COVID- 19 (novel coronavirus)
End of Life Care Information for Aged Residential Care
TERMINAL RESTLESSNESS/AGITATION

Restlessness and agitation during the terminal phase is a distressing problem, which can be difficult to manage. As with all other symptoms, the cause of restlessness needs to be identified and if at all possible reversed. Terminal restlessness is often "a pre-death event".

Delirium occurring in the last days of life is often referred to as terminal restlessness or agitation. In the last 24-48 hours of life, those who are COVID-19 positive may be severely hypoxic which could cause restlessness and agitation. Others who are dying from other causes but are infected by COVID-19 are likely to have restlessness and agitation caused by the irreversible processes of organ failure.

Individualised Assessment

Refer to attached flow chart on page 2, *"Assessment and Care Management of Restlessness and Agitation in the Dying Person"*.

Distinguish between agitation, anxiety, delirium, pain and consider potential reversible causes:

- Hypoxia
- Infection
- Constipation
- Dehydration
- Recent change in environment (room)
- Newly commenced or titrated medications
- Hypercalcemia

Non-Pharmacological Management of Restlessness/Agitation at End of Life

- Provide a calm environment, low stimulus as much as possible
- Ensure resident is safe at all times: i.e. low bed, sensor mat
- If family or significant others are unable to be present due to isolation consider other ways of communication, i.e. phone, skype
- Use radio, music or TV for distraction
- Ensure hearing aids and spectacles are in place
- Regularly re-orientate as needed

Pharmacological Management of Restlessness/Agitation at End of Life

- Use current medication guidelines to treat agitation as required. Utilise the advice of the residents GP/NP O2 may be appropriate to assist with underlying hypoxia. Clinical decision making will be the responsibility of the primary health provider.
- Midazolam is an effective medication often used first line that may reduce agitation at end of life.
- Administer medications(antipsychotics) such as haloperidol/levomepromazine by appropriate route oral/sub cut/syringe driver
- Remember to use analgesia (opioids) for pain if this is the underlying cause of restlessness/ agitation
- If fever is causing agitation/restlessness ensure cooling measures are applied: PR paracetamol etc.

Please contact Arohanui Hospice for advice required to support residents at the end of life with COVID-19. Advice may include how to manage dyspnoea at EOL with use of prn (without a syringe driver)

Assessment and Care Management of Restlessness and Agitation in the Dying Patient

There is often more than one cause of restlessness and agitation in a dying person that may not be obvious, so all the steps below should be actively considered.

Actively consider delirium in all dying people. International palliative care research suggests delirium is present in >80% of all dying patients (Palliative Medicine, 2004: 18, 184-194).

Are there signs of unrelieved pain or discomfort, i.e. moaning, groaning or facial grimacing?	YES	• Discomfort may be due to inability to change position. • Administer breakthrough Analgesia.
Does the patient have a distended bladder or rectum?	YES	• Perform a bladder assessment. • Consider an indwelling urinary catheter. • If faeces present in rectum, consider PR intervention.
Has the patient been incontinent?	YES	• Clean and dry patient and change linen. • Use incontinence pads or indwelling catheter to maintain patient's comfort.
Are respiratory secretions present?	YES	• Try repositioning as this may help to shift secretions. • Consider anticholinergic if noisy secretions present. • Suction can cause distress and contact bleeding. Use cautiously, i.e. only if secretions are sitting in the mouth.
Does the patient have a dry mouth?	YES	• Clean and moisten mouth with large swabs dipped in water or saline solution. • Moisten lips with mouth lubricant.
Is the patient dyspnoeic?	YES	• Consider morphine or renal-friendly opiod if appropriate. • If hypnoxic consider prescribing oxygen. • Consider benzodiazepine.
Is the patient febrile and hot to touch?	YES	• Fluctuations in body temperature are common in the dying process. • Treatment of infection may be inappropriate in the dying patient. • Consider cool sponges. • Consider paracetamol PO or PR.
Do recent blood tests indicate a likely cause of delirium?	YES	• Treatment of abnormal findings may be inappropriate in the dying patient.
Is restlessness/agitation secondary to delirium?	YES	• Discuss with treating team and consider an antipsychotic, e.g. haloperidol or levomepromazine. • Do not use benzodiazepine as sole treatment for delirium as it may worsen symptoms.
Is there evidence of opiod toxicity?	YES	• Switching opioids may be appropriate if evidence of myoclonus or allodynia. • If renally impaired will need renal friendly opiod.
Is the patient experiencing emotional or existential anguish or anxiety?	YES	• Provide a quiet environment to reduce stimulation with appropriate lighting. • Presence of a calm family member may help relieve anxiety. • Patients who respond to physical touch – consider hand-holding and company. • Consider appropriate rituals and practices. • Consider benzodiazepine.
If the patient remains distressed despite addressing the above issues:	YES	• Reconsider whether targeted interventions are appropriate, e.g. hypercalcaemia, anaemia. • Contact your specialist palliative care service.