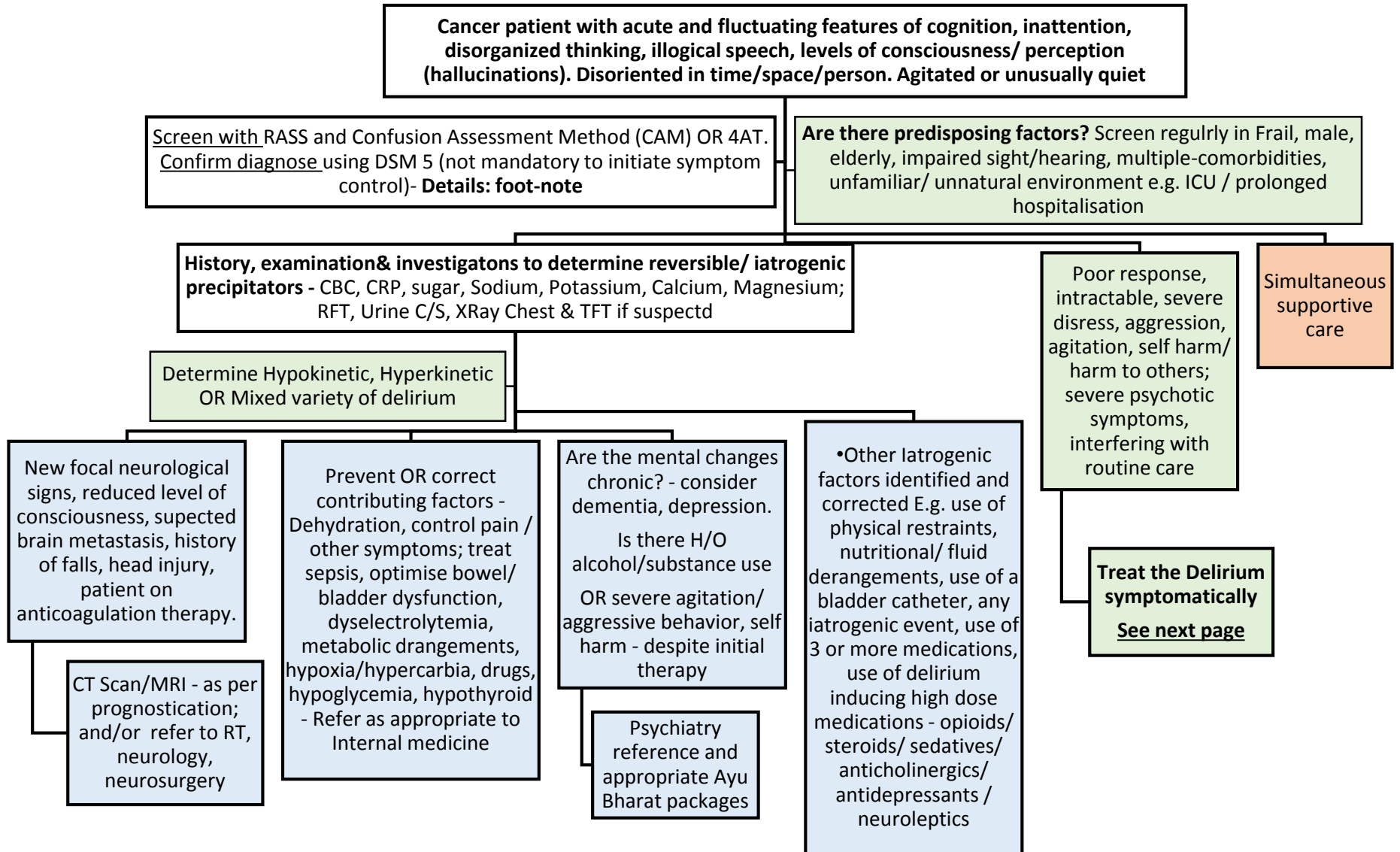


NCG Palliative Care Guidelines – Delirium

Approach to managing Delirium 1 2 3 4 5 6 7

■ - Existing Ayushman Bharat Package

■ - Palliative care package for Delirium



¹ Confusion Assessment Method - <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585541/pdf/nihms50514.pdf>.

² DSA 5- American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*. 5th ed. Washington,

³ RASS Calculator: <https://www.mdcalc.com/richmond-agitation-sedation-scale-rass>

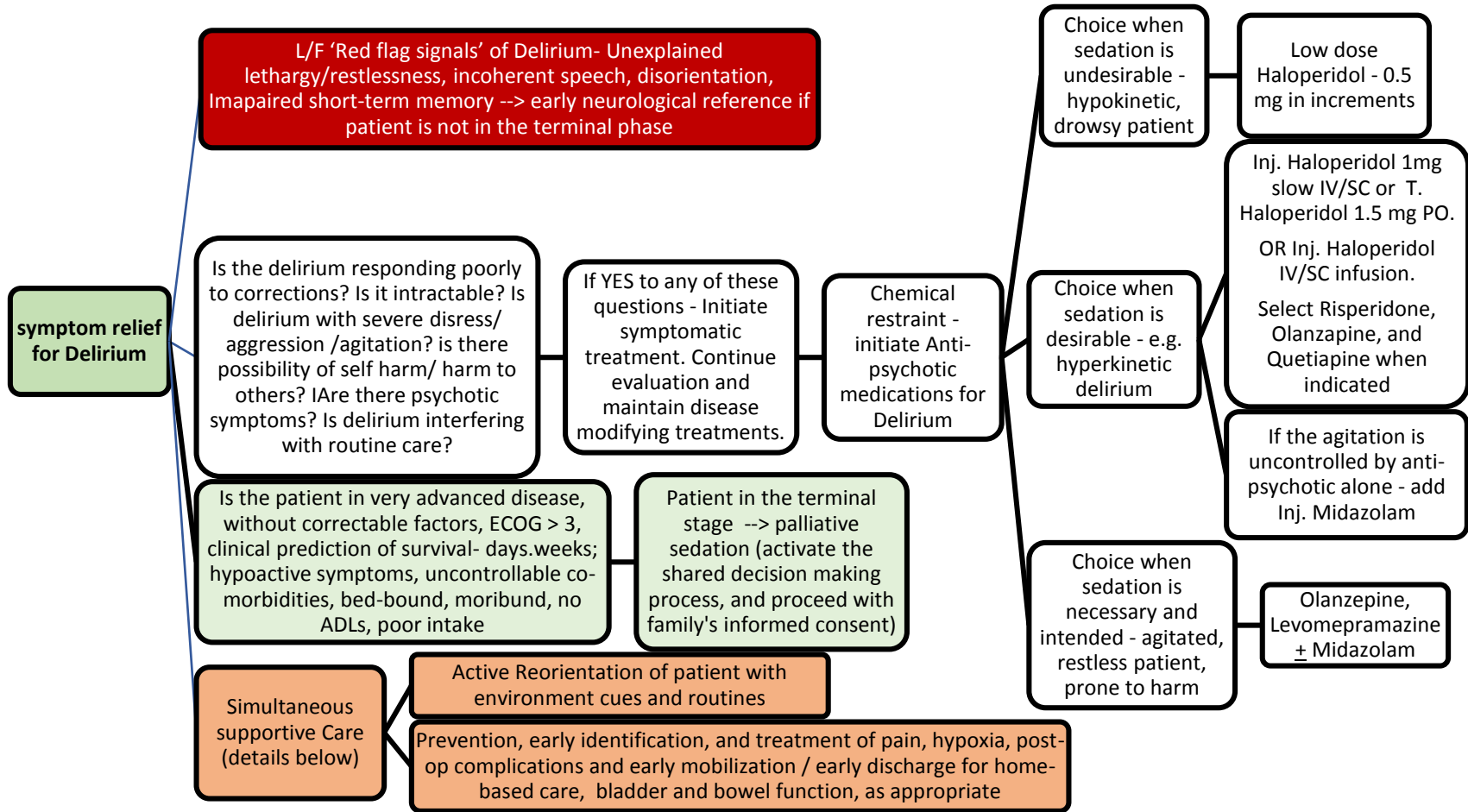
⁴ 4Ats - https://static1.squarespace.com/static/543cac47e4b0388ca43554df/t/5f0592e7917a0733e509ea0b/1594200808505/4AT+v1_2+Oct+2014.pdf

⁵ <http://www.delirant.info/DreamHC/Download/MDAS.pdf>

⁶ Effect of anti-psychotics and non-pharmacotherapy - <https://pubmed.ncbi.nlm.nih.gov/32730108/>

⁷ The Frequency, Characteristics, and Outcomes Among Cancer Patients With Delirium- <https://pubmed.ncbi.nlm.nih.gov/26417036/>

NCG Palliative Care Guidelines – Delirium



Drugs used in Palliative Care Management of Delirium

TABLE A

<p><u>Haloperidol</u> – avoid in patients with dementia, Parkinsonism Availability : Tablets/Liquid/Injection Routes of administration: Oral/ Subcutaneous/Intravenous Dose:</p> <ul style="list-style-type: none"> • Mild/ elderly - start with 0.5 mg with increments of 0.5 mg • Moderate- severe - start with Inj. Haloperidol 1.0 slow IV/SC as bolus followed by a continuous infusion of Haloperidol up to 15 mg/24 h or till reversal of symptoms • Max upto 15 -20 mg/24 h -based on response • Alternatively Haloperidol dose may be rotated every 4 hours with Chlorpromazine (equivalence: 1mg Haloperdol = 12.5 mg Chlorpromazine) 	<p><u>Olanzapine:</u> It has a sedating effect Increased mortality seen in patients with dementia, Parkinsonism, renal/liver dysfunction. (alternative to Haloperidol, if there is history of extrapyramidal side effects to Haloperidol)</p> <p>Availability: Tablets (Oral and MD Tablets)/ Injection Route:Oral/Buccal/ Intramuscular (deep) Dose: start with 2.5 mg with increments of 2.5 mg Max upto 15-20 mg/24h</p>
<p><u>Risperidone:</u> Sedative effect + Causes increased mortality in patients with dementia, Parkinsonism, renal/liver dysfunction Availability: oral tablets Routes: Oral Dose: start with 0.5 mg with increments of 0.5 mg Max upto 3.0-4.0 mg/24 hours</p>	<p><u>Quetiapine:</u> Sedative effect + lowest incidence of Extra-pyramidal side effects Availability: tablets, mouth-dissolving Routes: oral Dose: start with 12.5 mg with increments of 12.5 mg Max upto 100 mg/24 hours</p>
<p>Special situations</p>	
<p>Agitation uncontrolled with anti-psychotic alone <u>Midazolam:</u> Titrated Midazolam as intermittent Subcutaneous/ Intravenous Injections for calming a Hyperactive, delirius patient Dose: Inj. Midazolam 1- 2 mg slow IV/SC and repeat 2 hourly till the patient becomes quiet; up to a maximum dose of 30 mg/24 h as continuous infusion (IV/SC) until the patient becomes calm. Aim: symptom control. Used as a chemical restraint (avoid physical restraints)</p>	<p>Suspected raised ICT <u>Dexamethasone</u> Availability: Tablets/Injections Routes of administration: Oral/Subcutaneous/Intravenous Dose: 16-24 mg/ 24 hours od. *May be given before oncology/ neurology consultation , if there is evidence of cerebral metastases. Continuation depends on oncology/ neurology opinion and symptom improvement</p>

NCG Palliative Care Guidelines – Delirium

<p>Lorazepam (alternative if Midazolam is not available) Availability: Tablets/Injections Routes of administration: Oral/Sublingual/Intravenous Dose: 0.5 – 1mg every 2h Up to maximum dose of 10mg/day</p>	<p>Additional drugs required for correction of dyselectrolytemias</p> <ol style="list-style-type: none"> 1. Bisphosphonates 2. Calcium gluconate 3. Potassium binders 4. Magnesium Sulphate
<p>Monitor and optimise comorbidities – e.g. Hypertension, Diabetes, Asthma, others</p>	
<p>Address Drug-induced etiology: Discontinue/modify Delirium -inducing medications – listed below</p>	
<ol style="list-style-type: none"> 1. Anticholinergics (Benadryl, tricyclic antidepressants) 2. Narcotics (meperidine) 3. Sedative hypnotics (benzodiazepines) 	<ol style="list-style-type: none"> 4. Histamine-2 (H2) blockers (cimetidine) 5. Corticosteroids 6. Centrally acting antihypertensives (methyldopa, reserpine) 7. Anti-Parkinson drugs (levodopa)
<p>Terminal Delirium with severe agitation - Palliative sedation may be needed (This is a shared decision – after empathetic communications with the family & only after documented informed consent – Review Guidelines for Palliative Sedation under the NCG Guidelines of End of Life Care)</p> <ul style="list-style-type: none"> - 1st line: Midazolam added to Haloperidol – as intermittent Subcutaneous/ Intravenous Injections – Titrate gradually to maximum dose of 20 mg / 24 hours – rarely up to 25- 30 mg/24h depending on control of agitation. - If ineffective – monitored infusion – S/C or IV - Phenobarbitone / Pentobarbitone /Propofol. Dose is titrated to symptom control. 	
<p>TABLE B SUPPORTIVE CARE</p>	
<p>Communication</p>	<p>MDT referrals</p>
<p style="text-align: right;">Supportive environment</p>	

NCG Palliative Care Guidelines – Delirium

<p>Family meeting</p> <ul style="list-style-type: none"> • Respond to the family distress • Educate: <ul style="list-style-type: none"> ○ regarding relation to the disease and physiological derangements ○ their role in improving the situation – Non-pharmacological inputs (Refer to #) ○ support the burden of decision making ○ Importance of nutrition and hydration & use of right medicines, timely - Presence - with calm, patience and non-argumentative, non-challenging conversations - Seek information, and advice on maintaining important connectedness aspects for the individual e.g. being at home in their familiar settings, maintaining daily routines - Ensure effective communication among the family members 	<p>Dietician –hydration, Food supplements</p> <p>Physiotherapy – Improving ambulation</p> <p>Counseling – after the acute episode abates – facilitated discussions to address unresolved fears and anxieties</p>	<ul style="list-style-type: none"> • Reorientation techniques • Empathetic presence and support - Patients not to be left alone or unattended especially in evening hours • Natural light, moving patient to different bed / ward - closer to window to improve natural and diurnal cues • Mobilise, offer water, feeds intermittently • re-instate sensory aids - spectacles/Hearing aids / Walking aids/ Crutches/ wheel chair • Promote sleep /wake cycle, sleep hygiene-undisturbed at night • memory cues such as a calendar, clocks, and family photos. • A stable, quiet, and well-lighted environment.
<p>Non-pharmacological inputs # - How may family/ friend/ caregiver help? Ref: https://www.rcpsych.ac.uk/mental-health/problems-disorders/delirium</p>		
<ul style="list-style-type: none"> • Stay calm, talk to them in short, simple sentences and check that they have understood you • repeat things if necessary • remind them of what is happening and how they are doing • remind them of the time and date – make sure they can see a clock or a calendar • listen to them and reassure them • offer and help them to eat and drink • make sure they have their glasses and hearing aid • if they are in hospital, bring in some familiar objects from home 	<ul style="list-style-type: none"> • try to make sure that someone they know well, is with them – this is often most important during the evening, when confusion often gets worse • have a light on at night so that they can see where they are if they wake up. • After recovery – the patient may remember the emotions you felt at the time, and this can be unpleasant and frightening. It can be helpful to sit down with someone who can explain what happened (a family member, a friend, or nurse/doctor). Most people feel relieved when they understand what happened and why. 	

TABLE C - NURSING PROCEDURES and EQUIPMENTS

Procedures

1. Regular assessment of Delirium, Pain, Fever, feeds, bowel movements, Maintaining input-output chart

NCG Palliative Care Guidelines – Delirium

2. **Administration of drugs - (Oral/Injections – SC/IV)**
3. **Insertion of NGT and checking feeding schedules - NGT- Nasogastric tubes (Adult), Gloves, 2% Lignocaine gel**
4. **Bowel:** Constipation – **Review the NCG Guidelines for Constipation** (Insertion of suppository - Gloves , KY jelly,Bisacodyl (Adult); high-up enema as required)
5. **Bladder:** Catheter insertion/change- Sterile gloves/Nelaton’s catheters (Adult), Foleys /Silicone catheters (Adult)/ 2%Lignocaine gel, Sodium phosphate enema)
6. **Care for pressure points: Review the NCG Guidelines for Pressure Ulcer on the NCG Website**

References: Shirley Harvey Bush et.al. **Clinical Assessment and Management of Delirium in the Palliative Care Setting**; Drugs (2017) 77:1623–1643