NHS Shropshire Clinical Commissioning Group

NHS Telford and Wrekin Clinical Commissioning Group

RESTLESSNESS / AGITATION AT END OF LIFE

Consider and manage common causes of restlessness e.g. urinary retention, faecal impaction, hypoxia and pain

Patient is Restless/Agitated

Patient is NOT Restless/Agitated

Non Drug Intervention is Essential: Reassurance, calm environment, consider the use of sound/music
Have you taken into account their spiritual needs?

Immediate Management

Give Medication sub-cut stat:
Midazolam 2.5mg OR Haloperidol 2.5mg

Start Pump
Midazolam 10-20mg/24 hours
OR
Haloperidol 5mg/24 hours

Prescribe rescue dose sub-cut hourly:
Midazolam 2.5-5mg
And Or
Haloperidol 2.5mg

Planning Ahead

Prescribe Midazolam 2.5mg or Haloperidol 2.5mg sub-cut hourly if required (prn)

Review within 24 hours
If 2 or more doses needed in 24hrs, and are effective, start syringe pump of the same drug (see left)

If 2 or more doses tried in 24 hours but not effective, switch to the other drug or consider Levomepromazine (see below)

Review within 24 hours

Midazolam
1-2 extra doses needed increase pump dose by 50%, 3 or more extra doses, double the pump dose. Continue rescue doses of 5mg sub-cut prn

If Midazolam pump dose is >40mg/24hrs Consider Levomepromazine and seek advice

Haloperidol:
Any extra doses required increase pump dose to 10mg/24hrs and continue rescue doses
Maximum Haloperidol dose: 20mg/24hrs

Midazolam and Haloperidol are very effective when used in combination

Persistent Symptoms

Levomepromazine:
This is an effective sedative.
It may be added to Midazolam, if midazolam is partly effective or used to replace Haloperidol.
Start syringe pump at 25mg/24hrs
Use Rescue dose 12.5mg sub-cut hourly as needed

Higher doses are sometimes needed; please discuss with doctor, the Palliative Care Team or Severn Hospice if doses over 50mg/24hrs are used

If symptoms persist or you need help contact the Palliative Care Team or Severn Hospice Tel: 01743 236 565

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