NHS
Mid Essex
Clinical Commissioning Group

Mid Essex Medicines Standards

2018-21

Addendum- Palliative Care

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1. Purpose

1.1 The purpose of these standards is to ensure appropriate and effective prescribing and supply of anticipatory 'Just in Case' (JiC) medications is in place in anticipation of need.

1.2 The aim is to ensure that there is enough parenteral medication in the home potentially to last for 24 –72hour period. This will provide enough medication for a weekend period when a patient's regular GP is not available.

1.3 To prevent unnecessary admissions to hospital for symptom management in end of life care.

1.4 To promote choice as patients might be able to achieve their preferred place of care if they have these medications in place.

2. Introduction

2.1 'Anticipatory medication' usually refers to injectable medication to manage common symptoms that may occur in patients in the last days of life e.g. pain, breathlessness, agitation, nausea and vomiting and secretions

2.2 Anticipatory medication is prescribed in anticipation of symptoms, and is designed to enable rapid relief at whatever time the patient develops distressing symptoms. Drugs prescribed in anticipation may include previous or current prescriptions, sometimes with a change in the route of administration, and newly prescribed drugs for anticipated new symptoms.

2.3 NICE quality standard 144[1] states that

'Adults in the last days of life who are likely to need symptom control are prescribed anticipatory medicines with individualised indications for use, dosage and route of administration'. This same standard should also be applied to children but supporting documents e.g. standard operating procedures must clearly define whether for adults or children or both.

2.4 Patients in the last weeks or days of life should have available 'just in case' (JiC) anticipatory medication for end of life symptom control so they can be given if required without unnecessary delay. Patients within the last 12 weeks of life should have regular assessments and ensure that anticipatory medications are prescribed. JiC prescribing includes the most important medicines which might be required to manage predictable and distressing symptoms, or in the event that the patient cannot manage necessary oral medications.

[1] https://www.nice.org.uk/guidance/qs144/chapter/Quality-statement-3-Anticipatory-prescribing#quality-statement-3

2.5 If significant bleeding can be anticipated, it is usually best to discuss the possibility with the patient and their family. Ensure carers at home have an emergency contact number and an anticipatory care plan is in place and all professionals and services involved are aware of the care plan, including out-of-hours services. Every organisation will have a protocol for managing patients with bleeding and this will have been shared with the patient.

2.6 All healthcare professionals in all care settings and at all times shall have access to the medicines that may be needed and are able to get advice from colleagues with experience of end of life care if they need it.
Farleigh advice line 01245 455478

2.7 It is appropriate to prescribe anticipatory medicines for patients in all settings. Prescribing therefore may be undertaken by hospital/hospice specialists or by primary care prescribers-i.e. GPs or non-medical prescribers (with training), taking advice from specialists as necessary and having due regard to locally agreed protocols. Particular care will be required in secure (prison) environments. Alternative arrangements may be required in remote and rural locations considering ease of access to professional support.

2.8 Syringe pumps will be provided to patients when considered to be clinically necessary by a healthcare professional, and it will be provided as soon as possible based on patient need and absolutely within 24 hours. Arrangements for the supply of syringes, needles and sharps boxes must be put in place and provided to patients by healthcare professionals.

2.9 Discuss any prescribing needs with the dying person, those important to them and the multi-professional team.

2.10 The decision to prescribe medication for use in the future should always be based on a risk/benefit analysis. Reasons for not providing anticipatory medicines include risk of drug diversion or misuse.

3. Practicalities in community settings

3.1 Anticipatory medicines shall normally be prescribed using FP10s for dispensing by a community pharmacy. Specialists e.g. hospice should ensure that they have access to FP10s for such prescribing to avoid any delay when their usual supplying pharmacy is not open. The Electronic Prescription Service (EPS) sends electronic prescriptions from GP surgeries to pharmacies, and now includes sending controlled drug prescriptions. All providers should use EPS when available to them.

3.2 It is good practice to issue separate prescriptions for urgently required medicines so they can be dispensed at different pharmacies if needed.

3.3 Where hospital specialists prescribe using hospital prescriptions arrangements for timely dispensing such prescriptions must in place to avoid any delay to discharge, or discharge without JIC medication.

3.4 Some drugs e.g. octreotide, ketamine and alfentanil may only be prescribed for end of life patients, and then only by palliative care specialists. See MECCG website- Palliative Care –for more information. https://midessexccg.nhs.uk/medicines-optimisation/palliative-care

3.5 Arrangements must be in place to ensure that JiC medication can be accessed by the patient/carer/family at all times, including periods when community pharmacies are closed. It is recommended that a formal service is commissioned such that designated community pharmacies carry an agreed list of medications, and that on-call arrangements support access to these medicines when these pharmacies are closed.

3.6 The patient's usual community pharmacy should be the first port of call for dispensing JiC medication and will remain the usual supplier for non-urgent prescriptions and ongoing patient management. Whilst the pharmacy may not hold all JiC medicines in stock, they can usually order supplies of a prescribed drug to be available for the same day delivery, if ordered before 11.30am, and for the following morning if ordered before 5pm (Monday to Friday).

3.7 Community staff, including skilled non-registered staff, must be supported by their organisations and appropriate governance arrangements to administer medication in accordance with labelled instructions on medication dispensed within the last 3 months without the need for further written authorisation from a prescriber. These labelled instructions must contain full details including dose and frequency of administration, and in respect of 'when required' medication the circumstances in which this medication can be administered.

3.8 Skilled Non-Registered (SNR) staff are essential for enhancing the independence of people. SNR staff may be asked to provide support with and/or administer medication, including giving medication via a subcutaneous injection or subcutaneous injection line, as specified in the care plan and in accordance with Care Quality Commission, Mid Essex CCG and Essex County Council standards.https://www.livingwellessex.org/media/616926/medication-management.pdf see Appendix 1

3.9 Where instructions for administration cannot be accommodated on the dispensed label, separate written instructions must be provided using the community medication administration/directions to administer chart, which must be in place before healthcare professionals nurses/paramedics/SNR staff in the community can administer medicines. This must include the dose, route, frequency, indication(s), limits, and when to seek advice. See MECCG website- Palliative

Care –for more information. https://midessexccg.nhs.uk/medicines-optimisation/palliative-care

3.10 Organisations should put in place governance arrangements for healthcare professionals to support patients and carers to safely administer prescribed medication by routes other than oral e.g. subcutaneous route.

- The term 'carer' is a person who is either providing or intending to provide a substantial amount of unpaid care on a regular basis for someone who is disabled, ill or frail.
- Carers are usually family members, friends or neighbours and are not paid care workers.
- Carers have a significant role in symptom management and commonly administer or assist with the administration of oral medication. It is not uncommon for carers to administer subcutaneous medications such as insulin and low molecular weight heparin. In palliative care there are occasions when it may be helpful to train a patient or carer to give other subcutaneous medication.

3.11 Arrangements must be in place to ensure that patients have timely access to a syringe pump and a supply of syringes, needles and other consumables including sharps bins, when JiC medications are prescribed. Syringe pumps may be supplied by community nurses or hospitals on discharge. Syringes, needles and consumables, including sharps bin, should be supplied to patients by hospitals when JiC medicines are prescribed on discharge. Community pharmacies will supply a sharps container and the medicines upon receipt of individual prescriptions. Families should be encouraged to provide a box e.g. empty ice cream container for storage of JiC medicines if not stored in the syringe pump box. (JiC box)

3.12 Community staff must be provided with information/contact details about local pharmacies keeping an agreed list of drugs in stock and details of local out of hours/on-call pharmacist arrangements.

4. Management

4.1. Anticipatory medication-adults—for children see separate guidance

4.1.1 If a patient is currently receiving subcutaneous (SC) analgesics, anxiolytic/sedatives, anti-emetics, or anti-psychotics, an additional anticipatory medication supply may not be needed. Check what medicines are already available in the patient's home before prescribing new anticipatory medication.

4.1.2 If a patient is already prescribed an oral medication for symptom control and this is effective, the same medication may be suitable for prescribing by the subcutaneous route for the JiC box.

The dose stated below is for an opioid naïve patient.

- If the patient is taking a regular oral opioid, an SC breakthrough dose of the same opioid should be prescribed for the JiC box. SC dose would usually behalf of oral dose. The breakthrough dose should be calculated as 1/6th of the 24 hour opioid dose.
- Refer to the Essex Palliative Care and Management Guidelines for full guidance.
- Attention should be paid to renal function. If the patient has stage 4/5 chronic kidney disease or severe renal impairment (eGFR <30ml/min) seek palliative care specialist advice.

4.1.3 The medications available in the JiC box are prescribed for specific symptoms and for specific doses. These medications can in some circumstances be used for other symptoms, such as severe agitation, at higher doses. Clear instructions for the medication administration for the new symptom must be prescribed in the community medication administration chart, including dose, route of administration, frequency, indication(s), limits and when to seek advice.

4.1.4 The anticipatory prescription should include 10 amps/vials of each of the four medicines which might be required for end of life symptom control, plus diluent. Water for Injection is the diluent, unless advised otherwise.

- Opioid: The appropriate drug and dose should be chosen for the individual. Morphine Sulphate is the first line opioid of choice for SC administration, unless the patient is already maintained on an alternative opioid or is in renal failure. N.B. the highest concentration of injectable Morphine Sulphate is 30mg/ml therefore a maximum PRN injection dose is 60mg (2mls). Diamorphine should be used for higher doses.
- Antiemetic: The appropriate drug should be chosen for the individual. Tailor the anti-emetic choice based on the likely cause. Haloperidol is the preferred first line anti-emetic unless there is a history of Parkinson's or seizures
- Sedative: Midazolam is the usual first line drug for restlessness/anxiety at the end of life. Haloperidol or Levomepromazine should be used for delirium/hallucinations.
- Anticholinergic for secretions: Buscopan® (Hyoscine BBr) is the first line anti-cholinergic.

4.2 Symptom control in the last days of life

4.2.1 As a person approaches the last few days of their life, changes in their condition may lead to changes in existing symptoms, the emergence of new symptoms or changes in the person's ability to take medicines to manage their symptoms (such as swallowing oral medicines).

4.2.2 Medicines should be prescribed in anticipation to avoid a lapse in symptom control, which could otherwise cause distress for the person who is dying and those close to them. The drugs prescribed must be appropriate to the

individualised anticipated needs of the dying person and include written clinical indications (current or anticipated), dosage and routes of administration (some drugs may be prescribed for more than one indication at different doses). See Essex Palliative Care and Management Guidelines https://midessexccg.nhs.uk/medicines-optimisation/palliative-care

4.2.3 Consider non-pharmacological management of breathlessness in a person in the last days of life. Do not routinely start oxygen to manage breathlessness. Only offer oxygen therapy to people known or clinically suspected to have symptomatic hypoxaemia. See https://midessexccg.nhs.uk/medicines-optimisation/clinical-pathways-and-medication-guidelines/chapter-3-respiratory-system-2/3423-home-oxygen-order-form-hoof-guidelines-october-2019/file

4.2.4 For further information-refer to **'**Anticipatory Prescribing of 'Just in Case' Medication for Symptom Control in the Last Weeks of Life-Standard Operating Procedure and Clinical Guidelines for Mid Essex' https://midessexccg.nhs.uk/medicines-optimisation/palliative-care

5. Training

5.1 Some health and care professionals are uncomfortable discussing how long someone has left to live, and sometimes do not have the skills and confidence to give difficult news or talk about the dying process. Adequate training and continued support is important to help health and care professionals to communicate sensitively and effectively.

5.2 People at the end of life should have their care managed by a competent workforce. Providers must ensure that induction training and information about the governance framework, clinical and operational procedures for anticipatory medicines are in place for staff when they begin working in palliative care, this also includes short term locum/agency staff as well as employees.

5.3 Use of training programmes such as e-Learning for Healthcare's e-ELCA is encouraged to improve knowledge and skills in these areas. Relevant sessions include: Symptom management: last days of life.

6. References

https://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain/Anticipatory-Prescribing.aspx

https://www.nice.org.uk/guidance/ng31/resources/care-of-dying-adults-in-the-last-days-of-life-pdf-1837387324357

Managing medicines for adults receiving social care in the community
NICE guideline [NG67] Published date:March 2017
https://www.nice.org.uk/guidance/ng67/chapter/Recommendations

https://www.cqc.org.uk/guidance-providers/adult-social-care/training-competency-medicines-optimisation-adult-social-care

https://www.nice.org.uk/guidance/ng21/chapter/Recommendations#recruiting-training-and-supporting-home-care-workers

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Appendix 1-

Competencies for Skilled Non-Registered (SNR) staff to support administration of medicines

Level 1 - Induction Training

Induction Training will cover understanding of the medication policy and guidelines and should be carried out as part of the induction process and prior to Core Competency training.

Level 2 – Core Competencies

Core competencies are relatively straightforward, non-invasive tasks that approved staff may prompt, assist or administer after instruction and supervision within their workplace following completion of training and demonstrating the following core competencies:

Core Competencies

- Administer eye or ear drops
- Administer oral medication
- Administer homely remedies
- Apply topical treatments such as creams, ointments or patches
- Administer inhalers

Level 3 -Specialist Healthcare Tasks & Competencies

Specialist Competencies are to meet the more complex health needs of a particular identified patient. This is a task in addition to core competencies and identified as specific to the patient. The SNR staff member will be trained by a healthcare professional to support a named patient. This is NOT a generic competence AND cannot be applied to other patients or in different settings without individual authorisation on each occasion. Authorisation will be on a case by case based for named SNR staff caring for named patients with appropriate records kept.

The date for monitoring and reviewing the SNR staff member competency must be recorded. SNR staff must have completed the core medication training prior to training for specialist healthcare tasks.

Specialist Healthcare Tasks & Competencies

- Prescribed food and/or medication via a nasogastric tube, gastrostomy, or jejunostomy;
- Administration of nebulised medication (only in those circumstances where the person is stabilised and the dosage is pre-measured)

Specialist Healthcare Tasks & Competencies (contd)

- Administration of Rectal Diazepam for seizures (in emergency situations only)
- Administration of Rectal Paraldehyde for seizures (in emergency situations only)
- Administration of Buccal Midazolam for seizures (in emergency situations only)
- Administration of medication via a subcutaneous injection or subcutaneous injection line via a syringe pump.
- Assistance with oxygen management
- Oral suctioning only
- Specialist exercises as instructed by a therapist (for example, physiotherapy)

Level 4 - Specialist Healthcare Tasks needs not listed above

A level 4 task i.e. any medication route, healthcare intervention, therapy, alternative or complimentary treatment not listed above deemed necessary to meet the specialist healthcare needs of particular people must be agreed by an appropriate registered healthcare professional- e.g. doctor, nurse, pharmacist AND authorised by their employer before being undertaken by a SNR member of staff. Authorisation will be on a case by case based for named SNR staff caring for named patients with appropriate records kept

This should only happen after full discussion with the person, their carer, and the appropriate healthcare professional.

A Level 4 risk assessment will be completed by the provider organisation. Training and competence assessment must be in place and recorded prior to undertaking a Level 4 specialist healthcare task.