NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

Anticipatory Prescribing for Dying Adult Patients

1. Introduction

1.1. Many patients nearing the end of life wish to remain in their own home, or normal social care setting, for as long as possible. However, they often experience distressing symptoms or become unable to swallow essential medicines, such as analgesics or anti-emetics.

1.2. Anticipatory prescribing ensures that there is no delay in responding to a symptom if it occurs. 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, just in case. The decision to prescribe anticipatory medicines should be based on a risk/benefit assessment, and it is essential to discuss the need for anticipatory prescribing within the context of end of life care, with both the patient and their carer as well as healthcare professionals involved.

1.3. Palliative care has traditionally been thought of as being a part of cancer care but many life-limiting illnesses such as cardiac, neurological and respiratory diseases can benefit from this approach.

2. Purpose

2.1. This policy aims to:

Improve access to palliative care medicines in the community by encouraging prescribers in primary, secondary care and the hospice setting to anticipate common symptoms in the last few days of life (e.g. pain, nausea and vomiting, respiratory secretions, agitation and anxiety) and prescribe sufficient quantities of the appropriate medicines which are dispensed and kept in the patient's home or normal care setting.

2.2. This policy does not include the prescribing of regular medication or when required medication (PRN medication).

3. Guidance

3.1. Anticipatory prescribing should be considered for all patients who are in the last few days or weeks of life to treat new symptoms or when patients become unable to swallow.

3.2. Some patients and/or carers may be unwilling to have anticipatory medicines; they may misinterpret anticipatory prescribing as provision for euthanasia. However, good communication, reassurance and the explanatory leaflet should help to allay fears.

3.3. Caution is needed where there is a history of drug misuse by the patient, family members, carers or visitors to the house, and a risk assessment should be undertaken. Consider prescribing smaller quantities of controlled drugs or using a lockable box for storage.

3.4. Setting up Anticipatory Prescribing in Primary Care

3.4.1. Where a relevant patient is identified by a primary care health care professional, the prescriber must prescribe the appropriate anticipatory medicines on an FP10 prescription to reflect the individual needs of the patient, taking into account current use of medicines for symptom control.

3.4.2. The prescription is likely to include one medicine for each of the following indications: pain, nausea and vomiting, respiratory secretions, agitation and anxiety according to individual patient need and anticipated symptoms.

3.4.3. For example:

- Morphine injection (or an alternative such as oxycodone) for pain, based on current 24-hour oral administration if applicable.
- Sodium chloride 0.9% injection (or water for injections) if required to make up volume.
- Haloperidol injection (or levomepromazine) injection for nausea and vomiting
- Midazolam injection for agitation or restlessness.
- Glycopyrronium injection (or hyoscine butylbromide injection (Buscopan®)) for respiratory secretions.
- Oral lorazepam tablets for *sublingual use* by the patient for anxiety. NB this is an unlicensed method of administration.

3.4.4. Normally 5 ampoules of each medicine should be prescribed.

3.4.5. A sharps bin should also be prescribed.

3.4.6. Include the indication and full dosage instructions on the FP10 so they are added to the dispensing label. "As directed" is insufficient.

3.4.7. In addition to writing the FP10 prescription, the prescriber must write each of the subcutaneous anticipatory medicines on the "As required/Anticipatory medicines" section of the community prescription chart with clear instructions for use, including:

- Medicine name (matching that prescribed on the FP10)
- Dose
- Route
- Frequency
- Indication for use and maximum dose in 24 hours
- Each entry must be signed and dated

3.4.8. The syringe pump prescription should **not** normally be completed at this stage; it is not usually appropriate to anticipate an individual patient's requirements for continuous subcutaneous infusion of medicines in advance.

3.4.9. The prescriber must explain the purpose of anticipatory prescribing to patient and carer, and ensure the patient or carers have a copy of the anticipatory prescribing patient leaflet and how to access urgent medical advice.

3.4.10. The prescriber must explain that the medicines are for administration by a health care professional only, except for the lorazepam tablets.

3.4.11. The prescriber must explain the lorazepam tablets can be self-administered by the patient or administered by the carer in accordance with the instructions on the label and those included within the Cambridgeshire and Peterborough leaflet.

3.4.12. The prescriber should ensure that the patient and/or carer know who to contact out of hours should any symptoms or problems occur. This should be recorded for the patient/carers, preferably on the leaflet.

3.4.13. The prescriber or notified GP should place a note on the patient's record to indicate that anticipatory medicines are held in the home and update the electronic Cambridgeshire and Peterborough Clinical Commission Group End of Life Care Template.

3.4.14. The prescriber should inform the District Nursing service that anticipatory medicines have been requested/supplied. The OOH service should also be made aware via the

CCG EoLC template and patients should be encouraged to allow sharing of their GP medical record.

3.4.15. An electronic version of the prescription chart is available via the CCG End of Life Care Template or from the CCG website, which can be printed and filled in by the prescriber. For safety, it is essential that all 4 pages are printed, numbered and stapled together. Nurses/prescriber may choose to place the completed, printed electronic chart in a coloured wallet for ease of identification.

3.4.16. The prescriber, in conjunction with the patient and/or carer, will need to also review the patient's routine medication for continued clinical efficacy.

3.4.17. Assessment of patients and provision of medication should take place during routine surgery/community pharmacy hours so not to generate unnecessary delay by using out of hours' service.

4. Obtaining supplies of palliative care medication in the community

4.1. Community pharmacies and GP dispensaries (for dispensing patients only) are able to obtain medication from wholesalers at least twice daily, Monday to Friday.

4.2. Where an urgent palliative care medication is required, a list of community pharmacies commissioned to hold a defined emergency drug supply is available on the CCG website.

5. Setting up Anticipatory Prescribing on Discharge from Acute Care/Hospice

5.1. Healthcare professionals, in both primary, secondary care and the hospice setting should identify relevant patients ahead of need.

5.2. Where a patient is identified as needing anticipatory medications by a healthcare professional in hospital or hospice settings, (as detailed in section 3) and it is expected that anticipatory may be required soon after discharge, the prescriber should liaise with a GP in the patient's practice. Where it is expected the patient may die within days the GP must be informed prior to discharge.

5.3. Communication with the GP should include, diagnosis, prognosis, anticipated care needs including present and anticipated medications. The hospital or hospice prescriber should also clarify the medicines to be sent home with the patient, whether they will include Just in Case medications, or whether the GP will need to consider prescribing Just in Case medications following discharge.

5.4. To support discharge where anticipatory medicines have been prescribed and supplied, it is preferable to provide a completed community End of Life Care (EOLC) MAR chart. Where this is not possible a duplicate hospital/hospice inpatient chart should be provided together with the discharge prescription and labelled medication for District Nurses to use if needed before a Community EOLC MAR Chart can be completed by the patient's GP. The medication should be transferred onto the community EOLC MAR chart by the GP as soon as possible, and within 24 hours.

5.5. After notification, the GP should update the CCG EoLC template ensuring OOH are also aware.

6. Managing the Anticipatory Medicines in the Patient's Home

6.1. Once dispensed, the Health Care Professional (HCP) visiting the patient in their home (normally the District Nurse) should put the anticipatory medicines into a suitably labelled container/bag, unless this has been done by another healthcare setting, or clearly mark and store the medicines so that they can be easily identified in the patient's home.

6.2. The HCP should counsel the patient, and patient's family or carer, to store medications out of site and reach of children and pets.

6.3. In addition, ensure each patient has:

6.3.1. A leaflet explaining the purpose of the anticipatory medicines.

6.3.2. A leaflet explaining how and when the lorazepam tablets are used.

6.3.3. Ensure that adequate supplies of equipment (e.g. needles, syringes, sharps bin) are available in the home for administration.

6.3.4. Record receipt of the anticipatory medicines in the patient's notes and complete the contact details for the patient/carer.

6.3.5. Record the strength and quantity of injectable Schedule 2 and Schedule 3 CDs (opiate analgesia and midazolam) received on the Controlled Drug Balance Record Form. The quantity of the CD must be counted and recorded each time it is used or each time the bag/container is checked. (It is not necessary to record the balance of other injections or tablets but is good practice to ensure adequate supplies OOH and at weekends). Care Homes' procedures relating to CDs and medication security should also be followed.

6.3.6. Check the anticipatory medicines regularly, carrying out a risk assessment for each patient and document how often the anticipatory medicines need to be checked. Checks must be made at least once every 4 weeks to ensure that nothing has been removed, used or expired without a record being made.

6.3.7. If any of the medication including controlled drugs (after enquiry with the family and health care team) cannot be accounted for, the Controlled Drugs Accountable Officer should be informed immediately and a web based incident report completed e.g. Datix or www.cdreporting.co.uk.

6.3.8. A prescriber should review the prescription at least once a month and after any changes to circumstances to ensure that the anticipatory medicines are appropriate both in terms of strength and type. Requirements may increase, decrease or cease. Any changes should be clearly updated on the community prescription chart and communicated to individuals involved in the patient care.

7. Administration of Anticipatory Medicines

7.1. When a subcutaneous anticipatory medicine is administered, the administering healthcare professional must:

7.1.1. Record the medicine and dose given on the community prescription chart and update the balance record of any controlled drugs used. (It is not necessary to record administration of the oral lorazepam on the chart, but a record should be made in the notes stating the reason for use.)

7.1.2. Regularly review the patient's symptoms - the patient may need a change in route, dose or medicine prescribed. Any changes should be clearly updated on the community prescription chart and updated on the GP clinical system.

7.1.3. Monitor for benefits and any side effects at least daily and give feedback to responsible clinician.

7.1.4. Action any replacement medication to meet the patient's needs. This should be sufficient to cover weekends/bank holidays to prevent unnecessary pressure on out of hours' services.

7.1.5. Consider a regular prescription for symptom control.

8. Disposal

8.1. When the episode of care finishes a family member/carer should be advised to return all medicines to a community pharmacy or dispensary for disposal as soon as possible, including controlled drugs.

8.2. In exceptional circumstances, where high risk of diversion or misuse is identified the visiting clinician may return the drugs to a community pharmacy or dispensary in accordance with their local policy relating to the management of controlled drugs in patients' homes.

8.3. All medicines are prescribed for the named patient only and must never be used for any other patient or returned to stock.

9. Risk Management

9.1. The subcutaneous route is recommended for all injections. Many medicines administered via the subcutaneous route are not licensed for subcutaneous administration; therefore, their use is 'off label'. However, the effective use of medicines via the subcutaneous route is well documented and the prescriber should be conversant with such evidence and follow local policy on unlicensed medicines.

9.2. The NPSA Safer Practice Notice 12 (May 2006) High dose morphine and diamorphine injection advises caution when prescribing parenteral diamorphine and morphine for patients who had not previously received doses of opiates. However, it is also important that clinicians have appropriate access to medicines of sufficient strengths and a good understanding of which medicine can be used to best effect.

9.3. The NPSA Rapid Response Report (July 2008) Reducing dosing errors with opioid medicines aims to reduce dosing errors with opioid medicines caused by a lack of understanding of how opioid medicines are dosed correctly, or inadequate checks on previous doses resulting in mismatching the needs of the patient with the dose prescribed. **Every member of the healthcare team** has a responsibility to check that the intended dose of an opioid medicine is safe for the individual patient. 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.

9.4. Any incidents or near misses concerning Anticipatory Prescribing, and remedial action taken must be reported through the web-based incident reporting system, e.g. Datix or www.cdreporting.co.uk.

10. Specialist Advice and Information

10.1. For further prescribing information refer to Palliative Care Adult Network Guidelines Plus.

10.2. Specialist advice is available from your local hospice or specialist palliative care team:

10.2.1.	Arthur Rank Hospice, Cambridge (24-hour advice line)	01223 675 777
10.2.2.	Thorpe Hall Hospice, Peterborough	01733 225 900
10.2.3.	St Johns Hospice, Moggerhanger	01767 642 410

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