1 Delirium at End-of-Life

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2 Delirium at End-of-Life

- disordered attention and cognition
- clouding of consciousness
- acute/subacute
- fluctuating course
- agitation, somnolence, hallucinations, paranoia

3 Delirium at End-of-Life

- Hyperactive
  - confusion, agitation, hallucinations, myoclonus
  - not all agitated pts are delirious
- Hypoactive
  - confusion, somnolence, withdrawn
  - most common in hospice/pall setting
- Mixed

4 Delirium at End-of-Life

- Delirium – acute change in attention and/or cognition
- Dementia – chronic change in short term memory
- Anxiety – fear, worry, concern (cognition intact)
- Depression – attention and cognition intact

5 Delirium at End-of-Life

- adds to anxiety
- interferes with assessment and treatment of other symptoms
- increases caregiver burden
- interferes with meaningful communication and interaction

6 The Nursing Delirium Screening Scale

- score each 0-1-2; positive is 2 or greater
- *Disorientation* - Verbal or behavioral manifestation of not being oriented to time or place or misperceiving persons in the environment
- *Inappropriate behavior* - Behavior inappropriate to place, for the person, or both; e.g. pulling at tubes or dressings, attempting to get out of bed when that is contraindicated, and the like
- *Inappropriate communication* - Communication inappropriate to place, for the person, or both; e.g. incoherence, non-communicativeness, nonsensical or unintelligible speech
- *Illusions/hallucinations* - Seeing or hearing things that are not there; distortions of visual objects
- *Psychomotor retardation* - Delayed responsiveness, few or no spontaneous actions/words; e.g. when the patient is prodded, reaction is deferred, the patient is unarousable, or both

7 Delirium at End-of-Life

- not all delirium at eol is “terminal restlessness”
- bowels or bladder
- pain

- drugs – any change in medication is suspect
  - akathisia - antipsychotics
- infection
- environmental change
- psychosocial-spiritual 'change'

8 Delirium at End-of-Life

- Common drugs that cause ...
  - opiates
  - antisecretory
  - anxiolytics
  - antidepressants
  - antipsychotics
  - steroids
  - nsaids

9 Delirium at End-of-Life

- Psychosocial contributors
  - depression
  - vision/hearing impairment
  - emotional distress
  - spiritual distress
  - unfamiliar environment

10 Nonpharmacological Management of Delirium (Breitbart JAMA)

- Minimize the use of immobilizing catheters, intravenous lines,and physical restraints
- Avoid immobility, early mobilization
- Monitor nutrition & hydration
- Provide visual and hearing aids
- Control pain
- Monitor fluid-electrolyte balance
- Monitor bowel and bladder functioning
- Review medications

11 Nonpharm mgmt (Breitbart)

- Reorient communications with the patient
- Place an orientation board, clock, or familiar objects (ie, family photographs) in patient rooms
- Encourage cognitively stimulating activities such as word puzzles
- Facilitate sleep hygiene measures, including relaxation music or tapes at bedtime, warm drinks, and gentle massage
- Minimize noise and interventions at bedtime, eg, by rescheduling medication times

12 Delirium at End-of-Life

- non-pharm mgmt ...
- music during turns, personal care
- minimize ambient sounds (alarms, bells, voice)
- aromatherapy (lavender, melissa)
- spiritual interventions – prayer, ritual
- engaging family in care

13 Delirium at End-of-Life

- Environmental
  - materials to re-orient (clock, calendar)
  - adequate soft lighting
  - identify all individuals
  - limit number of different individuals
  - limit stimulation
  - sitters for safety
  - engage family
  - music

14 Delirium at End-of-Life

- haloperidol – 0.5-2.0 mg q 4hrs prn
- chlorpromazine (more sedating) – 10-25 mg q 4hrs prn
- in setting of severe agitation use above hourly until calm
- if accompanying agitation/restlessness – lorazepam after haloperidol or chlorpromazine on board
- risperidone – 0.5-1.0 mg bid
- olanzapine – 2.5-20 mg qd; quetiapine

15 Delirium at End-of-Life

- as patient nears end of life ...
  - decreased metabolism (liver and renal) of opiates so blood levels may build up
  - may have decreased need of drugs
  - consider decreasing routine (basal) doses
  - continue prn doses
  - family education

16 Delirium at End-of-Life

- as patient nears end of life ...
  - are symptoms the same she has been having (pain, etc) or ...
  - agitation, myoclonus, hyperalgesia?
  - is she delirous – medication side effect?
  - trial of decrease in basal dose of opiate or rotate to another opiate
  - family education

17 Delirium at End-of-Life

- Delirium and Psychosis. Gagnon & Ouellette, ch. 156 in Walsh et al Palliative Medicine.
- Agitation and Delirium at the End of Life: "We Couldn't Manage Him" Breitbart and Alici. JAMA. 2008; 300(24):2898-2910.
- First Do No Harm ... Terminal Restlessness or Drug-Induced Delirium?. White et al. J Pall Med. 10(2):345. 2007.