Anticipatory prescribing for end of life symptoms in the community

What is anticipatory prescribing?
Patients who are dying often experience new or worsening symptoms or become unable to swallow essential medication such as analgesics or anti-emetics. Patients who wish to remain at home may require District Nurses to administer injections or a syringe driver to control their symptoms. For patients in the community who are in the last few weeks/days of life it is good practice¹ for the GP to prescribe a range of medications which will be kept in the home, to minimise delay, in case they are needed for symptom control (anticipatory prescribing). This tool aims to guide healthcare professionals in the community on what medications should be prescribed after assessment of the individual patient. The principles are applicable to the care of patients who are dying whether of malignant or non-malignant disease.

Prescribing advice for GP
1. Stop unnecessary medications
   • For example, antihypertensive drugs or statins that are no longer needed.

2. Prescribe medications in case a syringe driver is needed
   • For patients who are able to swallow, continue essential medications.
   • For patients who are unable to swallow, convert essential medications, such as analgesics, antiemetics, and anxiolytics to a syringe driver for continuous subcutaneous infusion.
   • For all patients, prescribe subcutaneous medication for each of the 4 common symptoms stated overleaf in case they are needed in a syringe driver.
   • Ensure each drug has an appropriate dose range written on the syringe driver authorisation sheet in case increases are required.
   • Prescribe water for injection for use in case a syringe driver is needed.
   • Ensure patients are prescribed enough stock for weekends and bank holidays.

N.B For patients who have a fentanyl patch for pain, the patch should be kept in place and changed as usual. However, if they are unable to swallow, they will need PRN subcutaneous analgesic prescribed at a dose appropriate to their patch dose. For example 25mcg per hour fentanyl patch is equivalent to 60-90mg of oral morphine in 24 hours. A PRN dose of oral morphine would be 10-15mg and sc morphine injection 5-7.5 mg, every hour if needed. If a large number of PRN doses are needed, a syringe driver can be set up containing morphine or diamorphine in addition to the fentanyl patch.

3. Prescribe PRN medications
   • Prescribe and write authorisation for PRN subcutaneous medications for each of the 4 symptoms stated overleaf.
   • Consider prn lorazepam tablets sublingually for anxiety (0.5-1mg 8 hourly).

Practical tips for District Nurse/GP or key community health care professional
• Liaise with the local pharmacy to ensure that they have enough stock for the GP prescription. 3 pharmacies (Boots The Chemist, Locking Castle; Lloyds Pharmacy, Waitrose, Portishead; Milton Pharmacy, Weston Super Mare) in North Somerset are available for extended opening hours and have additional stock of palliative care drugs. Explain to the patient and carers about anticipatory prescribing and ensure they can get medicines dispensed.
• Leave syringes and needles in the house for PRN injections and store these with drugs in “Just in Case” box/syringe driver box.
• Update end of life register, out of hours GP and District Nurse service about present clinical situation, medications prescribed and possible problems that may occur.

Where can I get advice?
For complex patients e.g. those with renal failure seek advice from either St Peter’s Hospice advice line available 24 hours on 0117 915 9400 or Weston Hospicecare 24hr advice line on 01934 423912.

Reference. 1. www.goldstandardsframework.nhs.uk
WESTON HOSPICECARE
Subcutaneous drugs for symptom control at the end of life – ALWAYS prescribe medication for each symptom (1-4)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Drug</th>
<th>Starting dose range over 24 hours in syringe driver (subcutaneous)</th>
<th>Maximum dose/24hrs</th>
<th>Subcutaneous prn dose: ALWAYS prescribe prn medication for each symptom (1-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pain</td>
<td>Morphine</td>
<td>10-20mg (if not already taking opioids)</td>
<td>2.5-5mg 1 hourly prn if opioid naïve or 1/6th of 24 hr subcutaneous opioid dose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diamorphine</td>
<td>7.5-15mg (if not already taking opioids)</td>
<td>no upper limit</td>
<td>2.5mg 1 hourly prn if opioid naïve or 1/6th of 24 hr subcutaneous opioid dose</td>
</tr>
<tr>
<td>2. Nausea/vomiting</td>
<td>Haloperidol and/or Cyclizine*</td>
<td>2.5-5mg</td>
<td>10mg</td>
<td>1.5-3mg bd</td>
</tr>
<tr>
<td></td>
<td>Metoclopramide</td>
<td>150mg</td>
<td>150mg</td>
<td>50mg tds (if not on regular cyclizine)</td>
</tr>
<tr>
<td></td>
<td>Levomepromazine</td>
<td>30 - 60mg</td>
<td>80 mg</td>
<td>10mg qds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.25 - 25mg</td>
<td>25mg</td>
<td>6.25 mg tds</td>
</tr>
<tr>
<td>3. Agitation</td>
<td>Midazolam</td>
<td>10-30mg</td>
<td>60mg</td>
<td>2.5-5mg initially 1 hourly prn</td>
</tr>
<tr>
<td></td>
<td>Haloperidol</td>
<td>3-5mg</td>
<td>10mg</td>
<td>1.5-3mg bd</td>
</tr>
<tr>
<td></td>
<td>Levomepromazine</td>
<td>12.5-25mg</td>
<td>100mg</td>
<td>12.5-25mg (max tds)</td>
</tr>
<tr>
<td>4. Noisy breathing</td>
<td>Hyoscine Butylbromide*</td>
<td>60-100mg</td>
<td>240mg</td>
<td>20mg 2 hourly (total 24 hr max 240mg)</td>
</tr>
<tr>
<td></td>
<td>Hyoscine Hydrobromide</td>
<td>1.2-2.4mg</td>
<td>2.4mg</td>
<td>400microg 4 hourly (total 24hr max 2.4mg)</td>
</tr>
</tbody>
</table>

*cyclizine is not compatible with hyoscine butylbromide or oxycodone in a syringe driver.

Conversion of oral opioids to subcutaneous opioids via syringe driver/24hrs
- Oral morphine → sc diamorphine injection → divide oral total 24 hr dose by 3
- Oral morphine → sc morphine injection → divide oral total 24 hr dose by 2
- Oral oxycodone → sc oxycodone injection* → divide oral total 24 hr dose by 2


Reference. 1. www.goldstandardsframework.nhs.uk