St George Hospital Renal Department Guideline: INTERNAL ONLY

Management of delirium in patients with ESKD

1. Non-pharmacological management should be tried in all delirium patients, such as careful co-ordination of nursing care, preventing sensory deprivation and disorientation and, when appropriate, increased level of nursing observations to ensure patient safety.
2. For delirium not due to alcohol or benzodiazepine withdrawal, use haloperidol as 1st choice drug.
    a. **Haloperidol** to be only prescribed drug after hours for delirium, unless contraindicated. Start with doses 0.5-1.0 mg.
    b. If haloperidol is contraindicated, **quetiapine** is a reasonable alternative. The recommended staring dose is 12.5 mg bd prn
    c. All other benzodiazepines & antipsychotics are to be prescribed only with psychiatry input – call on-call psych reg/consultant if needed. ***Avoid risperidone, amisulpiride and sulpiride.***
3. In most circumstances it is best for pharmacological management of delirium to be via 'as needed' or 'prn' medication initially, with regular medication only used once the required dose has been established and only for a limited time, with regular reviews.
4. Temazepam is the only after hours prescribed benzodiazepine (except in the case of alcohol withdrawal where diazepam is to be used, with input from the on-call psychiatry team).
5. All delirious patients to have a medical assessment to determine precipitating cause; nursing staff to be aware of significance of low SaO2.
6. All medication charts to be re-written Thursdays.
7. Consultants and registrars will take careful notice of 'PRN' medication charts to avoid excessive dosing of benzodiazepines.
8. Discuss with consultant re criteria for when or if dialysis should be withdrawn (refer to renal supportive care section)