P02: Palliative Care - Delirium

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Introduction

Delirium is a syndrome of abrupt fluctuating disturbances in attention and awareness that represents a change from baseline status. It is typified by cognitive dysfunction along with changes in psychomotor behaviour, mood, sleep-wake cycle, and may include hallucinations. Delirium can be either hypoactive, hyperactive, or mixed. It is a common phenomenon in palliative care, occurring in anywhere from 20% to 88% of cancer patients.

Although delirium often occurs 24 to 48 hours before death, it should not be considered a normal part of the dying process. Management of delirium symptoms may allow for a more peaceful death. Prompt recognition and treatment of delirium is essential to improve patient and family outcomes.

Essentials

- Establish goals of care in consultation and conversation with the patient, family, and care team.
- Prevent over-stimulation and promote relaxation.
- Avoid the use of physical restraints as they can increase the risk of delirium.

Referral Information

All palliative and end-of-life patients can be considered for inclusion in the Palliative Care Clinical Pathway (treat and refer) approach to care. Paramedics must complete required training prior to applying this pathway. EMRs are required to contact CliniCall for consultation to proceed with the ASTaR clinical pathway.

General Information

- The signs and symptoms of hyperactive delirium may include:
  - Attention disturbances
  - Restlessness and agitation
  - Hallucinations
- Signs and symptoms of hypoactive delirium may include:
  - Drowsiness
  - Emotional or physical withdrawal
  - Depression
  - Lethargy
  - Decreased levels of consciousness
- Common causes of delirium:
  - Sepsis
  - Metabolic or electrolyte disturbances
  - Hypoxia
  - Organ failure
  - Withdrawal from alcohol or medications
  - Unmanaged or undermanaged pain
  - Sleep deprivation
  - Constipation or urinary retention
  - Dehydration
  - Changes to the patient’s environment or psychosocial situation

Interventions

First Responder

- Provide reassurance
- Provide supplemental oxygen if hypoxia is a potential cause of delirium
- Prevent over-stimulation and promote relaxation; consider repositioning

Emergency Medical Responder – All FR interventions, plus:

- Establish goals of care in consultation and conversation with the patient, family, and care team
- Prevent over-stimulation and promote relaxation; consider repositioning
- Reassure the patient

Primary Care Paramedic – All FR and EMR interventions, plus:

- Assist family with the administration of any medications that are recommended as part of an established care plan
  - Paramedics can only administer the patient's own medications where the symptom management plan is clear, they are trained and experienced in the technique of administration, and are operating within BCEHS scope
  - CliniCall consultation required prior to initiating treatment.

Advanced Care Paramedic – All FR, EMR, and PCP interventions, plus:

- If the patient has delirium and agitation that is moderate to severe (RASS +2 to +4), is unmanageable, pose concerns of harm to self/caregivers, and/or is causing distress to the patient and family:
  - First line:
    - MIDAZOLam SC for temporary sedation
    - Lorazepam 1 mg SL (only if prescribed for patient); ACP must have appropriate Schedule 2 (4(b)) license endorsement;
      - CliniCall consultation required prior to administration of lorazepam
  - Second line:
    - KetAMINE SC/IM
- Patients requiring MIDAZOLam or ketAMINE for management of agitation should have a follow-up from their palliative care team; if care team unable to attend within an acceptable time frame, consider conveyance to hospital for further support

Evidence Based Practice

Agitation

Supportive

- Haloperidol
- Ketamine

Neutral

Against

References

1. Alberta Health Services. AHS Medical Control Protocols. 2020. [Link]

2. Ambulance Victoria. Clinical Practice Guidelines: Ambulance and MICA Paramedics. 2018. [Link]
3. BC Centre for Palliative Care. B.C. Inter-Professional Palliative Symptom Management Guidelines. 2017. [Link]
4. Nova Scotia Health Authority. Nova Scotia Palliative Care Competency Framework. 2017. [Link]
5. Pallium Canada. Learning Essentials Approach to Palliative Care. 2019. [Link]
6. Pre-Hospital Emergency Care Council. Palliative Care by PHECC registered practitioners. 2016. [Link]
7. University of Colorado Denver. Delirium & RASS. 2002. [Link]

Practice Updates

- 2022-01-06: EMRs now authorized to access ASTaR clinical pathway.