North West Coast
Strategic Clinical Networks

Pre-emptive prescribing in the Community in the last weeks/days of life

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Pre-emptive Prescribing in the community in the last weeks / days of life

Pre-emptive prescribing in the community is important at end of life as it can avoid crises at home and reduces the number of hospital admissions at the end of life (1). Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms, and is based on the premise that although each patient is an individual with individual needs many acute events during the palliative period can be predicted and management measures put in place in advance.

There have been a number of concerns raised about anticipatory prescribing which need to be taken into account when drawing up local policies and procedures:

- **Controlled Drugs with the potential for misuse remaining in the community for extended periods of time:** Many anticipatory drugs will not be required. Consequently, there is the danger that drugs may end up discarded in the community with very little supervision of their use or disposal.
- **Prescribing for the future:** Normal good medical practice has the provision of a prescription as one of the last elements of the consultation, following and not preceding clinical assessment. Anticipatory prescribing involves uncertainty and risk concerning the drug's correct use, and prescribers are properly wary of providing drugs with less control over their use than is normal.

Guidance for best practice

Clinical Commissioning Groups

Working with Local Medical Committee (LMC), other lead GPs, Local Medicines Management committee and specialist palliative care professionals such as the local hospice and Clinical Nurse Specialist Teams agree:

- Policy and procedure around anticipatory prescribing at end of life that is agreed across the locality that enables patients to move seamlessly between care settings
- Policy and procedure around the administration of anticipatory prescribing at end of life that is agreed across the locality that enables consistency
- An agreed list of usual anticipatory drugs to be prescribed including quantities that should be supplied with agreed starting doses and frequency of administration.
- An agreed container and set of contents to go with the anticipatory medication including administration equipment, written instructions for professionals as to dose and indications for their use
- Appropriate arrangements with local pharmacies to provide a service to supply anticipatory medication in a timely fashion. Those pharmacies to be located in places accessible to reasonable numbers of their population and over as wide a time range as possible.
- Appropriate provision of access to medication in an emergency including out of hours.
- A means of ensuring out-of-hours service, and all others involved in the care of the patient, are aware of the clinical situation and of the availability of drugs in the home.
- Pre-printed prescribing sheets for anticipatory drugs to minimize the chance of prescribing error along with a means of recording administration of medication and monitoring of unused medication.
- Guidance to family around the safe disposal of unused medication after death
- Guidance to health and social care staff around their duties with respect to just in case medication including guidance about safe transportation etc.
- Audit and / or oversight of the policy and procedure with a mechanism for reporting near misses as well as clinical incidents
- Ensure provision of adequate training and updates around the policy and procedure for key staff are available

Prescribers

The decision to prescribe medication for use in the future is based on a risk/benefit analysis. Reasons for not providing anticipatory medicines need to be assessed and clearly documented. The health professional authorizing administration of a pre-supplied anticipatory drug

- Accepts responsibility for that decision.

- Should be satisfied that the patient and those important to them understand the reasons for the provision of the medications at that time.
- Ensures that a patient information leaflet has been provided
- Ensures reasonable alternative provision has been made if anticipatory medication is not prescribed.

Those administering anticipatory medication

- Are appropriately trained and are practising within their professional competence
- Are familiar and comply with their local policies and procedures around anticipatory prescribing
- Are aware of and use the procedures for reporting clinical incidents and near misses
- Undertake regular updates around anticipatory prescribing and just in case medication
- Seek specialist advice or advice from the prescriber if they are unclear about the prescription or the reason for administration

Based on local need each locality should select their preferred drug from each of the symptom control category
Each locality will need to decide:

- If there is to be range on the starting dose and if so what that range should be and guidance for choice around the starting doses
- If there is to be a range on the frequency of administration or extend the minimum frequency outlined below to mitigate risk of over medication
- The quantity of each medication to be dispensed which will reflect ease of access to the medication both in hours and out of hours

In the case of a patient with known renal failure and an eGFR of 30ml/min or less it is suggested that local specialist palliative medicine advice is followed around medication to be prescribed for pain

Symptom	Medication	Starting dose	Minimum frequency	Minimum quaintly	comments
Pain	Morphine* *(1st line)*	2.5 mg If opioid niave	1 hourly	5 x 10mg/2ml amp	Starting dose will be higher if already established on opioids
Nausea / vomiting	Cyclizine OR	50 mg	4 hourly	5 x 50mg/ml amp	
	Levomepromazine	2.5mg or 6.25mg	6 hourly	5 x 25mg/ml amp	Some areas may start at 6.25mg
Agitation	Midazolam	2.5mg	1 hourly	5 x 10mg/2ml amp	
Respiratory tract secretions	Glycopyrronium OR	0.2mg	4 hourly	5 x 200microgram/ml amp	
	Hyoscine Hydrobromide	0.4mg	4 hourly	5 x 400microgram/ml amp	
Breathlessness	Morphine*	2.5mg	1 hourly	5x 10mg/2ml amp	May use pain medication

*In some areas first line opioid for pain and breathlessness is diamorphine – check local policy

Appendix 1

Evidence for anticipatory prescribing framework

Allanson H (2004) http://www.out-of-hours.info/downloads/short_medicines_guidance.pdf

NICE (2004) Improving supportive and palliative care for adults with cancer

http://www.goldstandardsframework.org.uk/cd-content/uploads/files/Library,%20Tools%20%26%20resources/ExamplesOfGoodPracticeResourceGuideJustInCaseBoxes.pdf

Issues around administration of anticipatory drugs

Wilson, E., Morbey, H., Brown, J., Payne, S., Seale, C., and Seymour, J. (2014) Adminsteringanticipatory medications in end-of-life care: A qualitative study of nursing practice in the community and in nursing homes. *Palliative Medicine,*29(1):60-70. doi: 10.1177/0269216314543042. Epub2014 Jul 28

Faull C, Windridge K, Ockleford E, Hudson M 2013. Anticipatory prescribing in terminal care at home: what challenges do community health professionals encounter? BMJ Supportive and Palliative Care 3:91-97.

Evidence for individual Medications

Evidence base for choice of medication is small. Much of the basis for choice is local knowledge and expert opinion

Pain – morphine well evidenced

Nausea and Vomiting

http://cks.nice.org.uk/palliative-cancer-care-nausea-vomiting#!references/-489518

Glare, P., Miller, J., Nikolova, T. and Tickoo, R. (2011) Treating nausea and vomiting in palliative care: a review. *Clinical Interventions in Aging* **6**(), 243-259. – no evidence

Levomepromazine for nausea and vomiting in palliative care.
Darvill E[1], Dorman S, Perkins P.
Cochrane Database Syst Rev. 2013 Apr 30;4:CD009420. doi: 10.1002/14651858.CD009420.pub2. – no evidence

Systematic review of the efficacy of antiemetics in the treatment of nausea in patients with far-advanced cancer.
Support Care Cancer. 2004 Jun;12(6):432-40. Epub 2004 Apr 24.
Glare P[1], Pereira G, Kristjanson LJ, Stockler M, Tattersall M. – no evidence base for any of the anti-emetics in common use

A systematic review of the treatment of nausea and/or vomiting in cancer unrelated to chemotherapy or radiation.
J Pain Symptom Manage. 2010 Apr;39(4):756-67. doi: 10.1016/j.jpainsymman.2009.08.010.
Davis MP[1], Hallerberg G; Palliative Medicine Study Group of the Multinational Association of Supportive Care in Cancer. – moderate to weak evidence of effectiveness

Laugsand, E.A., Kaasa, S. and Klepstad, P. (2011) Management of opioid-induced nausea and vomiting in cancer patients: systematic review and evidence-based recommendations. *Palliative Medicine* **25**(5), 442-453. - The current evidence is too limited to give evidence-based recommendations for the use of antiemetics for opioid-induced nausea or vomiting in cancer patients.

Terminal agitation

Little evidence for midazolam at end of life
de Graeff, A.; Dean, M. (Feb 2007). "Palliative sedation therapy in the last weeks of life: a literature review and recommendations for standards.". *J Palliat Med* **10** (1): 67–85. doi:10.1089/jpm.2006.0139. PMID 17298256

Royal College of Physicians (September 2009). "National care of the dying audit 2009". United Kingdom. "[I]n their last 24 hours... 31% had low doses of medication to [control distress from agitation or restlessness]... the remaining 4% required higher doses"

Respiratory Tract secretions
http://cks.nice.org.uk/palliative-cancer-care-secretions#!references/-261510

Bennett, M., Lucas, V., Brennan, M. et al. (2002) Using anti-muscarinic drugs in the management of death rattle: evidence-based guidelines for palliative care. *Palliative Medicine* **16**(5), 369-374. Evidence for hyoscine hydrobromide and glycopyrronium – but not strong

Beach, P. (2003) Treatment of respiratory congestion in patients with end-stage disease. *Clinical Journal of Oncology Nursing* **7**(4), 453-455.

Hugel, H., Ellershaw, J. and Gambles, M. (2006) Respiratory tract secretions in the dying patient: a comparison between glycopyrronium and hyoscine hydrobromide. *Journal of Palliative Medicine* **9**(2), 279-284. Evidence for hyoscine hydrobromide and glycopyrronium – but not strong

Lawrey, H. (2005) Hyoscine vs glycopyrronium for drying respiratory secretions in dying patients. *British Journal of Community Nursing* **10**(9), 421-426. No evidence to support use of hyoscine hdrobromide or gylcopyrronium

Wildiers, H. and Menten, J. (2002) Death rattle: prevalence, prevention and treatment. *Journal of Pain and Symptom Management* **23**(4), 310-317. – evidence for Hyoscine hydrobromide

Wee, B. and Hillier, R. (2008) *Interventions for noisy breathing in patients near to death (Cochrane Review).* The Cochrane Library. Issue 1. *John Wiley & Sons, Ltd*. www.thecochranelibrary.com – no evidence for any intervention

Breathlessness
http://cks.nice.org.uk/palliative-cancer-care-dyspnoea#!references/-283998

Cheung, W.Y. and Zimmermann, C. (2011) Pharmacologic management of cancer-related pain, dyspnea, and nausea. *Seminars in Oncology* **38**(3), 450-459.

Booth, S. (2006) Palliative care for intractable breathlessness in cancer. *European Journal of Cancer Care* **15**(3), 303-314. – some evidence for morphine

Booth, S. and Dudgeon, D. (Eds.) (2006) *Dyspnoea in advanced disease: a guide to clinical management.* Oxford: Oxford University Press.

Simon, S.T., Higginson, I.J., Booth, S. et al. (2010) *Benzodiazepines for the relief of breathlessness in advanced malignant and non-malignant diseases in adults (Cochrane Review).* The Cochrane Library. Issue 1. *John Wiley & Sons, Ltd*. www.thecochranelibrary.com – limited evidence

Thomas, S., Bausewein, C., Higginson, I. and Booth, S. (2011) Breathlessness in cancer patients - implications, management and challenges. *European Journal of Oncology Nursing* **15**(5), 459-469.

Appendix 2:

Example of Professional Guidance around Just in case medication – showing a summary of medication chosen, starting doses and frequency and guidance for individual symptom(s).

JUST IN CASE FOUR CORE DRUGS (JiCD)

Anticipatory Prescribing for End of Life Care

- *The provision of JiCD at the end of life can support proactive symptom control by promoting anticipatory prescribing, which ensures common symptoms are anticipated and responded to in a timely fashion.*
- *Patients may be prescribed different end of life drugs anticipatory medications if they are intolerant of these recommended first line medications or have an eGFR of 30mlmin or less. For further information, please contact local Specialist Palliative Care Team for advice.*

Pain	Nausea and Vomiting	Agitation and Restlessnes	Respiratory Tract Secretions
Morphine 10 mg/mL *Supply: 5 x 1mL	**Levomepromazine** 25 mg/mL *Supply: 5 x 1mL	**Midazolam** 10 mg/2mL *Supply: 5 x 2mL	**Hyoscine Hydrobromide** 0.4 mg/mL *Supply: 5 x 1mL
Initial PRN dose **2.5 mg SC 1 hourly PRN	Initial PRN dose 2.5 mg SC 6 hourly PRN	Initial PRN dose 2.5 mg SC 4 hourly PRN	Initial PRN dose 0.4 mg SC 2 hourly PRN
Initial CSCI dose 5mg over 24 hours	Initial CSCI dose 6.25mg over 24 hours	Initial CSCI dose 5mg over 24 hours	Initial CSCI dose 0.8mg Over 24 hours

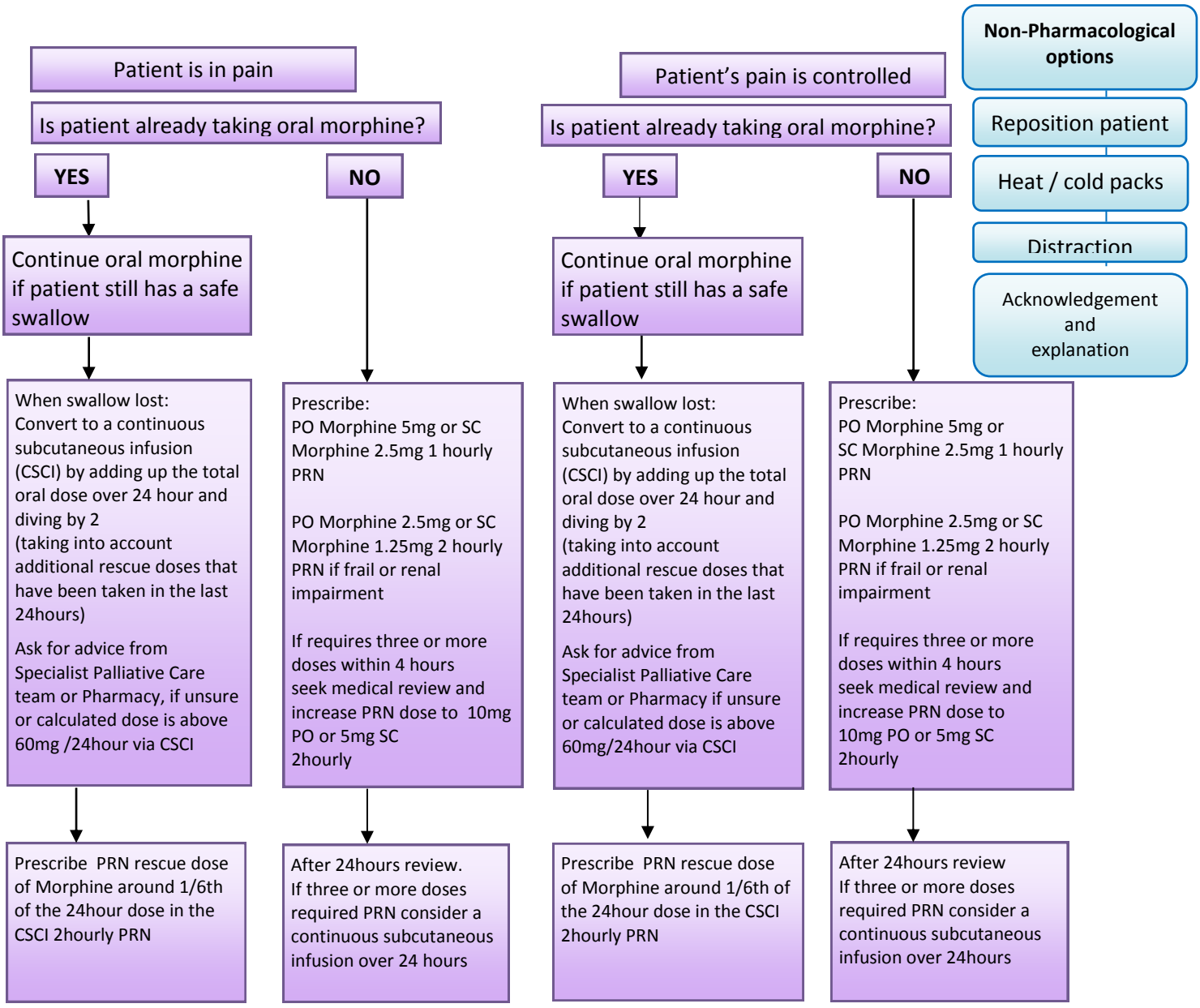
Water for Injections
10 x 10 mL
(to dilute CSCI)

- ** These quantities are "just in case" of need. If you anticipate that the medication will be needed in the near future please ensure adequate amount prescribed to ensure supply for 5 days (usually at least enough for 2 doses per day)*
- *** For patients established on oral morphine or oxycodone, follow guidance on page x for conversion of oral to equivalent subcutaneous dose. For patients on buprenorphine or fentanyl patches, follow guidance on page xx and discuss with Specialist Palliative Care Service for advice regarding further analgesia*
- *If a patient is receiving an alternative opioid, discuss with Specialist Palliative Care Service for advice on xxxxxxxxxxx*

QUICK GUIDE	PAIN IN THE LAST DAYS OF LIFE
Reference	Merseyside and Cheshire Palliative Care Network Audit Group Guidelines on Symptom Control in the Dying Person

GENERAL COMMENTS

In the majority of cases injectable Morphine is the first line opioid of choice in the last days of life.
If patient has been well established on an alternative opioid such as Oxycodone continue it and follow the principles outlined in the flow diagrams.
For patients who have not previously been given medicines for pain management, start with the lowest effective dose of pain killer and titrate as clinically indicated.
Alternative opioids may be needed if the patient has significant renal impairment – seek specialist advice.



ADDITIONAL INFORMATION

Transdermal opioid patches at end of life (Fentanyl /Buprenorphine)
It is recommended that opioid patches are left in place and changed regularly in last days of life
If pain occurs a rescue dose of an appropriate injectable opioid is administered—see page 10 for guidance about equivalent doses.
If 2 or more rescue doses are needed in 24hours consider setting up a CSCI with the total dose of rescue medication given in the previous 24 hours up to a maximum of 50% of the existing regular opioid (patch) dose.
Remember to combine the dose of the opioid patch and the dose of opioid in the syringe pump to work out the new rescue dose (1/6th—1/10th of the total 24hour dose)

IF YOU ARE IN ANY DOUBT ABOUT HOW TO MANAGE A PATIENT'S PAIN

Appendix 3:

Example of a risk assessment form where there is concern about the use of anticipatory medication

Logo here

RISK ASSESSMENT TOOL WHERE THERE IS CONCERN ABOUT THE USE OF "JUST IN CASE DRUG POLICY"

To be completed by a senior member of the healthcare team currently looking after the patient when there may be concerns about the use of Just in case medication including the following:

Patients where there is a history or suspicion of drug misuse
Patients with family members, carers or visitors to the house where there is a history or suspicion of drug misuse
Patients where there is concern about the safe storage of the medication
Patients where there is concern about the medication being accessed by children or other vulnerable members of the household
Patients where there are concerns about the mental well-being of a member of the patient's household or regular visitor where access to a controlled drug could be contra-indicated such as suicidal ideation.

Section 1: Diversion of Medication overview

To the best of your knowledge, in the past year has anyone in the household used an illegal drug or used a prescription medication for non-medical reasons?

YES ☐ NO ☐

To the best of your knowledge has anyone in the household ever been in a drug dependence treatment programme? YES ☐ NO ☐

If you answer yes to either question complete section 1a as fully as possible
If you answer no to both questions go to section 2

Section 1a: Detailed assessment

Name of individual (if known)			Relationship to patient	
Are the premises used by someone to either use drugs or deal drugs?	Occasionally	Regularly	Comments	
Tick which of the following drugs may be involved	Heroin		Ketamine	Amphetamine
	Benzodiazepines e.g. diazepam / temazepam		Other opioid (specify)	Other drug
	Comments			
Is the individual currently involved in a drug dependence treatment programme? YES ☐ NO ☐			Name and contact details for of support worker	
Comments				

Section 2: risk of medication access by children and other vulnerable family members

Do you have any concerns about how the "just in case drugs" will be stored in the property?
YES ☐ NO ☐

Do you have any concerns about the just in case drugs being accessed by children or other vulnerable members of the household? YES ☐ NO ☐

Do you have any concerns about a member of the household's mental well-being where access to a controlled drug could be contra-indicated e.g. suicidal ideation? YES ☐ NO ☐

If you answered no to all the questions in section 1 and section 2 issuing just in case medication is justified.

If you have answered yes to any of the questions complete section 3 and section 4

Section 3: Summary of concerns (continue on separate sheet if needed)

Summary of Concern	**Detail**

Section 4: Multi-disciplinary decision about use of Just in case drugs

Just in case drugs to be issued? YES ☐ NO ☐

If **YES** list actions to be taken to manage risk, e.g. additional checks on tamper proof bag etc.	If **NO** list actions taken to ensure patient gets adequate symptom control out of hours e.g. involvement of hospice at home etc.

Comments

Organisations informed of the risk assessment

Organisation	**Name and role of key contact**	**Contact details**	**Date informed**

Name and role of individual leading MDT decision	**Signature**	**Date**
Date of review of decision		

Appendix 4: Example of Patient information leaflet

What is this leaflet about?

Sometimes it can be difficult to get the medicines you might need in a hurry, especially at night or at weekends, so it is helpful to have them ready – "just in case". This leaflet explains why you have been given some "just in case" medication and how to look after it.

Why have I been issued with the "Just in case" medication?

The medicines you have been prescribed will help your District Nurse and/or GP to act quickly if you cannot take your usual tablets and develop symptoms such as pain or sickness. The medicines are ones that are effective when given into the skin by a small needle. Most people find this reassuring.

With it there will be some information and prescription (sometimes called a SPAR booklet) for the nurse and doctors looking after you. The booklet tells them what to give you and when to give it. It also allows them to record when they have given you something.

Who provides the "Just in case" medicines?

Your GP or District Nurse will have authorised its use. They will review if you need its contents on a regular basis.

The "just in case" medicines will come from a local pharmacy (chemist) who has been authorised to provide them, so it may not come from the pharmacy you usually use.

They may come in a sealed bag, with your name and a list of the medicines it contains on the outside. Please do not try and open it. The bag will only be opened by the team caring for you if it is needed.

Your caring team will check the medicines on a regular basis to make sure the medicines are accounted for.

What are the "Just in case" medicines?

There are a number of boxes containing ampoules of several different medications. These include:

Morphine Sulphate to relieve pain
Levomepromazine (Nozinan ®) or Cyclizine (Valoid ®) to relieve feeling or being sick
Glycopyrronium (Robinul ®) to relieve secretions in the chest
Midazolam to relieve anxiety and restlessness
Water – to help give medicines to you.

How do I look after my "Just in case" medicines?

The medicines should be kept in a safe place out of the reach of children and pets. It does not need to be kept in the fridge but should be kept in a cool and dry place.

Please make sure the nurses looking after you know where you have decided to keep the medicines.

Should I stop the medicines I am taking at the moment?

NO. The "just in case" drugs are not used to replace your usual medication, which you should continue to take as directed by your nurse or doctor.

They can only be given to you by a nurse or a doctor. They should not be given to you by a relative or carer.

Some people will never need the medications prescribed in this way. They are there "just in case."

They are only for use by you and should not be given to anyone else.

What should I do with the "Just in case" medication when it is no longer needed?

When the medicines are no longer needed they **MUST** be returned to a pharmacy for destruction. Where possible this should be the pharmacy who issued the medicines, (the name and address of the pharmacy concerned will be on the medicine's label).

If the pharmacy that issued the bag is too far away or you are not sure which pharmacy it is, the medication can be returned to any pharmacy for destruction.

As the "just in case" medication belongs to you it must be returned to the pharmacy by you or someone close to you. It cannot be returned to the pharmacy by a professional looking after you.

They must **not** be disposed of with the household waste.

Useful Telephone Contact details

ROLE	NAME	CONTACT NUMBER
GP		
District Nurse		
Nurse Specialist		

Other local useful contacts out of hours	

Options available for different versions of this leaflet

Please ask if anything is not clear to you.

Information leaflet for Patients and Carers

JUST IN CASE MEDICATION