Alberta Health Services

Nursing Management of 'Distressing' Symptoms of Delirium for Residents in Long-term Care and Supportive Living

The goal of this guide is to avoid transfers to hospital or hospice for symptoms that can be managed at the site.

MEDICATIONS that may be prescribed* by Physician/Nurse Practitioner and common doses **Note: upper doses are for more severe symptoms** **Doses should be tapered as symptoms improve** **All medications are intended for short term use** Medication not in order of preference	Risperidone (Risperdal) 0.25- 1 mg PO BID (or M-tabs) and/or Q12h prn	Quetiapine (Seroquel) 6.25-25mg PO BID-TID and/or Q8-12h prn	Olanzapine (Zyprexa) 2.5-5mg PO BID (tab or Zydis) and/or Q8h prn	Methotrimeprazine (Nozinan) 5-25 mg PO or subcu BID or TID and/or Q1h prn	Haloperidol (Haldol) 0.5-2.5 mg PO or subcu Q8-12h and/or Q2h prn	Midazolam (Versed) 1-2 mg subcu Q2h prn
NURSING IMPLICATIONS to medication use **Note: Check Drug Information for complete information** **If prescribed medication doesn't improve distressing symptoms within 24 hours, discuss with physician. Normally the medication will be discontinued and another trialed.** **A referral to either Geriatric Mental Health Consulting Team or Palliative Care could be considered if symptoms not improved with medication and delirium not resolving. Discuss with Physician.** **Communicate with resident/family re delirium and purpose of medication**	Most potent of atypical antipsychotics Most likely of atypical antipsychotics to cause +EPS so monitor closely M-tabs dissolve rapidly in saliva and may be swallowed with or without liquid	Most sedating of atypical antipsychotics and least likely to cause +EPS Least likely to accumulate Not available in dissolvable form	Atypical antipsychotic More sedating than risperidone Longer acting Variable peak and duration so activity less predictable. More metabolic side effects (not an issue short term) Zydis dissolve rapidly in saliva and may be swallowed with or without liquid	Antipsychotic More sedating than haloperidol Watch for and report +EPS and other anticholinergic side effects	Antipsychotic **More potent than atypical antipsychotics** Can have long duration of effect Minimally sedating, but highest risk of +EPS so monitor closely	**Benzodiazepine Prescribed occasionally for severe agitation or other very distressing symptom in a dying resident for temporary sedation when other** medication is not achieving relief. Very sedating Usually reserved for imminent death- discuss consultation to Palliative Care with Physician

***Note that the doses in this list are intended for short-term use in elderly residents and for delirium symptoms only, not for agitation or other behaviors in absence of delirium. Need for medication must be reassessed before each dose and improvement should be noted after first dose.** Note that none of these drugs is technically indicated for management of delirium and use of these medications in this manner could be considered a chemical restraint. These drugs however, have demonstrated evidence and have been shown to be clinically effective in reducing disturbing symptoms associated with delirium.

+EPS-Extra Pyramidal Symptoms include new drooling, facial and skeletal muscle spasms, shuffling gait, tremors (Parkinson's like symptoms). Report these symptoms promptly to Physician/NP.

* References: Pallium, Micromedex, Lexi-Comp, Rx Files

Developed by a Working Group of the LTC and SL End of Life Committees, Calgary, Final Draft June 7, 2012

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Delirium is an urgent medical situation. If a diagnosis of delirium has been made the FIRST priority is to treat the cause of delirium, if possible. Refer to ***DELIRIUM SCREENING in Long-term Care and Supportive Living*** tool, May 2010. If symptoms are not distressing to the person or their family, they are not normally treated. Medications to control symptoms should only be used to manage distressing symptoms until recovery from delirium or until death if the symptom is terminal restlessness. Terminal restlessness occurs when a person is within days of dying and the cause of delirium is not reversible.

NEW BEHAVIOUR OR SYMPTOM in Presence of Delirium in Resident	**New severe agitation** (e.g. constant verbalization, climbing out of bed or chair, pacing, unable to settle, aggression, grabbing at clothes or bedding, new 'sundowning') **New distressing** auditory or visual **hallucinations** or **paranoia** **Hypoactive delirium**- resident exhibiting new sedation or confusion (assume this is distressing and can be reversed)
ASSESSMENT	**Rule out and manage all possible causes of agitation.** (e.g. dementia, known psychiatric illness, pain, urinary retention, fecal impaction, etc.) **The agitation may not be related to delirium.** **Use CAM-** Confusion Assessment Method- to assess if delirium is present. **Determine length of time symptom** has been present Note **Goal of Care Designation** to help guide aggressiveness of investigations **Is resident very near death?** **What investigations are ordered** to try and resolve delirium? What are the results?
NON-PHARMOCOLOGICAL MANAGEMENT	**See *DELIRIUM SCREENING in Long-term Care and Supportive Living*** tool pg 2/2. Consider all of: **B- Bowels:** Bowel protocol, ongoing prevention and monitoring **U-Urinary tract:** Midstream urine for C & S, push fluids (1.5 L/day) if not medically contraindicated, inform MD/NP **R- Respiratory:** Push fluids (1.5 L/day) if not medically contraindicated, O2 if needed , inform MD/NP **P- Pain:** Inform MD/NP of new pain/discomfort, use prn medications, consider referral to Palliative Care Team **E- Environment:** Reassure, reduce stimulation, ensure hearing aids/glasses used, consistent staff, involve family **D- Dehydration:** Observe/supervise resident drinking 1.5 L/day, monitor output **Me- Medications:** Review of medications by Pharmacy/MD/NP, utilize behavior and symptom mapping tools **Other**- acute illness, exacerbation of chronic illness, sepsis, lab abnormalities

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