Association for Paediatric Palliative Medicine

Agitation:
Stage A: SCOPING AND SET UP PROCESS

Topic and/or Title of proposed guideline	Agitation in the life limited child or young person (CYP) in the palliative care setting where episodes of agitation may occur at any point in the disease process or at end of life. Prioritising symptom experience over sustaining life at all cost with focus quality of life from the individual patients and family's perspective.

Specialty area(s) to be addressed	1. Define/describe agitation, delirium and anxiety 2. Identify reversible/treatable causes that have a meaningful impact on improvement in symptom experience eg nausea, pain, basic care, biochemical changes, hypoxia 3. Consider causes of agitation to inform management approach 4. Consider episodic or escalating agitation, not occurring as part of the end of life phase, in the context of neurodegeneration or other considered conditions 5. Agitation experienced in the context of changes in skills eg communication needs, fine and motor functioning 6. Consider the role of the multi-professional team approach 7. Consider management of Agitation as part of end of life care 8. Define, recognise and manage terminal agitation 9. Consider agitation experienced at different phases of palliative care 10. Consider management of agitation at different developmental stages eg neonates
Background on the topic	NICE guidance- limited evidence shown Different patient groups eg CCLG Local guidance, Adult palliative care, Neonatal guidance Hauer's book on 'Caring for children who have severe neurological impairment: Life with Grace'
Clinical need for guideline	• Gap in evidence • Non-pharmacological guidance eg complementary therapy, psychological • Management of both escalating/episodic and end of life agitation • Balancing experience of agitation with side effects of medication to manage agitation including interference with perceived quality of life and interference of activities of daily living
Describe the specific issues planning to address through key recommendations	• To generate definitions • To enable a consistent approach • To enable auditing practice (national) • Other areas identified by APPM members
Overall objective(s) of guidelines (scope)	1. Improvement in quality of life for CYP and family 2. Recognising and reducing distress for CYP, carers/family and supporting them 3. Recognising agitation in the life limited CYP both at end of life and other periods of uncertainty or clinical change 4. Distinguishing agitation from other conditions including mental health disorders, delirium, neurological phenomenon, recreational drugs, drug misuse and drug withdrawal (including prescription medication) 5. Agitation reduction and reduction in associated symptoms (including post-agitation episode) 6. Support desired place of care 7. Guidance to approach by professionals when discussing the identification and management 8. Empowering professionals- minimising health care distress 9. Supporting a good death 10. Standardising care across UK and across all health care settings 11. Acceptability/Satisfaction experience for CYP and family 12. Transferability of care between care settings and maintaining choice 13. To support risk/ benefit discussions with families including young people when able. 14. To consider liaison with other specialities including CYP mental health for review of diagnosis and treatment of agitation alongside specialist palliative care providing complex symptom management when CYP is not at end of life, 15. Ensure identified and treated reversible causes

Specific Questions to be addressed	What pharmacological and non-pharmacological interventions are effective for the management of agitation in infants, children and young people with palliative care needs.
Current evidence existing guidelines? consensus expert opinion Include references	NICE guidance APPM master formulary CCLG guidance, Basic symptom control (Jassal) Adult guidance Julie Hauer book- caring for children with neurological impairment
Target audience	Professionals caring for life-limited CYP including primary, secondary and tertiary services. Third sector providers. CYP should ideally be cared for by MDT palliative care team. Funding and commissioning bodies. Infants, children and young people and those caring for them
Age range	1. Neonates 2. Children 3. Adolescents and young people (up to 19years)- over 16yrs may be managed by adult guidance
Population	CYP with life limiting conditions and benefiting from a palliative care approach. This might be defined by complexity, route of drug administration, place of care or phase of illness.
Excluded populations	1. CYP best managed by general paediatric or mental health teams who do not require palliative care input 2. CYP who are experiencing agitation who are not life limited 3. Age 19 years and over
Clinical condition(s)	Any CYP with life limiting condition who may experience or be at risk of experiencing agitation during their illness
Intervention(s)	<u>Pharmacological:</u> Benzodiazepines: Midazolam, lorazepam, clobazam, clonazepam, Phenobarbital, diazepam, Chloral hydrate, propranolol, Levomepromazine, oxygen, gabapentin, pregabalin, Risperidone, Haloperidol, Olanzapine, clonidine, SSRI, SNRI or tricyclics, methadone, cannabinoids <u>Non-pharmacological:</u> Soothing/Comforting methods eg gentle touch, calming voice, understanding/reassurance Complementary therapies- acupuncture, reflexology Play, distraction, Art therapy, Animal therapy, Music therapy Hypnotherapy, Guided imagery, Psychology- CBT, recognition of emotional and situation triggers Fan Spiritual/chaplaincy, Emotional support Access to appropriate Information sharing Exercise/physical activity Communication aides- SLT, Sensory needs- hyperacusis <u>Environmental triggers</u> including sleep / pain Place of care- location/environment- familiar environment and familiar belongings Basic cares- full bladder Kangaroo/skin to skin Light and dark Withdraw- of alcohol and drugs and cigarettes Postural care and positioning- setting and bedding
Comparison(s)	Placebo, No treatment / usual care Cross comparison between any of the above (within group and between group) Combinations of the above – reducing triggers and pharmacological management. Routes of administration (same drug or same drug class)
Health care setting or context	UK, Hospital, home, hospice and community settings where skills and resources allow. Managed clinical network support may enable this.
Outcome(s)	1. Reduced frequency or intensity of agitation. 2. Overcoming disabling agitation to a manageable level 3. Reduced distress as experienced by CYP and family 4. Care in place of choice 5. Improved patient and family experience/ carer satisfaction. 6. Improved trust in healthcare support/ perceived quality of care / quality of experience. 7. Improve confidence in recognition, awareness and understanding of agitation and possible causes and etiologies 8. Improved confidence in approach to managing agitation

	9. Reduction in presentation to acute care. 10. Minimise harm / side effects - e.g unwanted levels of sedation. 11. Acceptability to patients / families and professionals. 12. Achieving a 'good' death as determined by patient and family. 13. Improving confidence and ability to participate in activities of daily living
Stakeholders	APPM Clinical guidelines group and topic specific group Parents and users <u>Before literature review:</u> Neurologist (replied) Psychologist Ireplied) <u>After literature review</u>: Wider APPM membership Neurology (replied) Psychology (replied)
Conflict of interest form	Completed No conflict of interest
Questions formulated	1. What pharmacological and non-pharmacological interventions in infants, children and young people with palliative care needs are effective for: A. the reduction in episodes and severity of agitation? B. the management of agitation at end of life? C. the reduction in symptoms associated with agitation? D. supporting a good death? E. support desired place of care? 2. What interventions or measures may be helpful: A. in improving quality of life for patients who experience agitation and/or carers? B. in empowering professionals- minimising health carer distress C. in standardising paediatric palliative care across UK and across all health care settings D. in ensuring family/carer satisfaction (or minimising trauma) E. to enable transferability of care between care settings F. to optimise choice of care setting G. to support risk/ benefit discussions with families, including young people when able. 3. How do we define and describe and differentiate agitation (episodic, escalating and at end of life) from delirium and anxiety? 4. What reversible (complete or partial) may be considered when reviewing a CYP experiencing an episode of agitation including at end of life? 5. How do you recognise and manage terminal agitation? 6. How do we define when agitation management in collaboration with palliative care is recommended? 7. How do we identify and consider referral to other specialist services for supporting the management of agitation when the patient is not at end of life.
Literature review	20 years Child only to start, including adult, dependant on results. All study design – including single case reports, posters and abstracts from meetings.
Search strategies	Embase, MEDLINE, PsycINFO, CINAHL, Cochrane, CENTRAL, NICE, HDAS (health education England), Grey literature (abstracts, unpublished papers, posters)
Search words	Neonate, infant, children, young people, paediatric, Adolescent, minor, palliative, terminally ill, dying, terminal, hospice care, end of life care, life-limiting, quality of life Agitation, terminal agitation, restlessness, confusion, delirium, hallucinations, cerebral irritation, hypoxia , syringe driver, Midazolam, lorazepam, clobazam, clonazepam, Phenobarbital (phenobaritone), diazepam, Chloral hydrate, propranolol, Levomepromazine, oxygen, gabapentin, pregabalin, Risperidone, Haloperidol, Olanzepine, clonidine, amitriptyline, nortriptyline, SSRI, antidepressants, fluoxetine, Sertaline, citalopram, paroxetine, Complementary therapy- acupuncture, reflexology, massage, Play therapy, distraction, music therapy, art therapy, animal therapy, Hypnotherapy, Guided imagery, Psychology, cognitive-behavioural therapy, Religion, pray, Spiritual leader, spiritual play and chaplaincy Communication aides, augmented communication, sensory processing disorder, sensory diet

Agitation: Stage B: DEVELOPMENT

Guideline development process outline	Scope identified and PICO created (stage A) 1. Systematic review (stage B) 2. Expert opinion: draft developed against each scope identified using systematic review, where no evidence expert opinion used (stage B) 3. Delphi survey - where no consensus was met with expert opinion 4. Evidence linked to each statement
1.Systematic review	Completed by topic specific group and Cochrane Response Reports generated: 1. Systematic review Protocol (Cochrane Response) 2. Systematic review results
2.Expert opinion	Draft guidance created against each clinical statement Using systematic review but where no evidence expert opinion used Expert opinion process: -topic specific group created draft -wider clinical guidelines review (meeting and post-meeting written draft shared)
3.Delphi method	No Delphi survey needed- expert opinion consensus met
4.Evidence	Each stated guidance has evidence link and grade/rating of quality of evidence Reports generated: Evidence to Decision table Cochrane protocol Delphi survey
Guideline	Completed January 2023
Additional information	1. Methodology report 2. Guidelines process summary 3. Cochrane Response protocol for systematic review 4. Cochrane Response systematic review results 5. Evidence to Decision table 6. Clinical guidelines participants list 7. Conflict of interest forms (on request)
Funding	NHSE funding for completion of 3 topics and commencement of next 2 topics

Guideline process for Agitation

Stage A: Set up

Documents:
RCPCH Standards for development of Clinical guidelines
Methodology report
Conflict of interest form

Group

- 42 Clinical guidelines group members
- 2 parents; 1 patient
- 1 Cochrane Response
- 8 core topic group members
- Conflict of interest forms completed
- External stakeholders identified: Palliative care and Neurology

Topic

- Identify a topic leads: Caroline Sprinz and Jo Griffiths
- Methodology report completed for stage A including Clinical question(s), scope, aims,PICOs, search strategy developed by Clinical guideline group over 3 x 2hour virtual sessions

Review

- Reviewed by external Stakeholders: Paediatric Neurologist and Paediatric Palliative care
- Call for evidence from stakeholders and group
- Process follow RCPCH Standards for development of clinical guidelines

Stage B: Production

Documents:
RCPCH Setting standards for Clinical guidelines
Summary of Systematic review (Cochrane Response report)
Evidence to Decision table

Systematic review

- Systematic review via PRISMA method with search strategy
- Summary of Systematic review report (see Cochrane Response report)

Expert opinion meeting:

- 18 attendees including 2 laypeople
- Systematic review presented
- Where there was minimal or no evidence for questions then expert consensus discussion for each question
- Clear consensus for each question with no need for Delphi survey

Draft guideline

- Short version developed by core topic group
- Evidence to Decision table: linking evidence to recommendations
- Draft presented to guidelines group (one meeting)
- Internal Guideline group review (via email over 6 weeks)
- External review to Stakeholders: Paediatric Neurology and Paediatric Palliative care

Stage C: Completion

Guidance process completed (this document)

Revision

- Responses received from Paediatric Neurology and Paediatric Palliative care
- Core topic review responses

Dissemination

- APPM Website
- APPM Webinar 2023
- APPM study day 2022
- NHSE newsletter

Updating

- Review date: January 2026

Agitation: Stage C: REVIEW AND PUBLICATION

Guidance final	Final draft sent out to stakeholders including APPM membership, specialist paediatric palliative care group and those involved in the scoping.
Economic impact of guidance	As discussed in evidence to decision table, availability and range of non-pharmacological interventions may be a significant issue in many clinical settings. Specialist palliative care expertise workforce across the systems remains very low.
Barriers to guidance stated	Concern that providing guidance could lead to individual clinician's working beyond their scope of practice. It is a clinician's responsibility to consider and understand their level experience when using the guidelines.
Audit recommendations	To be developed
Dissemination and publication plan	APPM website and webinar series NHSE newsletter
Review date agreed	January 2026