

INTRODUCTION

This document provides information on commonly used medications for symptom management in the last days to week of life. It is intended to support clinicians across care settings including home care, primary care, and long-term care who are caring for individuals approaching end of life. The medications outlined in this resource are used to proactively anticipate and manage distressing symptoms such as pain, dyspnea, agitation, nausea, and respiratory secretions when death is expected. Timely access to and familiarity with these medications supports comfort-focused care and helps avoid crisis-driven interventions.

While some settings may access these medications through mechanisms such as an emergency terminal care drug kit, this resource is not limited to a specific delivery model or location of care. Clinical judgment should always guide medication selection, dosing, and administration in alignment with the patient's goals of care and applicable organizational policies.

Where applicable, clinicians should also refer to relevant provincial policies and clinical supports, including:

- The PEI Emergency Terminal Care Drug Kit Policy (Medworxx)
- Be Prepared: Palliative Care Emergencies in the home resources (Staff Resource Center (SRC) Palliative page)
- Speaking with Compassion: A conversation guide for last days and hours. (SRC Palliative page)

Drug	morphine
Class	Opioid analgesic
Uses	Helps treat moderate to severe pain, relieves shortness of breath
Onset	15 mins subcut
Usual Dose	<ul style="list-style-type: none"> • When transitioning from PO to subcut, subcut dose is half the current PO dose. • If opioid naive, use no more than 2.5mg subcut per dose as a starting dose. • The dose is highly individualized and dependent on many client factors.
Care Considerations	<ul style="list-style-type: none"> • Monitor for nausea & vomiting, constipation, and opioid neurotoxicity (e.g., myoclonus, hallucinations, confusion, etc.). • If using more than three breakthrough doses per day, consider consulting the ordering clinician regarding titrating the scheduled dose or adding coanalgesic drugs. • Use extra caution with high potency (HP) concentrations.

REFER TO DRUG MONOGRAPHS FOR MORE INFORMATION

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Drug	HYDRORmorphine (Dilaudid)
Class	Opioid analgesic
Uses	Helps treat moderate to severe pain, relieves shortness of breath
Onset	15 mins subcut
Usual Dose	<ul style="list-style-type: none"> • When transitioning from PO to subcut, subcut dose is half the current PO dose. • If opioid naive, use no more than 0.5mg subcut per dose, as a starting dose. • The dose is highly individualized and dependent on many client factors.
Care Considerations	<ul style="list-style-type: none"> • Monitor for nausea & vomiting, constipation, and opioid neurotoxicity (e.g., myoclonus, hallucinations, confusion, etc.). • If using more than three breakthrough doses per day, consider consulting the ordering clinician regarding titrating the scheduled dose or adding coanalgesic drugs. • Better choice than morphine for clients with renal impairment. • Use extra caution with high potency (HP) concentrations.

Drug	scopolamine
Class	Antimuscarinic
Uses	Pharyngeal/pulmonary secretions related to terminal congestion when the client is semi-responsive/unresponsive
Onset	30 mins
Usual Dose	0.4-0.6 mg subcut q1-4h PRN
Care Considerations	<ul style="list-style-type: none"> • Education is key! Educate families regarding terminal congestion during the dying process. If not effective within the first 2-3 doses, the client will unlikely benefit from a further increase in dose and/or frequency. • Consider non-pharmacological intervention for terminal congestion (e.g., positioning). • Scopolamine crosses the blood-brain barrier, resulting in increased sedation when compared to other alternatives, such as atropine drops or glycopyrrolate. • Side effects include sedation, dry mouth, decreased bladder/bowel function, increased temperature, and increased confusion. • If applicable, stop atropine before using scopolamine, as it leads to systemic toxicity. • You may want to initiate early in clients with a high risk of increased secretions (e.g., clients with known CHF, significant edema, ascites, etc.).

REFER TO DRUG MONOGRAPHS FOR MORE INFORMATION

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Drug	lorazepam (Ativan)
Class	Benzodiazepine
Uses	Anxiety/sedation
Onset	30-60 mins
Usual Dose	1-2mg sublingual or buccally PRN
Care Considerations	<ul style="list-style-type: none"> • If the client is taking other CNS depressants (especially opioids), the dose may need to be adjusted. • Consider dryness of the mouth before administering this medication. Add moisture if required. • Consider may be used as an adjunct to control seizures. • Any benzodiazepine can increase delirium at end-of-life.

Drug	haloperidol (Haldol)
Class	Antipsychotic
Uses	Nausea/vomiting, hiccups Agitation/delirium/sedation
Onset	15-30 mins
Usual Dose	<ul style="list-style-type: none"> • Nausea/vomiting, hiccups 0.5-1.5 mg subcut q6-8h PRN • Agitation/delirium/sedation 0.5-2 mg subcut q1h until calming occurs, then q4-6h for severe delirium
Care Considerations	<ul style="list-style-type: none"> • When transitioning from PO to subcut, the dose should remain the same. • For nausea/vomiting, first/second/third line use dependent on the underlying causes of nausea/vomiting. Consider the cause; however, this is not always known. • Avoid using with metoclopramide (Maxeran) to avoid extrapyramidal effects. • Consider an alternative medication for clients with Parkinsonism, as haloperidol will increase their tremors. • If methotrimeprazine (Nozinan) is not available, halperidol may be ordered as an alternative for agitation/delirium/sedation. • Haloperidol is less sedation then methotrimeprazine (Noxinan).

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Drug	metoclopramide (Maxeran)
Class	Antiemetic
Uses	Nausea/Vomiting
Onset	5-15 minutes
Usual Dose	5-10mg subcut q4-6h PRN
Care Considerations	<ul style="list-style-type: none"> • Effectiveness for nausea/vomiting is related to the underlying causes of vomiting (however, this is not always known). • Volume of medication is a higher volume therefore butterfly site may not last as long.

Drug	methotrimeprazine (Nozinan)
Class	Antipsychotic
Uses	Agitation/delirium/sedation Nausea/vomiting
Onset	30 mins
Usual Dose	Starting doses: <ul style="list-style-type: none"> • Agitation/delirium/sedation 6.25-12.5 mg subcut q4h PRN • Nausea/vomiting 5 mg subcut q8h PRN
Care Considerations	<ul style="list-style-type: none"> • When transitioning from PO to subcut, the dose should remain the same. • It's a more sedating option than haloperidol (Haldol). • Extrapyramidal symptoms may occur with high doses. • If methotrimeprazine is not available, haloperidol (Haldol) may be ordered as an alternative for agitation/delirium/sedation. • Monitor closely for site irritation. Subcut site may need to be changed more frequently due to high volume and viscosity of medication.

REFER TO DRUG MONOGRAPHS FOR MORE INFORMATION

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Drug	midazolam (Versed)
Class	Benzodiazepine (short-acting)
Uses	Agitation/delirium, catastrophic event, seizure activity
Onset	5-15 mins
Usual Dose	Initial dose <ul style="list-style-type: none"> • Agitation/delirium 2.5 mg subcut PRN • Catastrophic event (e.g., massive hemorrhage, intractable seizures) 5-10mg subcut STAT + repeat within 5-15 minutes if needed
Care Considerations	<ul style="list-style-type: none"> • If previous use of benzodiazepines, the dose may need to be higher for effectiveness. • Midazolam has a quick onset of action but also a short duration of action (60-120 mins) which would require frequent subcut injections or use of a continuous infusion. • Consider consulting the ordering clinician regarding a more long-acting molecule for sedation maintenance since intermittent dosing is not recommended due to the short half-life • It has amnestic effects, which is beneficial for distressing events.

Drug	dexamethasone (Decadron)
Class	Long-acting corticosteroid (systemic)
Uses	Symptom management of increased intracranial pressure (e.g., headaches, agitation, projectile vomiting) and bowel obstructions; adjunctive treatment of nausea/vomiting; decreases inflammation
Onset	1-3 hours
Usual Dose	4-8 mg subcut q12-24h (highly variable dosing)
Care Considerations	<ul style="list-style-type: none"> • Most clients, at end-of-life, can safely stop taking dexamethasone when they are no longer able to take it PO. A sub-set of clients with brain tumors or increased intracranial pressure will require a transition from PO to subcut when no longer able to swallow. • When transitioning from PO to subcut, the dose should remain the same. • The mechanism of action is unknown; however, it can help treat or prevent many distressing symptoms.

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