Guidelines for the management of agitation in the last weeks of life

14.09.17
Overview

• 1. Aim
• 2. Literature Review
• 3. Current Standards
• 4. Audit Results
• 5. Patient Representative Input
• 6. Proposed New Standards and Guidelines
• 7. Invited Expert
• 8. References
Group Members

• Dr Helen Bonwick (GDG Lead)
• Dr Claire Robinson (SpR Lead)
• Dr Mark Mills (Specialty Doctor MCHL)
• Kate Nolan (Nurse Manager MCHL)
• Ann Griffiths (CNS CCC)
• Dr Penelope Shepherd (SpR)
• Dr Najia Shah (SpR)

• Invited Expert
• Sophie Harrison (Macmillan Consultant in Palliative Medicine, University Hospital South Manchester NHS Foundation Trust, North West Audit Group)
Meetings to date

• 24.05.16 Presentation to Patient Focus Day
• 29.9.16
• 19.12.16
• 30.1.17
• 13.3.17
• 18.7.17
• 21.8.17
Aim

• Focus on agitation in the last days and weeks of life
• “In patients in the last weeks of life (P), which pharmacological and non-pharmacological interventions (I) are the most effective, compared to each other or no intervention (C), for the assessment and management of agitation (O).”
## Literature Review

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients over 18 years</td>
<td>Patients under 18 years</td>
</tr>
<tr>
<td>Life limiting illness</td>
<td>Not life-limiting illness</td>
</tr>
<tr>
<td>Or: palliative care patients</td>
<td>Non palliative care patients</td>
</tr>
<tr>
<td>Last weeks of life</td>
<td>Not in last weeks of life</td>
</tr>
<tr>
<td>Assessment and management of Agitation</td>
<td>Not specific to the assessment or management of agitation</td>
</tr>
<tr>
<td>Full text available</td>
<td>Unable to get full text</td>
</tr>
<tr>
<td>English language or translation available</td>
<td>Unable to get English language version of the paper</td>
</tr>
<tr>
<td>All settings</td>
<td>Review articles (except Cochrane)</td>
</tr>
<tr>
<td></td>
<td>Case reports</td>
</tr>
<tr>
<td></td>
<td>Delirium, Palliative Sedation</td>
</tr>
</tbody>
</table>
Search Terms

• Palliative/palliative care/palliative medicine OR
• Terminal Illness/Terminal Care/Life Limiting Illness OR
• Hospice
• Combined with AND
• Agitation OR restlessness

• Databases – Ovid, Embase, CINAHL
• APM/Cochrane/EAPC(nil)
• NICE – Care of dying adults in the last days of Life Dec 2015.
Literature Search

- 458 results
- Title review – excluded 379
- Included 79
- Remove duplicates (28)
- Abstract review of 51 – excluded 26
- Full text review of 25
- 5 included after full text review for full appraisal
<table>
<thead>
<tr>
<th>Study</th>
<th>Type</th>
<th>SIGN Level</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>The impact on the family of terminal restlessness and its' management. Brajtman Palliative Medicine 2003;17:454-460</td>
<td>Qualitative</td>
<td>3</td>
<td>Relatives perceived medication reduced patient ability to communicate and shortened life</td>
</tr>
<tr>
<td>The use of phenobarbitone in the management of agitation and seizures at end of life. Stirling L. JPSM 1999;17(5):363-368</td>
<td>Retrospective case note</td>
<td>2-52/60 used Midazolam prior to Phenobarbitone. 8% deaths received Phenobarbitone. Effective for agitation.</td>
<td></td>
</tr>
<tr>
<td>How is agitation and restlessness managed in the last 24h of life in patients whose care is supported by the Liverpool Care Pathway for the Dying patient? Gambles M. BMJSPC 2011;1:329-333</td>
<td>Retrospective case note</td>
<td>2-51% received medication for agitation. Low doses used compared to palliative sedation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No difference in survival between those who received haloperidol or midazolam or neither.</td>
</tr>
</tbody>
</table>
Section relating to agitation

Be aware agitation can be related to a full bladder/rectum

Consider non-pharmacological management

Treat any reversible causes for example psychological or metabolic

Consider a trial of a benzodiazepine for agitation

Consider a trial of an antipsychotic to manage agitation

Seek specialist advice if the diagnosis of agitation is uncertain, does not respond to antipsychotic treatment or if treatment causes unwanted sedation
Summary

• Poor evidence base from which to make recommendations
• Most evidence excluded as it related to delirium – particularly non-pharmacological management
• No assessment tools (all related to delirium)
DOCTRINE OF DOUBLE EFFECT

IS IT IMPORTANT IN MANAGING AGITATION AT THE END OF LIFE?
DDE

- Tries to draw a distinction between intended and foreseen outcomes

- This means that suffering/agitation may be relieved with the potential acknowledgement that this may ‘shorten life’

- Previously used with use of analgesia. Not necessary with titration regimes
THE PRINCIPLES

• The intention is for the control of symptoms, not the unwanted side effects

• The side effects do not outweigh the benefit

• The positive effect must be related to the good effect not the bad effect

• Proportionality
• Why is there an issue in the management of agitation?

• There are occasions when large doses of sedation may be needed and it ‘may be felt to shorten life’
• Should we use the doctrine to justify our care?

• We are responsible for side effect profile as well as benefits regardless of the treatment