End-of-life Care Tips and Common Medications for the In-Patient

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**Care Tips for End of Life Patients**

- The body is unable to regulate fluids well, causing edema and potential congestion [including intravenous (IV), oral (PO) and feeding tube fluids].
- Gastrointestinal (GI) motility will lessen, increasing the possibility of constipation and impaction.
- Treat the patient symptoms quickly as they occur, DO NOT worry about addictions.
  - When used appropriately, even high doses of opiates and benzodiazepines are appropriate.
  - Appropriate doses of medications should allow patient to have symptom control yet able to communicate.
  - Severe sedation may be from disease progression, don’t assume overdose.
  - Agitation cause is usually metabolic failure, treat.
- Symptoms CAN be objective at times, however, symptoms are ALWAYS subjective.
  - Monitor the patient closely for distress, watch for grimming, clenched jaw, or restlessness.
  - If the patient is able to communicate pain, treat it; if the family feels the patient is in pain, treat it.
  - Do not assume sleep or activity participation means no pain.
- If the patient has an IV be careful to not overload with fluids, but use for medications. If no IV and unable to use buccal mucosa, a Macy catheter may be rectally inserted for medication administration.

**Common Medications at End of Life**

**Pain Control**

- Toradol (ketorolac tromethamine) – IM injection, PO (oral)
  - Potent anti-Inflammatory, LIMIT of 5 day use.
- Tramadol (Ultram) – PO.
- Oxycodone (Roxicodone) – PO.
- Morphine (Roxanol) – IV, PO (tablet/sublingual)
  - Can be concentrated for smaller volume.
- Hydromorphone (Dilaudid) – IV, PO (tablet/sublingual).
  - 2-8 x more powerful than Morphine.
- Fentanyl (Duragesic) – Transdermal.
  - Patch can take 24 hrs to be effective.
  - Must be removed and replaced every 3 days.
  - Do not expose to heat, may increase absorption.
- Methadone – PO
  - Can cause respiratory arrest, must be prescribed by knowledgeable provider.
  - Replacement therapy for opioid drugs; blocks the effect of Morphine, Hydromorphone, etc.

- Check with Pharmacy: If patient is swallowing, oral meds can be crushed with applesauce.
- If patient not swallowing, change medications to liquid, use the buccal mucosa.
- Transdermal patches can take 24 hours to be effective (Do not expose transdermal patches to heat, can cause rapid absorption of medication).

**Oropharyngeal Secretions**

- Atropine (eye drop used as an oral medication) – work with pharmacy, may not be available.
- Hyoscyamine (Levsin) – Oral, place on tongue.
- Glycopyrrolate (Robinil) – IV, IM Injection.
- Scopolamine – Transdermal, place behind the ear
  - May cause delirium, carefully observe.

**Anti-Emetics**

- Prochlorperazine (Compazine) – PO, IV, IM, Rectal.
  - Can also help with anxiety.
  - Can cause dizziness (fall precautions).
- Ondansetron (Zofran) – PO, liquid, film or oral rapid dissolve tablet
  - Can cause drowsiness, dizziness and weakness (fall precautions)
- Scopolamine (Hyosine) – Transderm
  - Can cause drowsiness, dizziness, weakness, dry mouth, delirium (fall precautions).
  - Can take 4 hours to see results.
- Chlorpromazine (Phenothazine) – PO, IM, IV
  - Anti-psychotic, may cause seizures.
- Dronabinol (THC/cannabinoid) – PO, tablets and liquid.

**Anti-Anxiety**

- Lorazepam (Ativan) – PO, IV, IM
- Haloperidol (Haldol) – PO, IM

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