Policy for anticipatory prescribing of ‘Just in Case’ medication for symptom control in the last days of life in adult community palliative and end of life care patients.

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Name of originator/author:	Originated from the BNSSG document authored by Dr Cornish, transferred to Sirona policy by Karla Smith-Bishton and updated by key individuals referenced on page 3.
Name of executive lead:	Dr Alison Wint
Date ratified:	13 February 2023
Review date:	13 February 2025

N.B. Please check you are referring to the latest version, however the policy remains valid even if the review date has passed, until a new version is approved.

Applicable to

All registered clinicians who may be involved in the completion and/or use of Community Palliative Drug Charts within the Bristol, North Somerset, and South Gloucestershire (BNSSG) region.

This policy also applies to colleagues across the BNSSG region and therefore any amendments must be made in agreement with representatives from the BNSSG End of Life (EOL) Programme Board and disseminated to all relevant parties.

Including but not exclusively:

- St Peter’s Hospice, Charlton Road, Brentry, Bristol BS10 6NL. Please email CQITeam@StPetersHospice.onmicrosoft .
- Weston Hospicecare, Jackson-Barstow House, 28 Thornbury Road, Uphill, Weston-super-Mare, BS23 4YQ. Please email Community-team@westonhospicecare.org.uk .

- For dissemination to GPs, care homes, SWAST, BrisDoc, secondary care and others, Remedy will be updated (email BNSSG.referral.service@nhs.net) with any amendments being approved by the End of Life Programme Board whose responsibility will be to ensure effective communication and dissemination of any changes to relevant parties.

Executive Summary

Healthcare professionals provide care and support to adults dying with a life limiting illness in their own homes, in hospices, hospitals and care homes. Healthcare professionals (HCP) all aim for the optimum management of end of life (EOL) symptoms, with the comfort of the patient dying being of paramount importance for all. As they approach the last days of life and may be unable to swallow oral medication, this guideline seeks to avoid distress caused by delayed access to medicines by anticipating need, and providing appropriate medication in the home (GSF 2006, Wilcock et al 2020). For palliative care service users who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication.

Implementation

This policy must be cascaded by clinical managers to all clinicians who will be involved in end of life care. All staff involved in caring for people at the end of their lives should be aware of this policy and associated documents. All staff involved in caring for people at the end of their lives should attend training appropriate to their role. All staff involved in end of life care should be aware of the correct documents and record keeping requirements within EMIS and shared care records.

Consultation Process

Key individuals involved in developing the document

Name	Designation
Dr Dida Cornish	Consultant in Palliative Medicine, St Peter's Hospice & UHBW
Karla Smith-Bishton	Clinical and Operational Lead, Sirona End of Life Specialist Service
Dr Andrew Appleton	GP and Clinical Digital Lead and CCIO BNSSG ICB
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Kate Ryan	Medicines Optimisation Pharmacist

Circulated to the following individuals/groups for consultation

Name of Individual & designation	Date approved
BNSSG ICS wide Anticipatory Medicine Task & Finish Group	10 February 2023
Sirona End of Life Steering Group	10 February 2023
Sirona Medicines Management Group	10 February 2023
BNSSG ICB EOL Programme Board	10 February 2023
Fiona Chiplen Consultant Palliative Medicine Weston Hospice Care	10 February 2023

Details of approval by Lead Director

Director	Designation	Date approved
Dr Alison Wint	Interim Medical Director, Sirona care and health	13 February 2023

Circulated to the following Committee for Ratification

Name of Committee(s)	Date ratified
Sirona Professional Council	13 February 2023

Version Control

Version	Updated By	Updated On	Summary of changes from previous version

Contents

1. Introduction/Policy Summary

Service users with a terminal illness, who are deteriorating often experience new or worsening symptoms as they approach the last days of life and may be unable to swallow oral medication. This guideline seeks to avoid distress caused by delayed access to medicines by anticipating need, and providing appropriate medication in the home (GSF 2006, Wilcock et al 2020). For palliative care service users who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home for the management of symptoms which commonly occur in the last days of life (NICE 2015). A range of subcutaneous (SC) medication should be prescribed and authorised on the Community Palliative Care Drug Chart to allow clinicians working in the community, to administer if the service user is unable to take oral medication. Individuals who deteriorate or develop uncontrolled symptoms will always require full clinical assessment to ensure there is appropriate treatment of any reversible factors and a clear management plan. Anticipatory prescribing should be tailored to the individual person and circumstances, taking into account risks and benefits of prescribing in advance. Service users and carers must consent to JiC medication in the home.

The Dying without dignity report (Parliamentary and Health Service Ombudsman 2015) identified key themes in their casework;

- Not recognising that people are dying, and not responding to their needs – if the needs of those who are close to death are not recognised, their care cannot be planned or co-ordinated, which means more crises and distress for the person and their family and carers.
- Poor symptom control – people have watched their loved ones dying in pain or in an agitated state because their symptoms have been ineffectively or poorly managed
- Poor communication – poor communication is an important element in our complaints on end of life care. It is clear that healthcare professionals do not always have the open and honest conversations with family members and carers that are necessary for them to understand the severity of the situation, and the subsequent choices they will have to make.

- Inadequate out-of-hours services – people who are dying and their carers suffer because of the difficulties in getting palliative care outside normal working hours.
- Poor care planning – a failure to plan adequately often leads to the lack of co-ordinated care, for example, GPs and hospitals can fail to liaise.
- Delays in diagnosis and referrals for treatment – this can mean that people are denied the chance to plan for the end of their life and for their final wishes to be met.

In keeping with the Leadership Alliance for the Care of Dying People in its report One Chance to Get it Right (2014), and NICE Guidance NG 31 Care of dying adults in the last days of life (2015); considering the 5 priorities of care and providing pharmacological management of common symptoms at the end of life and appropriate non-pharmacological methods of symptom management are an important part of high-quality care at the end of life. Using an individualised approach to prescribing anticipatory medicines for people who are likely to need symptom control in the last days of life.

2. Definitions

Provision of medication in advance, in anticipation of symptoms occurring at the end of life has been termed anticipatory prescribing or pre-emptive prescribing. The terms 'Just in Case' (JiC) medication, anticipatory medication and 'Just in Case' box / bag (where available) are also used. For the purpose of this guideline the terms 'Just in Case' (JiC) medication and anticipatory prescribing (AP) will be used.

3. Purpose

To ensure that:

- Common symptoms in the last days of life (e.g. pain, secretions, nausea and vomiting, agitation and shortness of breath) are anticipated and treated promptly.
- Appropriate 'Just in Case' medicines are prescribed in advance for the service user and stored in the service user's home.
- The JiC medicines can be easily identified in the home by healthcare professionals by ensuring they are appropriately labelled and stored, this may be in a 'Just in Case' box or 'Just in Case' bag if available.
- Carers and service user's understand the purpose of the JiC medication.

- To provide uniform clinical guidance and a consistent safe framework for the use of JiC medication for patients in the community at the end of life, across the Bristol, North Somerset and South Gloucestershire area.
- To ensure that there are adequate local governance structures and excellent recording to facilitate evaluation and audit of the policy of anticipatory prescribing.

4. Scope

This guideline covers anticipatory prescribing for symptoms in the last days of life and does not include guidance on the diagnosis of dying or guidance on other aspects of care at the end of life.

It is relevant to:

- Service users in the community with a terminal illness who have been assessed by a qualified healthcare professional as actively deteriorating and are in the last few weeks or days of life.
- Healthcare professionals in the community and in inpatient settings caring for these service user's e.g.:
    - General Practitioners
    - Specialist Palliative Care Professionals
    - District Nurses
    - Community Nurses
    - Other Registered Nurses working in the community e.g., Community Matrons, Advanced Clinical Practitioners
    - Allied Health Professionals with appropriate competencies
    - Community pharmacists and dispensing staff
    - Out of hours services including GPs and Rapid Response.
    - Hospital and Hospice doctors discharging patients home for end of life care.
    - Ambulance staff

- It is accepted that healthcare professionals working in the community (with appropriate competencies) may take the lead, or be involved in provision, or

administration of JiC medication (e.g., Hospice at Home Nurses, Community Nurses or other registered professionals with appropriate competencies).

- Ambulance clinicians with the necessary competencies (defined by their own policy) may administer PRN medication recorded on an authorisation chart but are not trained in the use of syringe pumps.
- The principles of anticipatory prescribing apply to patients in Care Homes. Individual Nursing Homes may choose to use their own paperwork for prescribing. However it is recommended they use the Community Palliative Care Drug Chart and add a note on the regular Medicines Administration Record (MAR) chart that this is in use. See cautions below with regard to authorising syringe pumps in advance or with dose ranges in a Nursing Home setting.

5. Service user suitability for anticipatory prescribing

The service user will have been assessed by a qualified healthcare professional as actively deteriorating and in the last few weeks or days of life and this will have been communicated to the service user and, wherever possible, to their relative/carers.

The service user and, wherever possible, the relative/carer must understand the purpose of the JiC medication and agree to the principle of anticipatory prescribing for end of life symptoms. For service users who lack capacity the principles of the Mental Capacity Act (1983) regarding treatment decisions must be followed.

The service user may be dying of malignant or non-malignant disease. If there is uncertainty as to whether the service user is in the last few weeks or days of life, anticipatory prescribing should be considered only for those who have actively engaged in advance care planning discussions, favour a palliative approach to the management of their illness and have expressed the wish to avoid hospital admissions and remain at home.

Exclusions/Cautions:

The service user, their carers or visitors to the house have a history of drug misuse or there is a strong suspicion to indicate this. (individual risk assessment will be needed).

Service users who are themselves unwilling to participate, or with carers who are unwilling to participate.

Service users with a life limiting illness who are receiving active treatment, such as chemotherapy, who may require urgent medical assessment and hospital admission for treatment of a reversible condition for example complications of treatment and those with a life limiting illness who have a longer prognosis than last weeks of life, who would want active treatment in hospital for reversible factors. In these service users it is **imperative** that the box on the front of the chart is completed to indicate that the chart is being used for symptom control in a service user with a life limiting illness who is not end of life (**see image 1 below** and section 7 for more information).

See also 9.1 for specific cautions related to syringe pumps in advance and/or with ranges.

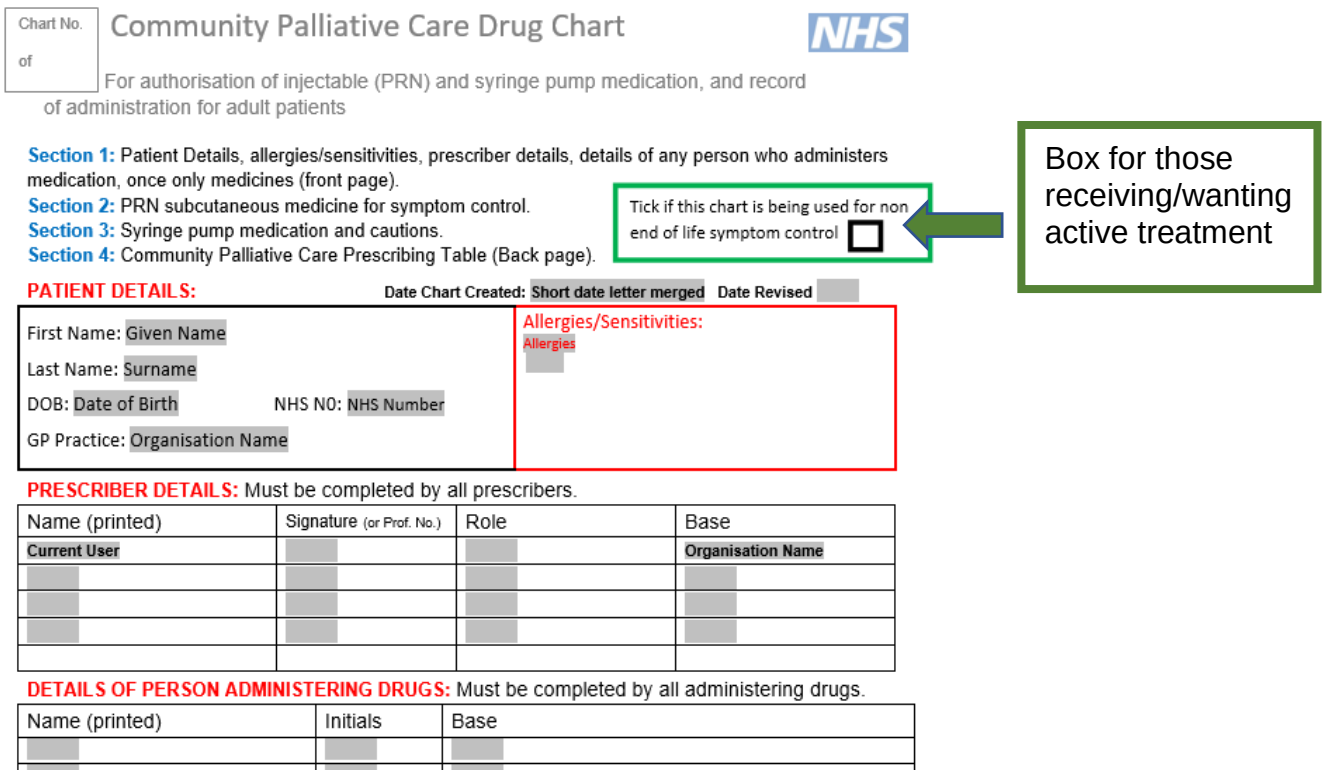


Image 1

6. Procedure for the provision of 'Just in Case' medication in the community

- Registered community clinicians, Specialist Palliative Care Nurse, GP or other relevant health care professional should identify appropriate service user ahead of need. The need for JiC medication should be part of the regular review of service users on the palliative/supportive care register during the practice palliative care (or Gold Standards Framework) meeting.
- Discussions by involved healthcare professionals with the service user and wherever possible the relatives/carers should include:
    - current medical situation and the plan of care.
    - the concept of JiC medication.
    - consent for medications to be left in the home.
- A GP, doctor or non-medical prescriber with appropriate training, who is actively involved with the service user should provide an individualised prescription (FP10) for JiC medications, taking into account the service user's current medication, current and past medical history and known intolerance or allergies to medication. The prescriber should refer to relevant guidelines (See section 8).
- The GP, doctor or non-medical prescriber should authorise the same drugs on the Community Palliative Care Drug Chart to allow registered clinicians to administer medications if needed for symptom control in the future.
- The prescriber or community clinician will ensure the service user/carer is able to get the medicines dispensed from the pharmacy.
- If the medications are needed urgently the prescriber or community clinician should ensure the local pharmacy has enough stock to dispense the prescription or refer to the list of pharmacies which stock Palliative Care Medication under the NHS Specialist Medicine Service and send the prescription to the most convenient one. Many of these pharmacies have extended opening hours.
- The prescriber or community clinician should check the understanding of the service user and carers about the plan of care and the JiC medication and give them a leaflet on 'Just in Case' medication (appendix 10), which will be available on Remedy.

- Depending on the current clinical situation, prognosis and setting (see below) it may be appropriate to prescribe and authorise only as required (PRN) subcutaneous medication (last weeks of life) or both syringe pump medication **plus** PRN medication (approaching last days).
- The prescriber must consider the risks and benefits of prescribing in advance, particularly in a rapidly changing service user. The drugs and doses prescribed will need regular review. In particular, it will not always be appropriate to prescribe syringe pump medication in advance due to the difficulty of predicting what drugs and doses a patient may need (see cautions below).

7. Community Palliative Care Drug Chart

All 'Just in Case' medication will need to be prescribed on an FP10 form in the community and written (authorised) on the Community Palliative Care Drug Chart. This chart has been approved across Bristol, North Somerset and South Gloucestershire to authorise Registered Clinicians working in the community to administer subcutaneous/injectable PRN or syringe pump medication for symptom control in palliative care service users who are in one of the following groups:

- Those who cannot take oral medication, because they are in the last few days of life.
- Those who cannot take oral medication for another reason e.g. nausea and vomiting or bowel obstruction. In those who have a longer prognosis than weeks it is important to tick the box **'non end of life'** on the front of the chart. In this situation clinicians should ensure appropriate advance care planning discussions have taken place and decisions related to future hospital admission for reversible factors should be clearly recorded on a ReSPECT form and in the ReSPECT plus electronic record.

In the community the chart can be completed by a GP, other doctor or non-medical prescriber (with the necessary skills, as specified by their respective organisation, in palliative care). Service users may also be discharged from a hospital or a hospice with the necessary JiC medications and the chart already completed (see section 8).

The chart includes the Community palliative care prescribing table: symptom control in last days of life for adults (appendix 7). This table represents local consensus based on local guidelines and the Palliative Care Formulary (Wilcock A, PCF7 2020).
The prescribing advice within the chart is general guidance only and as such a health care professional is at liberty to use their clinical judgement and take an individualised approach to prescribing. However, it is suggested that clinicians should seek specialist advice when deviating from this guidance and document the rationale for doing so. More guidance is available within this SOP and additional resources are available on the St Peters Hospice web-site. http://www.stpetershospice.org.uk/Clinical-Guidelines

7.1 Use of EMIS, the electronic and paper prepopulated charts

Electronic rich text versions of the chart are available in EMIS, in Brisdoc out of hours service and in some other settings such as hospitals and hospices. These charts will often be printed out in black and white with typed drug names and may be signed electronically with a professional number not a 'wet' signature next to each drug. There are also pre-printed colour card booklet charts which can be handwritten. Both charts are acceptable, but if you are hand writing the chart you must apply a wet signature and date to each drug and the front page of the chart. It is essential that the electronic charts are printed out (ideally double sided) and stapled safely to represent the booklet with drugs and administration pages lined up correctly.This may be undertaken by the prescribing clinician and placed for collection by the community team/relative or printed directly from EMIS or email by the community nursing team and taken into the house.

A locally developed Anticipatory Drugs Protocol is available for GP EMIS to issue FP10s and an appropriate EMIS document version of the Community Palliative Care Drug Chart. The protocol is designed with specific prompts so that the most appropriate chart and prescription is produced. Resource publisher is available to nearly all local practices, so it is vital that practices use the most recent version of the protocol which is available in the One Care Shared folders, and delete all old versions from their own folders.

It is best practice to individualise prescribing in AP. There is a pre-populated chart within the EMIS protocol which should only be used for patients who are opioid naïve, have an eGFR>30 ml/min/ 1.73m^2 and where metoclopramide is appropriate. For all other patients it is important to select 'no' when asked if you want to issue the default set of anticipatory medications. Always follow the prompts and take note of the automated alerts (e.g., for Parkinson's Disease or renal function). If followed correctly for all other patients the chart produced will have drop downs for each drug option which can be selected. There are also boxes with no drop downs where more unusual drugs can be authorised.

Prescribers MUST ensure the front page is completed with their details and signature/professional number (electronic version) in addition to adding their signature/professional number and DATE for each individual drug on the PRN and Syringe pump pages. Within EMIS/on the electronic version it is acceptable to sign each drug with a GMC or other professional number and type the date for each one. All those administering drugs must complete their details and signature on the front page in addition to signing and dating each drug administered.

It is possible for Community Nurses to print the completed chart from GP EMIS and take to a patient's house, but essential that the prescriber has discussed this directly with the relevant team via Sirona SPA to check this can be achieved in time. For out of hours prescribers completing an electronic chart, it is essential that a telephone referral is made to Sirona Single Point of Access (SPA) giving an indication of how urgently the chart will be needed in the home. The SPA staff will give instructions on emailing the chart. For patients being discharged from an inpatient setting with a chart, it would be ideal if the chart could be emailed to Sirona, after making a telephone referral to the SPA.

To update an existing electronic chart in EMIS with new drugs, doses or ranges the prescriber can edit the previous chart in EMIS but then 'save as' in EMIS documents to create a new version renamed e.g. as version 2. This will ensure it appears with the correct date without over writing the previous version. They must ensure they add the new date on the front of the chart and sign and date any changes. If creating a 2nd chart to be used

in addition to existing chart this must be clear on the front e.g. 2/2. See section regarding superseded charts.

For additional prescribing advice see section 9.

8. ‘Just in Case’ medication for inpatients being discharged into the community

The principles of anticipatory prescribing for end of life symptoms apply to service users being discharged from a hospital/hospice who meet the criteria set out in section 5. A discussion should take place to ensure the service user understands and consents to JIC medications being sent home with them (see section 6) and if the service user agrees, informal carers/relatives should be informed if possible.

Individual hospital trusts will produce their own policy/guidance regarding the procedure and governance for providing JiC medication and completing Community Palliative Care Drug charts for appropriate patients on discharge. However, the principles here will be followed by all inpatient organisations.

For inpatients being discharged into the community from hospital or hospice who meet the criteria for anticipatory prescribing, the appropriate injectable JiC medication should be supplied on discharge. The Community Palliative Care Drug Chart should be completed with ‘as required’ JiC medication by doctors or non-medical prescribers based in the Hospital Palliative Care Team (HPCT), on the hospital wards or based at the local hospice. Individual trusts will put in place processes to ensure there is prescribing advice or checking of the anticipatory prescribing on the charts if not completed by a member of the HPCT.

For inpatients being discharged from hospices who are approaching last days or on syringe pumps, the hospice prescribers will follow the guidance in this policy and where appropriate authorise syringe pumps in advance, ‘to start when needed’ and appropriate syringe pump ranges.

If the inpatient is being discharged from an acute trust on a syringe pump the current medication will be authorised on the Community Palliative Care Drug Chart by a hospital prescriber. Due to the high turnover of staff it may not be possible to train/supervise junior doctors in the acute trusts to authorise syringe pumps in advance or ranges for pumps on

the Community Palliative Care Drug Chart. If the HPCT are involved the team may be able to facilitate the authorisation of syringe pumps to start when needed or appropriate syringe pump ranges, prioritising those being discharged from hospital and who are approaching last days, particularly those who already have 1 or 2 drugs in a syringe pump. If this has not been possible they should inform Sirona SPA that the patient is approaching last days when they make the referral.

When sending service users home with JiC medication staff must inform the GP via the discharge letter and Sirona care and health via the Single Point of Access (SPA) by making a referral on 0300 125 6789. A service user should not be discharged without prior arrangements being made and confirmed by phoning Sirona's SPA. If completed, the Community Palliative Care Drug Chart should accompany the service user home with the prescribed medication on discharge. If possible the SPA may also advise emailing a copy of the chart to Sirona for their records.

Once the service user is in the community it is the responsibility of primary care prescribers to complete / update the chart.

8.1 Process for inpatients discharged into the community on a syringe pump

Any service users who are discharged to the community and require a syringe pump should be discussed in advance with the relevant community nursing team. Community teams should not be using hospital's syringe pumps whilst a service user is in the community. If a service user is discharged to the community with a hospital or hospice syringe pump in situ, the relevant community team should endeavour to swap the syringe pump for a Sirona community syringe pump and send the original pump back to the hospital or hospice at the earliest practicable opportunity.

The protocol for when service users are discharged from University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), who have been on a syringe pump, is that they are administered appropriate STAT doses by the hospital staff prior to being discharged. This is because the syringe pump will have been removed by the ward prior to discharge. Service users should not be discharged until ward staff have received confirmation from Sirona care & health's Single Point of Access (SPA) that the community teams are able to

accept the referral. Once the referral has been accepted, UHBW ward staff are to contact the relevant community team, on the number that SPA will provide, when the person has left hospital so that their visit can be scheduled. Sirona care and health community staff will then meet the individual at their home or new setting to set up a Sirona syringe pump as required. The syringe pump must be signed out of the Integrated Network Team (INT) hub completing the relevant information.

9. Prescribing guidance for Just in Case medication

See also appendix 6: Anticipatory prescribing (AP) of Just in Case (JiC) medication for symptom control in adult palliative care patients in last days of life: BNSSG quick reference guide and appendix 7: Community palliative care prescribing table.

In general, individualised prescribing is recommended. For example, if a service user is already on a specific opioid or antiemetic that suits them, then this should be converted to the equivalent subcutaneous dose if available. For those on patches the opioid which they use as required should be converted to the equivalent subcutaneous dose. Advice about prescribing is contained within the Community palliative care prescribing table: symptom control in last days of life for adults.

Please note: The prescribing advice here and within the table is general guidance only and as such a health care professional is at liberty to use their professional judgement (following recognised formularies/guidance) to take an individualised approach to choice of drug, dose range, frequency and number of ampoules provided. However it is suggested that clinicians should seek specialist advice when deviating from this guidance and document their reason for doing so.

9.1 Provision of as required (PRN) subcutaneous medications only

For service users who have been assessed by an experienced clinician(s) as deteriorating and thought to be in the last few weeks of life (i.e., those who are likely to have difficulty with oral medication in the next few weeks) the prescriber should consider prescribing and authorising PRN JiC medication. When authorising PRN medication the prescriber may indicate a maximum dose which includes PRN and syringe pump doses. It is common

practice not to indicate a maximum for the opioid unless there is a specific concern, such as opioid toxicity or history of abuse.

PRN subcutaneous medications should be provided for each of the 5 symptoms commonly experienced at the end of life: i.e.: pain (opioid), dyspnoea (also use opioid), nausea/vomiting, agitation and respiratory tract secretions.

The following medications are usually provided (refer to the table in Appendix 6 for more detail)

- Opioid: The appropriate drug and dose should be chosen for the individual. If the service user is on oral morphine; SC Morphine is first choice due to cost. NB the highest concentration of injectable morphine is 30mg/ml therefore the maximum PRN injection dose is 60mg (2mls). The equivalent SC diamorphine dose should be prescribed instead of morphine for higher doses than this.
- Anti-emetic: The appropriate drug should be chosen for the individual depending on likely cause of nausea and any contra-indications. If the patient is already on an antiemetic convert this to SC dose if available. NB cyclizine is not the first choice as it is a painful injection and is incompatible in a syringe pump with hyoscine butylbromide and with higher doses of oxycodone.
- Sedative: Midazolam is the usual first line drug for agitation at the end of life. Haloperidol (less sedating) may be used for hallucinations/delirium and levomepromazine may be used second line for agitation if midazolam is not effective.

  Anticholinergic for secretions: Hyoscine butylbromide is the first choice in BNSSG due to the small risk of delirium with hyoscine hydrobromide. Hyoscine butylbromide is not compatible with cyclizine so if this antiemetic is prescribed glycopyrronium should be prescribed as the antisecretory.

For all patients the amount prescribed should be tailored to the individual person. For most service users at least 10 doses of each medication are recommended. For less complex patients, for example those who are currently not symptomatic e.g., those with frailty of old age 5 ampoules may sometimes be sufficient. For more complex service users e.g., those requiring frequent PRN medications it is important to consider their 24 hour requirements

and estimated PRN use. Water for injection should also be prescribed at this time, so it is available if a syringe pump is needed.

Standard example if prescribing PRN drugs only:
Midazolam 10mg/2ml (10 vials)
Hyoscine butylbromide 20mg/ml (10 vials)
Opioid (10 PRN doses)
Antiemetic (10 doses)
Water for injection 10ml (20 doses)

PRN lorazepam tablets may be prescribed sublingually for anxiety (0.5-1mg 8 hourly).

The need for other oral PRN medication should also be considered but is beyond the scope of this guidance.

9.2 Provision of syringe pump medication for subcutaneous administration over 24 hours

For service users who have been assessed by an experienced clinician as approaching the last days of life, with no reversible factors consider prescribing and authorising syringe pump drugs (Collis 2013) in the circumstances described in this section.

For service users who are unable to swallow, the prescriber will usually provide an FP10 and authorise on the Community Palliative Care Drug Chart the following:

- Current regular medication for symptom control, such as analgesics and anti-emetics, converted to equivalent doses for subcutaneous use in a syringe pump. Tick box 'start today' and indicate starting dose.
- Any other medications that are now required for symptom control in the syringe pump. Tick box 'start today' and indicate starting dose.
- PRN subcutaneous medication for the 5 common symptoms.

- If appropriate syringe pump medication may be authorised in advance and tick box to ‘start when needed’ for any of the 5 common symptoms ‘Just in Case’ they are needed in the in the future (see cautions below).
- Authorisation of an appropriate range may be considered for syringe pump drugs, see cautions below.
- A diluent should be prescribed and authorised for the syringe pump (usually water for injection).

For service users who can still swallow but are likely to have difficulty with oral medication in a number of days, as they approach the last days of life, the prescriber should complete an FP10 and authorise the following:

- PRN subcutaneous medication for each of the 5 common symptoms.
- If authorising syringe pump drugs where it is anticipated they are needed imminently, this should include appropriate conversion of current regular oral drugs for symptom control. In this instance the prescriber may choose to tick the box ‘start when needed’.
- Authorisation of an appropriate range may be considered for syringe pump drugs, see cautions below
- A diluent should be prescribed and authorised for the syringe pump (usually water for injection).

If appropriate, the prescriber may authorise a modest dose range for the syringe pump medications to allow for 1 or 2 dose increases by community clinicians (see cautions below).

If authorising a dose range for syringe pump drugs the prescriber should tailor this to the individual person and circumstances. A conservative range would allow for incorporation of 2 PRN doses of opioid or midazolam. The usual maximum range would allow for incorporation of up to 4 PRN doses.

E.g. Morphine 30mg SC over 24 hours via syringe pump (PRN dose is 5mg) Conservative range: 30-40mg/24 hours. (A range of 10mg i.e. 2 x 5mg) Usual maximum range: 30-50mg/24 hours.(A range of 20mg i.e. 4 x 5mg).

Seek specialist advice e.g. from a hospice healthcare professional if considering authorisation of a wider range for syringe pump drugs.

For those requiring a syringe pump the prescriber should ensure there is enough medication for 7days including PRN medication.

For those where JiC syringe pump medication is being provided in advance, to start when needed, the prescriber should ensure there is at least enough medication for 3 days (e.g. to cover a long weekend).

For all opioids except alfentanil the correct SC PRN dose should be equivalent to 1/6th of the total 24 hour background SC opioid. For alfentanil PRN the calculation is 1/10th of SC alfentanil equivalent over 24 hours. Therefore, when increasing a syringe pump dose the PRN should be increased in line with these calculations. Seek specialist advice for complex calculations e.g., involving more than one opioid.

9.3 Cautions re authorisation of syringe pump drugs to start when needed and/or with range

There are some risks associated with prescribing syringe pumps in advance and/or with dose ranges as identified in the recent report of the Gosport Independent Panel (2018). However, it is accepted practice in many regions and an audit, in this region, following the launch of stricter guidelines incorporating the cautions below showed good adherence to safe practice (Cornish 2017)

Syringe pump drugs should usually only be authorised ***in advance to start when needed*** for patients who are thought to be approaching the last days of life, with no reversible factors who are likely to lose their oral route in a number of days. Occasionally syringe pump drugs may be authorised to start when needed for symptom control in a palliative care service user who is at high risk of a specific symptom e.g. vomiting from bowel obstruction where decisions about future admission to hospital for reversible causes are clearly documented. If authorised in advance for a specific symptom in someone who is not in last weeks or days of life the box on the front 'non end of life care' should be ticked and it would not be appropriate to prescribe in advance for other end of life symptoms such as midazolam for agitation.

In some settings (e.g. some nursing homes) the nurses may not have received adequate training to administer syringe pump drugs based on an authorisation written in advance 'to

start when needed' and/or with a range of drug doses. In these situations the prescriber should assess whether it is more appropriate to prescribe PRN drugs only. Syringe pump drugs would then be authorised with a specified start dose at the time they are required. Alternatively for those approaching last days a clinician may choose to authorise a tighter range or no range on the syringe pump drugs in these settings.

9.4 Prescribing for patients in the last days of life: guidance for specific circumstances*

Service users on fentanyl or buprenorphine patch

The dose of opioid patch is not usually titrated in last days of life, as the slow absorption would result in delays achieving required increases, but the patch is kept in place and changed as usual. Tick the box if on an opioid patch on the PRN page of the chart and complete details.

PRN subcutaneous analgesic (converting their usual oral PRN opioid) should be prescribed at a dose appropriate to the patch strength in case the patient is unable to swallow. If a person is approaching last days of life consider authorising a syringe pump to start when needed for the 5 common symptoms. The dose range for the opioid can be the calculated equivalent to two-four SC PRN doses of opioid. If several PRN doses are needed, a syringe pump can be set up containing appropriate opioid in addition to the fentanyl or buprenorphine patch.

Patch type	Patch strength Micrograms/hr	Equivalent 24 hour dose oral morphine	Equivalent 24 hr dose subcutaneous morphine	PRN SC dose of morphine	Syringe pump 'to start when needed'
Fentanyl	25mcg/hr	60-90mg/24hrs	30-45mg/24hrs	5-7.5mg 1 hourly	Morphine 15-30mg/24 hrs
Buprenorphine	20mcg/hr	36-65mg/24hrs	~15-30mg/24hrs	2.5-5mg 1 hourly	Morphine 10-20mg/24 hrs

Steroids

Continue steroids if considered essential for symptom control for example if symptomatic of raised intracranial pressure or bowel obstruction. In those where they were prescribed

for general wellbeing or not thought to be helpful for symptoms consider discontinuation or gradual reduction. See St Peter's Hospice clinical guidelines on their website for more detail on steroids in palliative care.

Dexamethasone 4mg orally is considered equivalent to dexamethasone 3.3mg injection prescribed as dexamethasone base. Dexamethasone may be given as a single daily SC injection, preferably in the morning, if dose is 6.6mg or less (ampoules are 3.3mg/ml or 6.6mg/2ml). Dexamethasone at doses of >6.6mg can be administered via a syringe pump. It is incompatible with most other drugs so a second syringe pump is usually required.

Seizures/anticonvulsant drugs

For individuals approaching last days of life, on anticonvulsant drugs for the control of seizures who are unable to take oral medication (or those likely to become unable to take oral medication in the next few days): prescribe and authorise midazolam 20-30mg/24 hours SC via syringe pump for control of seizures (seek advice about using lower doses e.g. 10-15mg/24 hours in frailer/very low weight patients with good seizure control on monotherapy). Prescribe Midazolam 10mg SC/IM or Buccal PRN for treatment of a prolonged seizure >5 minutes, which can be repeated after 10 minutes in status epilepticus (seek advice about using lower doses in frailer/very low weight patients). Some antiemetics lower the seizure threshold. If patient has a primary brain tumour/history of seizures consider cyclizine as 1st line antiemetic and glycopyrronium as the anti-secretory for anticipatory prescribing (hyoscine butyl bromide does not mix with cyclizine in a pump). Seek specialist advice from epilepsy/neurology experts for those **not** in last days of life. Levetiracetam can be administered in a syringe pump but only with involvement/guidance from hospice or palliative care teams.

Service users at risk of major haemorrhage

Consider authorising crisis medication e.g., Midazolam 10mg IM/Buccal on the front of the chart as a once only medication but seek advice from the local hospice team.

Service users with Parkinson's Disease

For service users with Parkinson's Disease avoid use of anti-emetics such as haloperidol and metoclopramide. Ondansetron is the subcutaneous anti-emetic that is least likely to worsen Parkinson's symptoms. For difficult to control nausea or vomiting Cyclizine is 2nd line and levomepromazine is 3rd line, although both carry some risk of exacerbating Parkinson's symptoms. Seek advice on managing rigidity from Parkinson's Disease Specialist Nurse if available. Convert oral medications to a patch using http://parkinsonscalculator.com/. Additional guidance is available on St Peter's Hospice Guidelines page.

Service users with inoperable complete gastro-intestinal (GI) obstruction

Seek specialist advice from the local hospice team. Metoclopramide may be used in a syringe pump if there is incomplete obstruction and absence of colic. Avoid metoclopramide in complete obstruction or in the presence of colic. Hyoscine butylbromide can be used via a syringe pump for colic and to reduce volume of GI secretions alongside haloperidol or levomepromazine as an antiemetic.

Service users with Renal failure

It is not usually necessary to adjust doses of JiC medications if eGFR is > 30 ml/min/1.73m^2 If eGFR <30 ml/min/1.73m^2 the clinician can make a judgement about reducing doses if there is a clinically relevant risk of side effects. This will include weighing up prognosis, severity of symptoms and risk of side effects. Appropriate dose reductions are available on the community prescribing table appendix 6. For guidance on the use of opioids if eGFR <30 ml/min/1.73m^2 see guidance on fentanyl and alfentanil available on St Peter's Hospice guidelines web page, and seek specialist advice from the local hospice team. Again it is important to weigh up the risk of side effects from using more commonly used opioids

against the risk of prescribing drugs where community staff are less familiar with their use and there is a greater risk of administration error.

Service users with liver impairment

It is not usually necessary to change opioid prescribing for AP in mild to moderate liver impairment but seek specialist advice if needed. Those with severe impairment, classified as Charles-Pugh score of C may be more at risk of side effects from JiC medication. This is more likely in those with cirrhosis than liver metastases. The clinician should make a judgement about reducing doses if there is a clinically relevant risk of side effects. This will include weighing up prognosis, severity of symptoms and risk of side effects. Consider seeking specialist advice from local hospice team. Appropriate dose reductions are available on the prescribing table (appendix 6).

Service users with severe frailty and/or low body mass index

The clinician should make a judgement about reducing doses if there is a clinically relevant risk of side effects. This will include weighing up prognosis, severity of symptoms and risk of side effects. Appropriate dose reductions are available on the prescribing table (appendix 6). Consider seeking specialist advice from local hospice team.

Informal Carer Administration of Subcutaneous Injections in the Community for End of Life Care

Informal carers such as family members or close friends can be trained to give SC as required injections for symptom control at the end of life. There is a robust Sirona policy relating to the approval, training and documentation of this process which must be followed.

10. Communication and documentation

Good communication with service users, their relatives and carers is an essential aspect of end of life care. “End of life care is care that affects us all, at all ages, the living, the dying and the bereaved.” (Ambitions for Palliative and End of Life Care 2021). The ambition is for everyone approaching the end of life to receive high quality care that reflects

individual needs, choices and preferences (DoH 2016). Supported by NICE Quality Standard for End of Life Care (2017), One Chance to get it right (Leadership Alliance 2014), Ambitions for Palliative and end of life care (2021) and the NHS Long Term Plan (2019). Anticipatory prescribing is designed to provide prompt symptom relief at whatever time the service user develops distressing symptoms. It involves the prescribing by a GP, other doctor, or Non-Medical Prescriber of a range of medications that are dispensed and kept in the persons house until they are needed. They may be kept in a specially marked container called a 'Just in Case Box or Bag' if available and should be individualised to the person's needs.

Research (Bowers et al 2022) has shown that informal care givers and patients are generally reassured by anticipatory prescribing (Bowers et al 2019). However there can be confusion and concern for carers relating to AP and therefore it is essential that the patient and, with their consent, relevant carers receive an adequate explanation. Concerns include that they are an unwelcome reminder of impending death but also there may be incorrect assumptions that drugs will be used to hasten death. Therefore they should always be offered a copy of the local leaflet, which is available on Remedy and found in appendix 10.

Advance care planning is a process whereby an individual makes clear their wishes relating to their care in the future should they not have capacity to make decisions related to their care and/or have lost the ability to communicate their wishes to others in the future. Everyone approaching the end of their life should be offered the chance to create a personalised care plan. Any information about the person's wishes and relevant advance statements that they made prior to their loss of capacity should be taken into account when making best interest decisions. This should be recorded in the service user's medical record and if they consent in the ReSPECT plus electronic record. Provision of 'Just in Case' medication will usually take place as part of this care plan after a discussion with the service user (and relatives/carers if possible/relevant) about their current situation and what to expect in the future. Detailed guidance on care and communication in the dying person is beyond the scope of this guidance.

The detail of communication and prescriptions should be documented in the relevant clinical notes and the community nursing record in the home. If the service user consents,

or a decision is taken in their best interests, all relevant information should be entered on to ReSPECT Plus record, which contains a specific section for anticipatory prescribing.
Out of hours teams and all relevant professionals e.g. Hospice Teams/ambulance should be informed of the present clinical situation, plan of care and medications prescribed. This is best achieved through completion of the ReSPECT plus record as there will be automated notification to the ambulance and write back into EMIS records.

11. Managing 'Just in Case' medication in the home

The service user/carer will obtain the dispensed medicines from the pharmacy.
If only PRN drugs have been prescribed, to aid with the easy identification of the JiC medication the Registered Clinician working in the community will do one of the following:

- Where available provide a 'Just in Case' box or bag to the service user's home and ensure medications are placed inside with syringes, needles and diluent.
- If syringe pump drugs are prescribed Sirona clinicians will bring the syringe pump box to the house when the equipment is required and ensure medications are placed in the box with syringes, needles, giving sets and diluent. If JiC medication is already authorised and in the home these drugs can be added to the syringe pump box and the JiC box or bag (if available) should then be removed by the clinician.
- Sirona clinicians will complete the Stock Card (appendix 4) for any subcutaneous controlled medication in the home. (e.g., opioid or midazolam).
- Clinicians should offer the service user the leaflet "Guide to your 'Just in Case' Medication" *(see appendix 10)* and leave the Community Palliative Care Drug Chart (completed by prescriber) in the home *(see appendix 5)*.
- The clinician should ensure the service user's carer is aware of the safe storage requirements for the JiC medication.
- The JiC medicines are prescribed for the named patient only and should never be used for any other patient.

Service users' anticipatory needs may change during the course of the illness. The community clinician should check JiC medications regularly and liaise with the GP to ensure they are appropriate in terms of quantity, dose and type. Every time any palliative

care injectable drug is administered, all injectable JiC medication should be checked. In service users who are not requiring frequent visits, a check at least every 4 weeks or after any change in clinical condition or medication is recommended. It is important to ensure medicines do not go out of date, although this is unlikely as they will usually only be in the home for a number of weeks. All checks should be documented in the patient's community record and on the stock card if appropriate (CQC 2020).

If the community clinician discovers during these checks that controlled drugs have gone missing and cannot be accounted for they should report this via Ulysses (for Sirona clinicians) or their organisations appropriate reporting procedure.

If the service user's condition unexpectedly improves it may no longer be appropriate to have JiC medication in the house. The appropriate clinician working in the community should ask the GP to review the situation and follow guidance in section 15 if JiC medication is no longer required.

The Community Palliative Drug Chart should be reviewed within 6 months and rewritten to reflect the current clinical indications or withdrawn.

12. Administration of 'Just in Case' medication

Any service user who develops uncontrolled symptoms will require a clinical assessment by a competent healthcare professional.

Administration of prescribed medication should only take place following full clinical assessment.

Assessment should include the cause of the symptom, whether there are any reversible or treatable factors and whether further investigation or assessment by a medical practitioner is required. The service user must consent to treatment (or for those who lack capacity the principles set out in the Mental Capacity Act must be followed) and wherever possible (with consent from the service user) the carer/relative should be informed. If the healthcare professional assessing the service user is unsure about the appropriate management they should seek further advice from a GP or a palliative care/hospice healthcare professional.

A medical review by GP may be required:

- If there are unexplained symptoms or an unexpected sudden change in the service user's condition.
- If there is a potentially reversible condition which requires further assessment.
- If symptoms are not controlled with prescribed JiC medication.
- If the patient or carer requests medical assessment.

The healthcare professional working in the community will document the rationale for the administration of the medication within the patient's clinical records.

If the clinician initiates or increases syringe pump medication in line with an authorised range they must take into account the service user's symptoms and their requirements over the previous 24 hours, including PRN and regular doses. **When initiating or increasing opioid in the syringe pump any regular or PRN oral opioid doses must be considered for conversion to subcutaneous equivalent. Note, it is not always appropriate to incorporate all PRN doses into the syringe pump, particularly if this would result in more than a 50% increase in total dose of opioid or midazolam. Particular caution is required if a service user has mainly movement related pain or complex psychosocial issues affecting their request for opioid or midazolam. In these circumstances consider advice from local hospice teams. The clinician must document rationale to explain the choice of dose and it is good practice to record relevant calculations.**

If the clinician starts a syringe pump based on an authorisation written in advance they should usually start on the lowest dose in range but if assessment of PRN requirements indicates the need for a higher dose (within the range) the clinician must document rationale to explain the choice of dose and it is good practice to record relevant calculations.

Clinicians will record the dose and sign for the medication administered on the Community Palliative Care Drug Chart. They will also clearly record their assessment, reason for administering the medication and clinical response in the service users record. If controlled drugs (e.g. opioid or midazolam) are administered the Stock Card (appendix 4) must be completed. Any discrepancies should be reported via Ulysses and if controlled drugs have gone missing and cannot be accounted for clinicians should also report this via Ulysses.

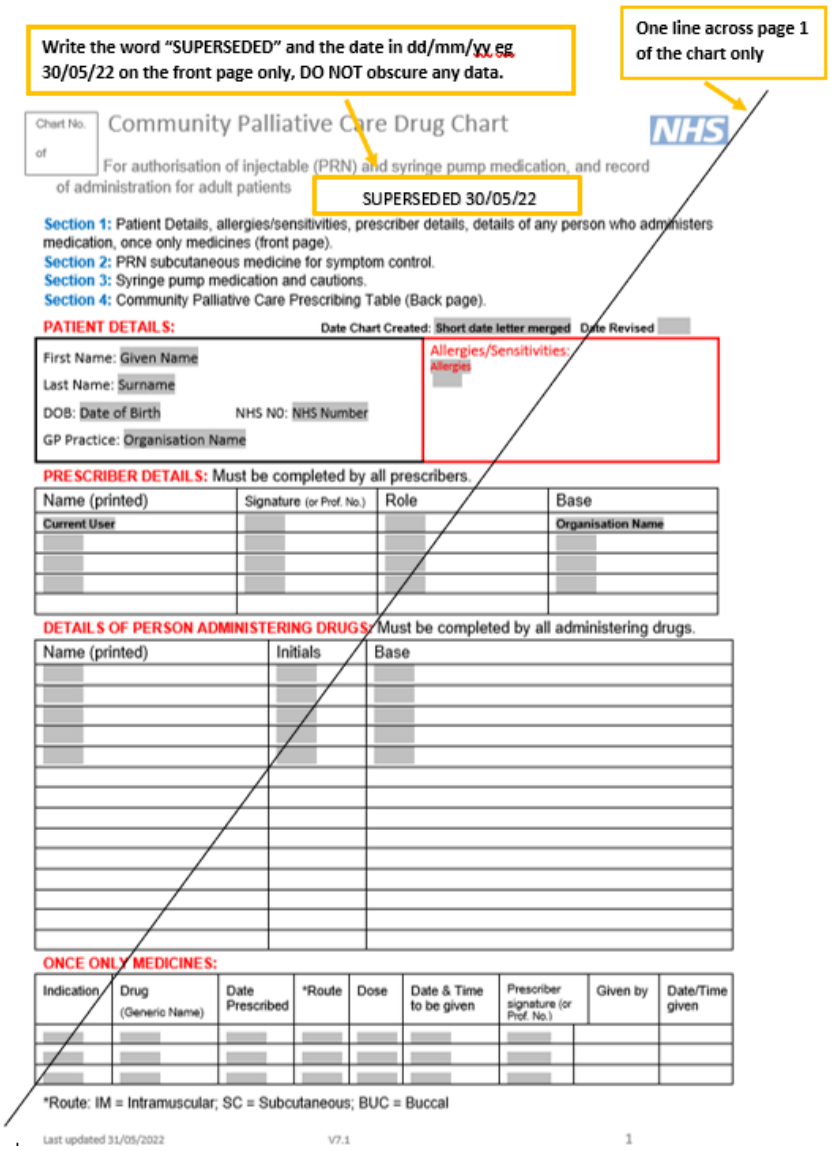
Individual care homes may choose to use their own drug chart, although it is recommended they use the Community Palliative Care Drug Chart, therefore, the record of administration must be written on the appropriate chart in addition to the organisation's nursing care plan/record. Where Sirona clinicians are required to support with syringe pumps in Care Homes, a Community Palliative Care Drug Chart must be used.

13. Following administration of 'Just in Case' medication

The service user must be reviewed by a suitably qualified healthcare professional to assess symptom control, with evidence documented in the records. How quickly this review is required should be defined by the clinician administering the medication. If a community clinician has made 2 or 3 changes to a syringe pump, based on an authorised range, and feels further changes may be needed, a review by a GP is recommended and advice from a hospice/palliative care healthcare professional may be considered. If the service user has on-going symptoms a review by a suitable community clinician e.g. GP is recommended and advice from a hospice healthcare professional should be considered (e.g. Hospice Community Nurse Specialist or Hospice Advice Line). Following GP assessment any new SC medications required should be prescribed, on an FP10 and authorised on the Community Palliative Care Drug Chart as before.

14. Superseded Community Palliative Care Drug Chart

When a replacement updated chart is issued by a prescriber it is acceptable for a community clinician who is not a prescriber to discontinue the old chart(s) by drawing a single line diagonally from bottom left corner to top right corner on the front page only. 'SUPERSEDED' should then be written at the top with the date in dd/mm/yy format e.g. 'SUPERSEDED 30/05/22', with the expectation the old chart is **removed within 48 hours**. This is because we cannot rely solely on electronic records to have the most up to date information and clinicians require the preceding doses for 24hrs to review any syringe pump medication.



See section 10 on electronic charts in EMIS.

15. Process for disposal of 'Just in Case' medication if no longer required

JiC medication should be removed from the home in the following circumstances:

- The service user dies.
- The service user is admitted to a hospice, nursing home, or hospital and does not return home before their death.
- The service user's condition improves and they are no longer actively deteriorating.

A healthcare professional should tell the service user, relative/carer to return the unused drugs to a community pharmacy for destruction. This should be documented in the service user's community record. Controlled drugs (e.g. opioid or midazolam) are also recorded on the Stock Card (appendix 4), where the 'Disposal of Controlled Drugs' section must be completed. Sirona clinicians should refer to the Controlled Drugs Policy for further information regarding the disposal of controlled drugs.

If a JiC box or bag was in use it should be returned to Sirona's Community Team, cleaned in line with the Infection Control Policy and kept ready for re-use.

16. Risk Management / Liability

As with all drugs open to abuse, medicine supplies in service user's homes may be subject to misuse. If factors related to the patient, carer or environment suggest an increased risk then healthcare professionals should carry out individual risk assessment relating to the provision of 'Just in Case' medication.

Service users and/or carers may misinterpret anticipatory prescribing as a way of hastening death. Good communication and the provision of the explanatory leaflet should improve understanding.

Professionals will need to explore fears and provide appropriate support. Anticipatory prescribing should be tailored to the individual person and circumstances, taking into account risks and benefits of prescribing in advance. Prescribing medication in advance is only safe if those prescribing and administering the medication have the appropriate skills, knowledge and competencies (see section 17).

NICE Guidance 46: Controlled Drugs and Safe Use (2016) covers the systems and processes for using and managing controlled drugs safely in all NHS settings except care homes. It aims to improve working practices to comply with legislation and have robust governance arrangements, also aiming to reduce the safety risks associated with controlled drugs. As an Integrated Care System we must have in place the minimum standard operating procedures for processes relating to prescribing, supplying and administering controlled drugs, including clinical monitoring for people who have been prescribed controlled drugs, in line with Regulation 11 of the Controlled Drugs (Supervision

of Management and Use) Regulations 2013. The NPSA Rapid Response Report (July 2008) aimed to reduce dosing errors with opioid medicines which may be caused by a lack of understanding of opioid doses or inadequate checks on previous doses resulting in mismatching the needs of the person with the dose prescribed. Therefore every healthcare practitioner involved in prescribing, dispensing and administering opioid medicines has a responsibility to check that the intended dose is safe for the individual service user. The World Health Organization (2016) highlight factors that may influence medication errors with health care professionals;

- Lack of therapeutic training
- Inadequate drug knowledge and experience
- Inadequate knowledge of the patient
- Inadequate perception of risk
- Overworked or fatigued health care professionals
- Physical and emotional health issues
- Poor communication between health care professional and with patients.

Prescribers should note that prescribing injectable medicines for subcutaneous injection is an unlicensed route but is supported by established clinical practice. Further information is available from the Medicines Healthcare Regulatory Agency (MHRA) and in the Palliative Care Formulary (2020).

Any incidents or near misses concerning anticipatory prescribing, and remedial action taken must be reported through the local incident reporting systems, for Sirona clinicians this is via Ulysses and any areas of concern will be incorporated into the annual audit programme. Any learning from such incidents should be shared with relevant colleagues to reduce the likelihood of the incident re-occurring.

In the event of a medication incident or an adverse drug reaction, immediate care will need to be undertaken to minimise harm to the patient. The standard process using the yellow card system should be followed where applicable.

17. Training and competence

This policy / standard operating procedure (SOP) will be made available to all relevant healthcare staff.

All healthcare staff to whom it applies are required to read the policy / SOP including new staff on induction.

Staff should seek further advice from their clinical manager or medicines management team if there are any aspects of the policy / SOP that they do not fully understand.

All healthcare professionals who may be involved in administering subcutaneous medication via syringe pumps for palliative care service users in the community must attend syringe pump and other relevant training as directed by their respective organisations and have adequate knowledge of the administration and titration of medication at the end of life.

Every member of the healthcare team has a responsibility to check that the intended dose of an opioid medicine is safe for the individual service user. When opioid medicines are prescribed, dispensed or administered, the healthcare practitioner concerned should be familiar with the usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose and common side effects.

Medicines should only be prescribed, dispensed and administered by staff that have the necessary knowledge and skills and are confident and competent to carry out this practice. Healthcare staff must identify their own training needs and inform their manager if training needs are identified.

The requirements for safe management of medicines may change due to changes in legislation or best practice guidance. It is therefore essential that all healthcare staff keep up to date with current practice. Clinicians employed by Sirona care and health must have attended Syringe Pump Training (Introductory) and demonstrated associated competencies and thereafter attend the 3 yearly update with self-assessment.

Staff should reflect on their medicines-related learning needs when discussing their Personal Development Plans with their manager.

18. Ordering the Community Palliative Drug Chart - Booklet

Requests for the booklet version of the Community Palliative Drug Chart are made via the CHC Fast Track team who can be contacted at bnssg.fasttrack@nhs.net. The CHC Fast Track team will place an order via the single appointed printer (Whitehall Printing) and distribute to all partners.

19. Dissemination and Implementation

Within Sirona care & health:

1. Circulate to Associate Locality Directors for dissemination
2. Update colleagues in the digital team to update EMIS template
3. Advertise the new policy on Workplace
4. Deliver webinar, which will be recorded, to highlight changes to the policy
5. Use of Link Practitioners to share within localities and teams, providing ongoing awareness
6. In-reach to provide ongoing awareness
7. Audit to monitor use of correct chart

Full details can be found in appendix 1.

Across the Integrated Care System:

1. Dissemination from EOL Programme Board (membership includes representatives from health and social care professionals across the ICB such as Hospices, Social Services, GPs, Continuing Health Care, SWAST, BrisDoc)
2. Escalation to the ICB from EOL Programme Board
3. Use of GP Net to advertise and inform
4. Webinars and Vimeo's available across the ICB to communicate changes
5. Remedy update

20. Monitoring compliance

A Bristol, North Somerset and South Gloucestershire Integrated Care System working party will undertake a review of the policy every 2 years. Reviewing the effectiveness and safety of this SOP and guidance. Ongoing evaluation will include:

- Audit of Community Palliative Care Drug Charts and patient's community notes.
- Evaluation of number of complaints relating to symptom control or provision of medication for symptoms at the end of life.
- Evaluation/audit of medication errors/clinical incidents.

Minimum requirement to be monitored	Lead	Frequency of Report of Compliance	Reporting arrangements	Lead(s) for acting on Recommendations
Sirona: Provision of staff training	EOL SASS	Monthly	Summary of training undertaken and feedback	EOL SASS
Sirona: Audit of patient records	EOL SASS	Monthly	Audit records using a combination of data via BI Dashboard and Ulysses audit tool	EOL SASS
Sirona: Feedback from incidents, complaints and bereavement survey	EOL SASS	Monthly	Collating information received via compliments, complaints, incident reports and bereavement survey	EOL SASS
Accuracy of links and information	EOL SASS	Quarterly	Checking of links and information	EOL SASS

21. Links to procedural documents

Guideline for the Recognition of Clinical Deterioration and Escalation of Care (Adults) Medical Emergency and Resuscitation Policy Clinical Competency Policy

Adverse events policy (including Serious Incident Process)

Service User Engagement Policy

Customer Care Policy

Duty of Candour Policy

Verification of Death Policy

End of Life Policy

Care after death policy

Medical Examiner SOP

Syringe Pump Policy

Controlled Drugs Policy

Consent Policy

Disposal and destruction of controlled drug SOP

22. Other relevant policies

Informal Carer Administration of Subcutaneous Injections in the Community for End of Life Care

23. References

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St Peters Hospice (2022) Clinical Guidelines Clinical Guidelines - St Peter's Hospice (stpetershospice.org)

Wessex Palliative Physicians (2019) Palliative Care Handbook. Ninth edition. Microsoft Word - GB 9th ed Final June 2019.docx (ruh.nhs.uk)

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Further reading:

http://www.stpetershospice.org.uk/Clinical-Guidelines

Guidelines on the management of pain due to cancer in adults: Bristol Palliative Care Collaborative

Appendix 1 Policy Implementation Plan

Policy Ref:	
Policy Name:	Policy for anticipatory prescribing of 'Just in Case' medication for symptom control in the last days of life in adult community palliative and end of life care patients.
Name of Author/Originator:	Dr Dida Cornish Karla Smith-Bishton
Date Ratified at Professional Council/Quality	13/02/23

A Policy needs to be communicated clearly and easy to interpret if it is to be implemented effectively.

To guide the implementation that will be needed, you should consider the following questions:

a) Does the Policy require a change to current practices? **Yes**

b) Who are the key stakeholders that need to be informed of the Policy? **All health and social care providers across BNSSG; Primary care and GP's, out of hours services including BrisDoc, SWAST, Sirona care and health, St Peter's Hospice, Weston Hospice, secondary care, care homes including residential and nursing homes.**

c) How do you get staff engaged ensuring that they have read and understood the Policy?
Within Sirona; for dissemination via Associate Locality Directors, Workplace communication, webinars, during in-reach, EOL Link Practitioner & Champion roles and meetings.
Across BNSSG; via the ICB for a system wide communication to disseminate to all services and update on Remedy.

d) How are you going to monitor that the Policy has been implemented into practice effectively? **As outlined in section 19, Monitoring Compliance.**

e) Do you have an Audit tool attached to the Policy? **YES - Sirona 'Measurements of Person Centred Care' audit within Ulysses**

f) How will the policy and processes be accessible to the end user? (Consider the Accessible information Standard). **The policy is available electronically which can be printed and interpreted if required. The drug Community Palliative Drug Chart will be available in electrical (protected word document), printed booklet and as a template which can be completed within EMIS and printed.**

Implementation processes

Sirona care & health;

1. Group key stakeholders together and educate/upskill them to inform and communicate new policies to their teams and staff via webinar and in-reach teaching sessions.
2. The policy will involve communicating changes to existing work practices that could impact on staff time management, or require changes in behaviour. EOL Champions will be updated to support with this along with EOL SASS in-reach. Information will be shared via Workplace.
3. Webinar to support the changes specific to the new community palliative care drug charts
4. EOL SASS undertake monthly audits via Ulysses and in-reach to check the correct

completion of the new drug chart and highlight concerns with the prescriber.

Implementation Plan

Sirona care & health:

1) Circulate to Associate Locality Directors and Integrated Network Team Managers for dissemination
2) Advertise the new policy on Workplace
3) Deliver a webinar, which will be recorded, to highlight changes to the policy

Across the Integrated Care System:

1) Dissemination from EOL Programme Board (membership includes representatives from health and social care professionals across the ICB such as Hospices, Social Services, GPs, Continuing Health Care, SWAST, BrisDoc)
2) Escalation to the ICB from EOL Programme Board
3) Use of GP Net to advertise and inform
4) Webinars and Vimeo's available across the ICB to communicate changes

Completed By (Policy Lead):	Karla Smith-Bishton
Date:	13/02/23

Appendix 2 Equality Impact Assessment Tool

Name of the policy/service/strategy: Policy for anticipatory prescribing of 'Just in Case' medication for symptom control in the last days of life in adult community palliative and end of life care patients.
Author(s) or Lead Person carrying out this assessment: Karla Smith-Bishton
Job title(s) and directorate: Clinical and Operational Lead, Sirona End of Life Specialist Service
Date:

1. What are the main aims, purpose and outcomes of the policy?
Service users with a terminal illness, who are deteriorating often experience new or worsening symptoms as they approach the last days of life and may be unable to swallow oral medication. This guideline seeks to avoid distress caused by delayed access to medicines by anticipating need, and providing appropriate medication in the home (GSF 2006, Wilcock et al 2020). For palliative care service users who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home for the management of symptoms which commonly occur in the last days of life (NICE 2015). A range of subcutaneous (SC) medication should be prescribed and authorised on the Community Palliative Care Drug Chart to allow clinicians working in the community, to administer if the service user is unable to take oral medication.

2. Is this policy/service/strategy:		
New	Existing	**Up-dated**
Joint partnership	State partnership name and lead body: **Anticipatory Medication Task & Finish Group, BNSSG EOL Programme Board**	

3. Who is this policy likely to have an impact on?			
Patients	**Carers**	**Visitors**	**Staff**
Other (state who) _____			

4. Please describe how the service/policy/strategy may advance equality of opportunity, eliminate discrimination and foster good relations between different groups
The policy highlights the importance of anticipatory prescribing in palliative and end of life care, as an integral part of our service. Ensuring all staff involved in caring for people at the end of their lives use a clear framework to deliver patient centred care, that is safe, effective, caring, responsive and well-led (CQC). “End of life care encompasses all care given to patients who are approaching the end of their life and following death.” CQC (2017). Making sure all are treated equitably and fairly.

5. Assessment of the effects of the service/policy/strategy on the protected characteristic groups				
Does the service/policy/strategy have a negative, positive or neutral impact on each of the protected characteristics listed below? Please mark with an 'x' in the relevant column. Clear comments that explain your rationale for each group must be provided. *Please note that for many individuals and groups there may be multiple layers of how people experience discrimination, e.g. people can be part of more than one group so consider this in your analysis.*				
Protected Characteristic	**Negative**	**Positive**	**Neutral**	**Comments**
Age [Children and Young people 0 to 19; Older People 60+]			X	
Disability [Physical Impairment; Sensory Impairment; Mental Health; Learning Difficulty; Long-Term Condition]			X	
Gender Reassignment [Trans people]			X	

5. Assessment of the effects of the service/policy/strategy on the protected characteristic groups				
Does the service/policy/strategy have a negative, positive or neutral impact on each of the protected characteristics listed below? Please mark with an 'x' in the relevant column. Clear comments that explain your rationale for each group must be provided. *Please note that for many individuals and groups there may be multiple layers of how people experience discrimination, e.g. people can be part of more than one group so consider this in your analysis.*				
Protected Characteristic	**Negative**	**Positive**	**Neutral**	**Comments**
Race			X	
Religion or Belief			X	
Sex (Male or Female)			X	
Sexual Orientation [Lesbian, Gay or Bisexual]			X	
Pregnancy & Maternity			X	

5. Assessment of the effects of the service/policy/strategy on the protected characteristic groups				
Does the service/policy/strategy have a negative, positive or neutral impact on each of the protected characteristics listed below? Please mark with an 'x' in the relevant column. Clear comments that explain your rationale for each group must be provided. *Please note that for many individuals and groups there may be multiple layers of how people experience discrimination, e.g. people can be part of more than one group so consider this in your analysis.*				
Protected Characteristic	**Negative**	**Positive**	**Neutral**	**Comments**
Marriage & Civil Partnership			X	
Other disadvantaged groups			X	

6. Next Steps
Does the Service/Policy have a negative impact on any protected characteristics? Yes **No**
If yes to above, please ensure you complete a robust action plan as Appendix A to this template. Action Plan attached? Yes No **N/A**
Date assessment completed:
Review date:

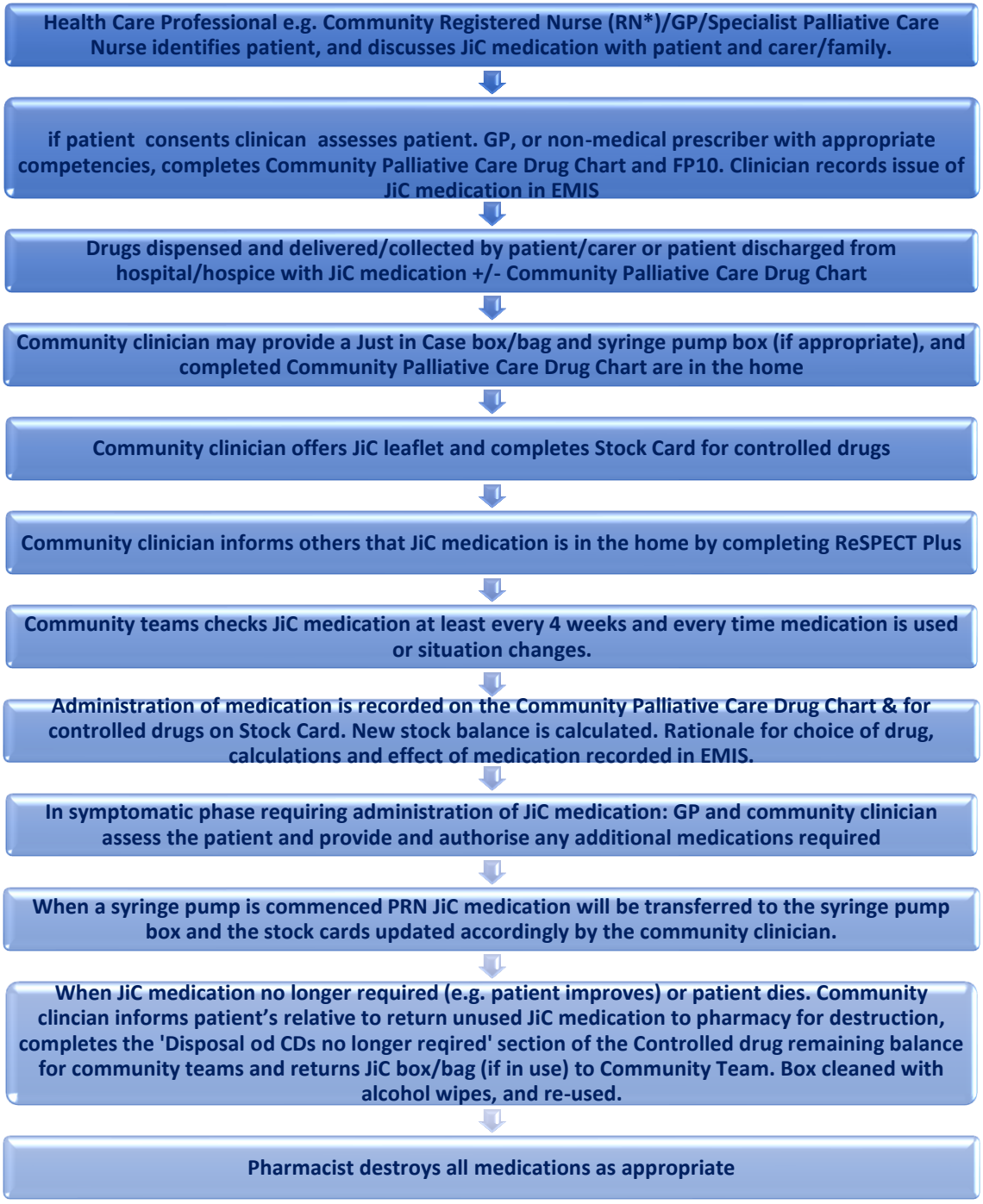
Action Plan Example

Action Plan				
Protected characteristics with negative impact	Actions	Responsible person	Timeframe/ target date	Measure of success

Appendix 3 Process flow chart

Process flow chart: Provision of 'Just in Case' medication to palliative care patients in the community

For palliative care patients who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home, for the management of symptoms which may occur at the end of life.



Appendix 4 Controlled drug record

Patient name	
Date of birth	
NHS no.	
Address:	

GP Practice	
Phone no.	

Allergies:

No known drug allergies ☐ (tick)

USE ONE CD BALANCE RECORD FOR EACH DIFFERENT DRUG, STRENGTH AND FORM. RECORD QUANTITY RECEIVED, GIVEN AND WASTED, AND BALANCE.

Name of Drug:			
Strength: *(state mg/ml or micrograms/ml for injections and liquids)*		**Size of ampoule:** *(injections only)*	
Form: *(e.g. tablet, capsule, injection, patch, liquid and state if modified release (MR))*			

Date	Time	Received from (e.g. pharmacy/ hospital name)	Quantity received	Quantity given	Quantity wasted	Balance	Print Name	Sign
		Balance carried forward from previous page:						
		Balance carried forward to next page:						

Patient name	
NHS no.	

CD name, form, strength	

Date	Time	Received from (e.g. pharmacy/ hospital name)	Quantity received	Quantity given	Quantity wasted	Balance	Print Name	Sign
		Balance carried forward from previous page:						
		Balance carried forward to next page:						

Disposal of CDs no longer required

Wherever possible the patient, relative or carer should return the CD to a local pharmacy for disposal. In **exceptional circumstances** if no-one else is available a Sirona employee may return CDs to a pharmacy on the patient's behalf (see SOP for disposal and destruction of CDs for details).

Patient, relative or carer accepting responsibility for returning CD to pharmacy	Name: Sign: Relationship to patient:	Quantity: Date: Time:
Professional accepting responsibility for returning CD to pharmacy	Name: Sign: Role:	Quantity: Date: Time: Pharmacy name:
Witness (*if available*)	Name: Sign:	Date: Time:

Destruction of CDs

CDs may **only** be destroyed by Sirona staff following a risk assessment (see SOP for disposal & destruction of CDs for information & denaturing instructions). Record destruction & CD balance.

Registered professional, destroying CD	Name: Role:	Sign: Date: Time:
Staff member witnessing destruction of CD	Name: Role:	Sign: Date: Time:

Appendix 5 Community Palliative Care Drug Chart

Community Palliative Care Drug Chart

NHS

Chart No. ___ of ___

For authorisation of injectable (PRN) and syringe pump medication, and record of administration for adult patients

Section 1: Patient Details, allergies/sensitivities, prescriber details, details of any person who administers medication, once only medicines (front page).
Section 2: PRN subcutaneous medicine for symptom control.
Section 3: Syringe pump medication and cautions.
Section 4: Community Palliative Care Prescribing Table (Back page).

Tick if this chart is being used for non end of life symptom control ☐

PATIENT DETAILS: **Date Chart Created:** Short date letter merged **Date Revised**

First Name: Given Name
Last Name: Surname
DOB: Date of Birth NHS NO: NHS Number
GP Practice: Organisation Name

Allergies/Sensitivities:
Allergies

PRESCRIBER DETAILS: Must be completed by all prescribers

Name (printed)	Signature (or Prof. No.)	Role	Base
Current User			Organisation Name

DETAILS OF PERSON ADMINISTERING DRUGS: Must be completed by all administering drugs.

Name (printed)	Initials	Base

ONCE ONLY MEDICINES:

Drug (Generic Name)	Indication	Date Prescribed	*Route	Dose	Date & Time to be given	Prescriber signature (or Prof. No.)	Given by	Date/Time given

*Route: IM = Intramuscular; SC = Subcutaneous; BUC = Buccal

Last updated 22/11/2022 V8 1

Either wet signature or electronic GMC / NMC number

Patient Name: Full Name NHS No: NHS Number

AS REQUIRED PRN DRUGS (TICK If on opioid patch ☐ Details)

Authorisation: Administration:

PRN 1	Drug: Please Select		Date:							
	Indication: Please Select		Time:							
	Dose Range: mg	Max Frequency:	Dose:							
	Route: SC	Max in 24hrs including pump: mg	Route:							
	Prescriber Sig. /Prof.No.:	Date:	Initials:							
PRN 2	Drug: Please Select		Date:							
	Indication: Please Select		Time:							
	Dose Range: mg	Max Frequency:	Dose:							
	Route: SC	Max in 24hrs including pump: mg	Route:							
	Prescriber Sig. /Prof.No.:	Date:	Initials:							
PRN 3	Drug: Please Select		Date:							
	Indication: Please Select		Time:							
	Dose Range: mg	Max Frequency:	Dose:							
	Route: SC	Max in 24hrs including pump: mg	Route:							
	Prescriber Sig. /Prof.No.:	Date:	Initials:							
PRN 4	Drug: Please Select		Date:							
	Indication: Please Select		Time:							
	Dose Range: mg	Max Frequency:	Dose:							
	Route: SC	Max in 24hrs including pump: mg	Route:							
	Prescriber Sig. /Prof.No.:	Date:	Initials:							
PRN 5	Drug:		Date:							
	Indication:		Time:							
	Dose Range: mg	Max Frequency:	Dose:							
	Route: SC	Max in 24hrs including pump: mg	Route:							
	Prescriber Sig. /Prof.No.:	Date:	Initials:							
PRN 6	Drug:		Date:							
	Indication:		Time:							
	Dose Range: mg	Max Frequency:	Dose:							
	Route: SC	Max in 24hrs including pump: mg	Route:							
	Prescriber Sig. /Prof.No.:	Date:	Initials:							

Apply a wet signature OR if electronic GMC / NMC number. Apply date

If increasing the pump range, increase max dose in 24hrs to reflect this

If increasing the pump range, increase the PRN dose to reflect1/6th of total SC background opioid in 24 hours except for alfentanil (PRN is 1/10th)

ast updated 22/11/2022 V8 2

Diluent required: wet signature / electronic GMC / NMC number and date

Patient Name: Full Name **NHS No:** NHS Number

DRUGS TO BE MIXED TOGETHER IN A SYRINGE PUMP FOR CONTINUOUS SUBCUTANEOUS INFUSION OVER 24 HOURS. N.B. see cautions*

Authorisation: **Administration:**

DRUGS TO BE MIXED TOGETHER IN A SYRINGE PUMP FOR CONTINUOUS SUBCUTANEOUS INFUSION OVER 24 HOURS

	Month: Year:	DATE:							
S1	**Diluent:** ☐ Water for injection ☐ Normal Saline (tick as appropriate) Prescriber Sig. /Prof.No.: Date:	Time:							
		Initials:							
		Syringe Pump A or B**:							
S2	Drug: Please Select..								
	Indication: ..Please Select..	Time:							
	Dose Range: From: mg To: mg	Dose:							
	☐ Start today Start dose: mg ☐ Start when needed* Prescriber Sig. /Prof.No.: Date:	Initials:							
		Syringe Pump A or B**:							
S3	Drug: ..Please Select..								
	Indication: ..Please Select..	Time:							
	Dose Range: From: mg To: mg	Dose:							
	☐ Start today Start dose: mg ☐ Start when needed* Prescriber Sig. /Prof.No.: Date:	Initials:							
		Syringe Pump A or B**:							
S4	Drug: Please Select..								
	Indication: ..Please Select..	Time:							
	Dose Range: From: mg To: mg	Dose:							
	☐ Start today Start dose: mg ☐ Start when needed* Prescriber Sig. /Prof.No.: Date:	Initials:							
		Syringe Pump A or B**:							
S5	Drug: ..Please Select..								
	Indication: ..Please Select..	Time:							
	Dose Range: From: mg To: mg	Dose:							
	☐ Start today Start dose: mg Prescriber Sig. /Prof.No.:								
		A or B**:							

** If more than one syringe pump in use, indicate A or B.

If increasing pump ranges, please increase the max dose in 24hrs on page 2 of the drug chart

Wet signature or electronic GMC / NMC number and date next to EACH drug

Appendix 6: Anticipatory prescribing (AP) of Just in Case (JiC) medication for symptom control in adult palliative care patients in last days of life: BNSSG quick reference guide.

For palliative care service users who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home for the management of symptoms which commonly occur in the last days of life. Individuals who deteriorate or develop uncontrolled symptoms will always require full clinical assessment to ensure there is appropriate treatment of any reversible factors and a clear management plan. Anticipatory prescribing should be tailored to the individual person and circumstances, taking into account risks and benefits of prescribing in advance. This is a quick reference guide, for more detail refer to full Standard Operating Procedure. For prescribing guidance refer to '*Community palliative care prescribing table: symptom control in last days of life for adults'* all available on St Peter's Hospice Guidelines page: https://www.stpetershospice.org/for-professionals/resources-for-professionals/clinical-guidelines/

Prescribing JiC medication and using Community Palliative Care Drug Chart to authorise administration

- Prescribe medication on an FP10 and authorise for administration on the chart. There are 2 versions of the chart in use:
    - 1. Electronic version (typed in EMIS, or rich text document completed by BrisDoc or in acute trusts) and printed on paper-often in black and white
    - 2. Colour card booklet version which is completed by hand (orders: bnssg.fasttrack@nhs.net)
- For both versions of the chart the prescriber and clinician administering medications must add their details to the front of the chart.
- The Anticipatory Drugs Protocol in GP EMIS will issue FP10s and produce a chart. It supports best practice with inbuilt alerts to aid individualise prescribing. The default set of medication and prepopulated chart should only be used for patients who are opioid naïve, have an eGFR>30 ml/min/ 1.73m^2 and where metoclopramide is appropriate.
- For all other patients it is important to select 'no' when asked if you want to issue the default set of medication and then the protocol will launch the chart with drop downs to select individualised drugs.
- For the electronic version ensure: each drug is 'signed' by typing professional number and date, chart is printed off (preferably double sided) and stapled into booklet version with administration pages aligned. A wet signature is not required.
- Sirona staff can print the chart from EMIS or if emailed by Brisdoc, to take into the home, but the prescriber must always communicate clearly what is needed by telephoning the Sirona Single Point of Access (SPA: 0300 125 6789).
- A GP can alter doses, drugs and ranges by editing the previous version in EMIS and using 'save as' to create a new document. They should record the version number on the front of the chart.
- A non-prescribing community clinician can discontinue any old charts by putting a line through the front with the words 'superseded' and the date.
- If urgent ensure the local pharmacy has enough stock to dispense the prescription or refer to the list of pharmacies which stock Palliative Care Medication on St Peter's Hospice Guidelines page.
- If a chart is being used for symptom control for a palliative care patient with a longer prognosis than weeks or days, tick the box 'non end of life symptom control' on front of the chart and do **not** authorise other syringe pump drugs for last days of life such as midazolam 'to start when needed'.

JiC medication in last weeks of life

- Prescribe and authorise as required (PRN) medication for each of the 5 symptoms commonly experienced at the end of life listed here with the 1st line drug: pain, dyspnoea (opioid for both), nausea/vomiting (individualised antiemetic), agitation (midazolam) and respiratory tract secretions/colic (Hyoscine butyl bromide).

- Convert their usual PO PRN opioid to appropriate SC dose. If an individual is on a regular antiemetic provide this as SC PRN if available. Otherwise choose antiemetic according to cause of nausea. (See prescribing table) Cyclizine is not used first line unless specifically indicated, e.g. in brain malignancies.
- Do not authorise medication for syringe pump in advance until approaching last days of life
- Provide **10 doses** of each drug if patient already requiring symptom control medication or **5 doses** for less complex patients, e.g. frail patients in a nursing home. >10 doses may be needed if very complex/symptomatic.
- Prescribe water for injection 10ml x 20 so it is available should a syringe pump be needed

JiC medication when approaching or in last days of life

- If an individual has lost their oral route convert any medication needed for symptom control to a syringe pump using the prescribing table and conversion factors and tick box 'start today' on chart
- Consider **appropriate ranges** (see cautions): For opioid or midazolam a conservative syringe pump range allows for incorporation of 2 PRN doses (e.g. morphine 30 - 40mg/24 hours, PRN 5mg SC) and the usual maximum syringe pump range allows for incorporation of 4 PRN doses (e.g. morphine 30 - 50mg/ 24 hours). ***Seek specialist advice if considering a wider range.***
- If likely to be needed in a few days, consider authorising syringe pump medications in advance with ranges for each of the 5 common symptoms and tick box 'to start when needed' BUT **see cautions**
- **Remember to prescribe and authorise diluent usually water for injection.**
- Prescribe enough medication for 7 days if starting a syringe pump or for at least 3 days if authorising pump to 'start when needed'.

Cautions regarding authorisation and administration of syringe pumps

- Authorising syringe pumps ***in advance to start when needed*** is usually only appropriate if an individual is ***approaching last days of life*** and their deterioration is not reversible OR occasionally for a patient who is at high risk of a specific symptom. e.g. vomiting in recurrent bowel obstruction.
- Some nursing home staff may not be trained in the use of ranges or pumps in advance, consider tighter ranges, no ranges or PRNS only after making a careful assessment.
- When selecting a dose from a range for syringe pump administration start on the lowest dose unless assessment of PRN requirements indicates the need for a higher dose. Rationale for the chosen dose should be documented.
- Consider titrating doses in syringe pump according to PRNS in last 24 hours but it is **not** always appropriate to incorporate all PRNS from previous 24 hours when titrating a syringe pump dose. Seek specialist advice when increasing total 24 hour dose by more than 50% of previous 24 hour dose in the syringe pump.
- If the individual has ongoing symptoms or a community clinician has made 2-3 changes to a syringe pump dose based on an authorised range consider a GP review and advice from a hospice health care professional before increasing the range.

Communication and advance care planning

- Individuals and their informal care givers must receive information about AP and consent to JiC medications. They should be offered an information leaflet.
- It is important to consider advance care planning, document decisions on a ReSPECT form and include information on AP in the electronic 'ReSPECT plus' record, where it will be available to health care services in all settings.

Anticipatory Prescribing in specific circumstances

Individuals on opioid patches

- The dose of opioid patch is not usually titrated in last days of life, as the slow absorption would result in delays achieving required increases. The patch is kept in place and changed as usual. Tick the box if on opioid patch on the PRN page of the chart and complete details.
- PRN subcutaneous analgesic (converting their usual oral PRN opioid) should be prescribed at a dose appropriate to the patch strength. If a person is approaching last days of life consider authorising a syringe pump to start when needed for the 5 common symptoms. The dose range for the opioid can be the calculated equivalent to approximately two-four SC PRN doses of opioid.

Patch type	Patch strength Micrograms/hr	Equivalent 24 hour dose oral morphine	Equivalent 24 hr dose subcutaneous morphine	PRN SC dose of morphine	Syringe pump 'to start when needed'
Fentanyl	25mcg/hr	60-90mg/24hrs	30-45mg/24hrs	5-7.5mg 1 hourly	Morphine 15-30mg/24 hrs
Buprenorphine	20mcg/hr	36-65mg/24hrs	~15-30mg/24hrs	2.5-5mg 1 hourly	Morphine 10-20mg/24 hrs

- If several PRN doses are needed, a syringe pump can be set up containing appropriate opioid, which can easily be titrated, alongside the patch. PRN doses must be adjusted to take into account patch and syringe pump opioid.

Steroids (Additional guidance is available on St Peter's Hospice Guidelines page.)

- Continue steroids if considered essential for symptom control otherwise consider discontinuation or gradual reduction.
- Dexamethasone 4mg orally is considered equivalent to dexamethasone 3.3mg injection
- Dexamethasone may be given as a single daily SC injection, preferably in the morning, if dose is 6.6mg or less (Ampoules are 3.3mg in 1ml or 6.6mg in 2ml as dexamethasone base). For higher doses give via a syringe pump. It is incompatible with most other drugs so a second syringe pump is usually required.

Seizures/anticonvulsant drugs *(seek specialist advice for those **not** in last days of life)*

- For individuals on anticonvulsant drugs for the control of seizures who are unable to take oral medication (or those likely to become unable to take oral medication in the next few days): prescribe and authorise midazolam 20-30mg/24 hours SC via syringe pump for control of seizures (seek advice about using lower doses e.g. 10-15mg/24 hours in frailer/very low weight patients with good seizure control on monotherapy).
- Prescribe Midazolam 10mg SC/IM or Buccal PRN for treatment of a prolonged seizure >5 minutes, which can be repeated after 10 minutes in status epilepticus (seek advice about using lower doses in frailer/very low weight patients).
- Some antiemetics lower the seizure threshold. If patient has a primary brain tumour/history of seizures consider cyclizine as 1st line antiemetic and glycopyrronium as the anti secretory for anticipatory prescribing (hyoscine butyl bromide does not mix with cyclizine in a pump).

If at risk of major haemorrhage

- Consider authorising Midazolam 10mg IM/Buccal on the front of the chart as a once only medication.

Parkinson's Disease and other movement disorders

- Additional guidance is available on St Peter's Hospice Guidelines page
- Avoid use of anti-emetics such as haloperidol and metoclopramide. Due to risk of side effects consider Ondansetron 1st line, Cyclizine 2nd line and levomepromazine 3rd line for nausea and vomiting.
- Seek advice on managing rigidity from Parkinson's Disease Specialist Nurse if available or use guidance to convert oral medications to a patch using http://parkinsonscalculator.com/.

Inoperable complete gastro-intestinal obstruction

- Seek specialist advice from the local hospice team. Metoclopramide may be used in a syringe pump if there is incomplete obstruction and absence of colic.
- Avoid metoclopramide in complete obstruction or in the presence of colic. Hyoscine butyl bromide can be used via a syringe pump for colic and to reduce volume of GI secretions.

Adjustments for renal failure, liver impairment, severe frailty and/or low Body Mass Index

If there is a **clinically relevant risk of side effects** which outweighs the risk of suboptimal symptom control consider adjustments in the doses of some JiC medications as identified in the prescribing table in the following circumstances:

- For renal failure with < eGFR <30 ml/min/1.73m^2.
- When prescribing opioid if eGFR <30 ml/min/1.73m^2 see guidance on fentanyl and alfentanil available on St Peter's Hospice guidelines web page. It is important to weigh up the risk of side effects from more commonly used opioids against the risk of prescribing drugs such as fentanyl/alfentanil where community staff are less familiar with their use and there is more risk of administration errors. Seek specialist advice from hospice teams.
- For those with severe liver impairment, classified as Charles-Pugh score of C (e.g. advanced cirrhosis/liver failure).
- It is not usually necessary to adjust the JiC opioid in liver impairment but seek specialist advice if there are concerns about side effects.
- For those with severe frailty and/or low BMI-use clinical judgement regarding the need for dose adjustment.

C Cornish 01/ 23 review 2025

Appendix 7 Community Palliative Care Prescribing Table

Community palliative care prescribing table: symptom control in last days of life for adults

Anticipatory Prescribing (AP): ***Last weeks of life*** authorise at least 1 PRN drug for symptoms 1-4
If ***approaching last days*** consider authorising syringe pump to 'start when needed' with appropriate ranges, but note ***cautions on syringe pump page*** and remember diluent: usually water for injection.

AP: *supply the following number of doses:* PRN drugs only:10. Complex symptoms or authorising syringe pump in advance: >10 e.g. 3 days supply. Non complex/no symptoms: 5				**Starting dose range over 24 hours via subcutaneous syringe pump**	**Usual total maximum dose/24 hours**
Symptom	**Injectable Drug**	**Subcutaneous (SC) as required (PRN) dose and minimum interval:**	**Ampoule Strengths**		
SYMPTOM 1: PAIN/DYSPNOEA					
If on oral opioids see table for conversion[¥] If eGFR <30 seek guidance	Morphine 1st Line	2.5-5mg 1 hourly if opioid naïve OR 1/6th 24 hour subcutaneous dose 1 hourly	10, 15, 20 or 30mg/ml in 1ml or 2ml amps	if opioid naïve: 10-15mg *5-15mg[FL]*	No upper limit but prescriber may indicate a max dose
	Diamorphine	Useful if SC PRN morphine doses >2ml (>60mg of 30mgml) i.e. Pump morphine /24 hours SC>360mg	5, 10, 30 or 100mg amps	Convert using table[¥]	
SYMPTOM 2: NAUSEA AND VOMITING					
Opioid or chemical	Haloperidol	1-1.5mg 6 hourly *0.5-1mg 8 hourly [RLF]*	5mg/ml	1.5-5mg *1-3mg [RLF]*	5mg *3mg [RLF]*
Prokinetic	Metoclopramide	10mg 6 hourly *5-10mg 8 hourly [RL]*	10mg/2ml	30-60mg *20-30mg [RL]*	80mg+ *30mg [RL]*
Centrally induced	Cyclizine* Not 1st line	50mg 8 hourly: if not on regular *Avoid in severe liver impairment[L]*	50mg/ml	150mg	150mg
Broad Spectrum	Levomepromazine	5mg 6 hourly	25mg/ml	5-25mg	25mg
Parkinson's or 3rd line	Ondansetron	4mg 6 hourly *4mg 12 hourly[L]*	4mg/2ml	8-16mg	24mg *8mg[L]*
SYMPTOM 3: AGITATION IN LAST DAYS OF LIFE					
1st line	Midazolam	2.5-5mg 1 hourly	10mg/2ml	10-20mg *5-15mg [RLF]*	60mg
+ hallucinations or confusion	Haloperidol	1-1.5mg 6 hourly *0.5-1mg 8 hourly [RLF]*	5mg/ml	1.5-5mg *1-3mg [RLF]*	10mg *5mg [RLF]*
2nd line	Levomepromazine	12.5-25mg 6 hourly	25mg/ml	12.5-25mg	100mg
SYMPTOM 4: RESPIRATORY TRACT SECRETIONS IN LAST DAYS OF LIFE					
Chest/gastro-intestinal secretions or colic	Hyoscine Butylbromide *	20mg 2 hourly -1st line If prescribing cyclizine use glycopyrronium	20mg/ml	60-140mg	240mg
	Glycopyrronium	200 micrograms 2 hourly-2nd line	200 microgram/ml	600-1200 micrograms	1.2mg

[RLF] Consider dose adjustments if clinically relevant: R: eGFR <30 ml/min/1.73m²; L: Severe liver impairment: Child-Pugh C; F: Severe frailty: clinical judgement or very low BMI

[¥]Conversion of oral to subcutaneous opioids via syringe pump/24hrs (Do not change patient's opioid drug unless indicated)		
Oral morphine ⟶	s/c morphine	Divide oral total 24hr dose by 2
Oral morphine ⟶	s/c diamorphine	Divide oral total 24hr dose by 3
Oral oxycodone ⟶	s/c oxycodone	Divide oral total 24hr dose by 2

*Specialist advice suggested for metoclopramide doses >60mg

*Cyclizine is incompatible with hyoscine butylbromide and has dose related incompatibility with oxycodone in a syringe pump

See guidance notes ** /seek advice for:

- Patients on opioid patches: do not discontinue, prescribe SC PRN opioid and syringe pump if needed
- Opioids if eGFR <30ml/min/1.73m²: consider SC fentanyl or alfentanil if appropriate: seek advice or see specific guidance**
- Parkinson's Disease antiemetics: 1st ondansetron, 2nd cyclizine, 3rd levomepromazine. Avoid haloperidol & metoclopramide.

**For AP guidance notes, specific guidelines, full SOP plus link to pharmacies stocking AP/palliative care medication see https://www.stpetershospice.org/for-professionals/resources/clinical-guidelines/

Hospice 24 hour telephone advice: St Peter's Hospice: 0117 9159430; Weston Hospice: 01934 423900

Community Nurse 24 hour contact Sirona Single Point of Access: 03001256789

Dr C Cornish/Dr K Davies 2023 with adjustments based on local trust guidelines, PCF and BNSSG consensus. Review 2025

Appendix 8 Pharmacies providing specialist medication

Available via Remedy;

https://remedy.bnssg.icb.nhs.uk/media/5948/2022-2023-specialist-medicines-enhanced-service-drug-list-for-icbs.pdf

Appendix 9 Medications to be held by participating pharmacies

2022-2023 NHS England South West Enhanced Service for the availability of specialist medicines, list of medications to be held in stock.

https://remedy.bnssg.icb.nhs.uk/media/5948/2022-2023-specialist-medicines-enhanced-service-drug-list-for-icbs.pdf

Appendix 10: A guide to your ‘Just in Case’ medications: Information for patients and carers.