Guidelines for the use of the K&M Palliative Care Drug Chart

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Acknowledgements	MCH and Virgin Care lead pharmacists
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Approved by JPC, KMMOC, Clinical Cabinet
Date: Approved by Clinical Cabinet August 2021
Review Date: August 2023

EXECUTIVE SUMMARY

The main purpose of these guidelines, on the use of the Kent & Medway (K&M) Palliative Drug Chart, is to reduce the risk of harm to patients by having standardised practice of prescribing and administering medication on a standardised drug chart.

These guidelines have been agreed by the Community Providers across Kent & Medway, namely Kent Community Health NHS Foundation Trust, Medway Community Trust and Virgin Care.

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1.0 INTRODUCTION

1.1 These guidelines provide an overview of the use of the K&M palliative care drug chart but staff members should refer to local policy for detail e.g. Syringe Pump Policy, Medicines Policy, End of Life Care Policy.

1.2 These guidelines provide an overview relating to the K&M palliative care drug chart of the following: prescribing; supply of medication; syringe pumps; administering medication; monitoring and review of the patient and the process following death.

2.0 PRESCRIBING

2.1 Key References:

Care of dying adults in the last days of life. NICE guideline [NG31] Published: 16 December 2015.
https://www.nice.org.uk/guidance/NG31

See also: Symptom Control and Care of the Dying Patient: Palliative Care Guidelines. 6th Edition. Kent Palliative Medicine Forum.

2.2 Anticipatory Prescribing

Use an individualised approach to prescribing anticipatory medicines for people who are likely to need symptom control in the last days of life. Discuss any prescribing needs with the dying person, those important to them and the multi-professional team.

Ensure that suitable anticipatory medicines and routes are prescribed as early as possible.

A registered medical practitioner or non-medical prescriber, who has access to the patient's current medical record, must prescribe the anticipatory medication for the individual patient.

A review of medicines prescribed should be undertaken according to local policy, individual circumstances and frequency of multidisciplinary meetings. Discontinue medicines as appropriate.

Use caution and seek specialist advice for patients with (this list is not exhaustive):

- Complex symptom control persists despite optimising treatment
- Severe renal / hepatic impairment
- Neurological disorders such as dementia, Parkinson's, epilepsy, multiple sclerosis, motor neurone disease etc.
- Opioid use in impaired respiratory function

The prescribing sections on the drug chart provide some pre-printed medication and doses, of particular value when planning ahead.

2.3 Choice of medication

Assess what medicines the person might need to manage symptoms likely to occur during their last days of life (such as agitation, anxiety, breathlessness, nausea and vomiting, noisy respiratory secretions and pain).

Refer to local symptom control guidelines to ensure that prescribing is in accordance with formulary.

When deciding which anticipatory medicines to prescribe consider:

- the likelihood of specific symptoms occurring and the likely cause of the symptom.
- the benefits and harms of prescribing or administering medicines
- the benefits and harms of not prescribing or administering medicines.
- individual or cultural views that might affect their choice.
- any other medicines being taken to manage symptoms.
- any risks of the medicine that could affect prescribing decisions, for example prescribing cyclizine to manage nausea and vomiting may exacerbate heart failure.
- the possible risk of the person suddenly deteriorating (for example, catastrophic haemorrhage or seizures) for which urgent symptom control may be needed.
- the place of care and the time it would take to obtain medicines.
- patient factors such as renal function to ensure that medication prescribed is appropriate to the individual. For example, it is essential to be aware of the renal function of the individual to avoid medication which could cause patient harm such as opioid toxicity.

Space is available on the drug chart for the prescribing of an anti-emetic and advice is given about choice. Each locality or organisation may have their own ‘default’ antiemetic.

2.4 Route of administration

Decide on the most effective route for administering medicines in the last days of life tailored to the dying person's condition, their ability to swallow safely and their preferences. Consider prescribing different routes of administering medicine if the dying person is unable to take or tolerate oral medicines.

Avoid giving intramuscular or intravenous injections and give by the subcutaneous route.

2.5 Dose

For people starting treatment who have not previously been given medicines for symptom management, start with the lowest effective dose and titrate as clinically indicated.

A range can be prescribed to allow dosing flexibility in response to symptoms. However, an excessively wide range is not acceptable. A range starting at zero is not recommended due to the possibility of inadvertently giving a sub-therapeutic dose or giving too high a starting dose.

2.6 Appendix 2 gives some prescribing examples.

3.0 SUPPLY OF MEDICATION

The K&M Palliative Care Drug Chart may not be used to obtain supplies.

Medication must be prescribed according to local policy e.g. on an FP10 or on a hospital discharge letter. See Appendix 1 for guidance on the first-line recommended 'standard' medication.

3.1 Just in Case Box Schemes

Some organisations will formalise the supply of medicines within a 'Just in Case Box Scheme', although the principles of these guidelines apply regardless of whether such a scheme is in place. Where 'Just in Case boxes are available the following need to be defined:

- Criteria for patient inclusion / patient exclusion in the scheme
- Assessing a patients' suitability for inclusion in the scheme
- Informing patients and carers of the scheme
- Action to be taken is a patient declines inclusion in the scheme
- The process for setting up the scheme including for Care Homes

4.0 SYRINGE PUMPS

Follow the Syringe Pump Policy for your organisation.

4.1 A syringe pump will take a number of hours to reach therapeutic levels, therefore it is good practice to give a 'stat' dose of necessary medicines when starting a syringe pump. It is NOT necessary for a patient to have had a certain number of 'stat' doses before starting a syringe pump. A syringe pump should only be set up when the patient needs it.

4.2 A range of doses can be prescribed to allow dosing flexibility; however, an excessively wide range is not acceptable. A range starting at zero is not recommended. A person setting up the syringe pump may decide to omit medicines following patient assessment. If a dose is omitted, use a relevant omission code and document the reason.

4.3 Calculating a 'breakthrough dose'. The PRN dose will need to be reviewed when starting a syringe pump. An appropriate PRN dose would be 1/6th of the total daily opioid dose. Seek further advice if necessary.

4.4 Transdermal opioids. If setting up a syringe pump for a patient using transdermal patches, continue with the patch as usual and 'top up' the analgesic requirements with the infusion. Remember to include the opioid dose equivalent within the patch as well as the syringe pump when calculating the breakthrough dose of opioid.

5.0 ADMINISTERING MEDICATION

5.1 Anticipatory medication that has been prescribed for an individual patient should not be administered to any other patient.

5.2 Anticipatory medication can be administered as needed by a registered nurse, a registered medical practitioner or paramedic or another health professional authorised to administer medication. Some organisations may allow the patient's family or informal carers to administer anticipatory medication in certain circumstances. Please refer to local policy.

5.3 Before anticipatory medicines are administered, review the dying person's individualised symptoms and adjust the individualised care plan and prescriptions as necessary. A person may decide to omit medicines following patient assessment e.g. those in a syringe driver. If a dose is omitted, use a relevant omission code and document the reason. See also 4.2.

5.4 Seek specialist palliative care advice if the dying person's symptoms do not improve promptly with treatment or if there are undesirable side effects, such as unwanted sedation.

5.5 All persons administering medication will record the Controlled drugs (CD) as a minimum on the 'Medicines Records' form.

5.6 Inform the GP and persons involved in the patient's care if there is a change in the situation.

6.0 MONITORING AND REVIEW OF TREATMENT

6.1 The patient's individualised treatment, including a review of medicines prescribed, should be reviewed according to local policy, individual patient circumstance and frequency of multidisciplinary meetings.

There is no legal requirement for revalidation of the documentation at 28 days. An interval is recommended of no more than 6 months.

7.0 PROCESS FOLLOWING DEATH OF THE PATIENT

All remaining anticipatory medicines no longer required for treatment following a change in regime or death, should be returned to a community pharmacist by the family or carer according to local policy.

8.0 REPORTING SUSPECTED INCIDENTS OR DEFECTS

Any errors or incidents in relation to the use of the K&M Palliative Care Drug Chart must be urgently recorded and reported. This should be done via the practitioner's Line Manager and the incident should be recorded on their incident reporting system. Any further documentation must be completed as per local policy.

Errors must also be escalated to the CCG so that action may be taken which may include a review of the chart.

9.0 EXCEPTIONS

Children under the age of 18 are excluded from these guidelines.
There is a separate palliative care drug chart for children in use.

10.0 GLOSSARY AND ABBREVIATIONS

Anticipatory medicines
Medication prescribed in anticipation of symptoms, designed to enable rapid relief at whatever time the patients 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.

11.0 REFERENCES

1. National Institute for Health and care Excellence (NICE) (2015). *Care of the dying adults in the last days of life.* NICE
2. National End of Life Care Strategy (2008): Department of Health: London.
3. Royal Pharmaceutical Society and the Royal College of Nursing (2019). Professional Guidance on the Administration of Medicines in Healthcare Settings.
4. GSF (2006) *The Gold Standards Framework. Examples of Good Practice Resource Guide. Just in Case Boxes.* Place: Publisher.
5. Kent Palliative Medicine Forum (2019). *Symptom Control and Care of the Dying Patient: Palliative Care Guidelines. 6th Edition.*

GOVERNANCE SCHEDULE

Ratification process

Governance Group responsible for developing document	
Circulation group	Intranet, Policy Distribution
Authorised/Ratified by Governance Group/Board Committee	
Authorised/Ratified On	
Review Date	3 years from ratification
Review criteria	This document will be reviewed prior to review date if a legislative change or other event dictates.

DOCUMENT TRACKING SYSTEM

Version	Status	Date	Issued to/Approved by	Comments/Summary of Changes
First Version Draft 3	Draft	14 July 2021	Kent & Medway Joint Prescribing Committee	1.2 Further explanation of what the guidelines cover. 5.2 Statement added: *Some organisations may allow the patient's family or informal carers to administer anticipatory medication in certain circumstances. Please refer to local policy.* Further advice on what to do if drug is not required in a syringe pump. Other minor updates.
First Version Draft 4	Draft	27 July 2021	Kent & Medway Medicines Optimisation Committee	Made clearer the document is approved for use by the Community Providers of Kent & Medway.
First Version Draft 5	Draft		Kent & Medway Clinical Cabinet	

Appendix 1

First-line recommended 'standard' medication
Whilst the list below details first-line recommended 'standard' medication, an individualised approach is advocated

Dose recommendations for a syringe pump are outside the scope of this policy.

Drug	Indication	PRN Dose	Frequency	Quantity
Morphine Sulphate Injection	Pain	2.5mg to 5mg	2 hrly	10 ampoules 10mg in 1ml
Midazolam Injection	Agitation	2.5mg to 5mg	2 hrly	10 ampoules 10mg in 2ml
Drug of Choice According to local policy	Nausea & Vomiting			
Glycopyrronium Injection	Secretions	200 micrograms (Maximum 1.2mg in 24 hours)	2 hrly	10 ampoules 200micrograms in 1ml
Water for Injection	Diluent			10 ampoules 10ml

Additional items: *1ml and 2ml syringes, subcutaneous safety needles, needles for drawing up, occlusive dressing, community sharps bin, Palliative Care Drug Chart*

Appendix 2 Prescribing Examples

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PALLIATIVE MEDICINES TO BE GIVEN AS REQUIRED – Prescribe pro-actively
Refer to page 2 for guidance

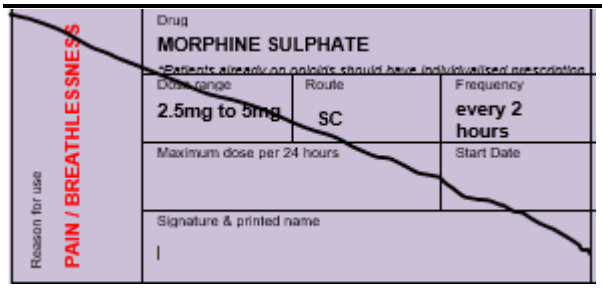
There is variation across organisations regarding the choice of ant-emetic. Prescribe as per local policy, and make sure the choice of drug and the dose takes the individual patient into account.

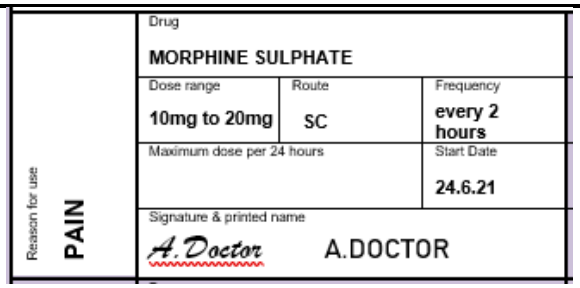
Reason for use	Drug	Dose range	Route	Frequency	Maximum dose per 24 hours	Start Date	Signature & printed name
PAIN / BREATHLESSNESS	MORPHINE SULPHATE	2.5mg to 5mg	SC	every 2 hours			
NAUSEA AND/OR VOMITING	Drug (see prescribing guidance)		SC				
ANXIETY / SEDATION	MIDAZOLAM	2.5mg to 5mg	SC	every 2 hours			
RESPIRATOTY SECRETIONS	GLYCOPYRRONIUM	200 microgram	SC	every 2 hours	Total max 1.2mg in 24 hours (including syringe pump)		

Reason for use	Drug	Dose range	Route	Frequency	Maximum dose per 24 hours	Start Date	Signature & printed name
PAIN / BREATHLESSNESS	MORPHINE SULPHATE	2.5mg to 5mg	SC	every 2 hours		24.06.21	A.Doctor A.DOCTOR
NAUSEA AND/OR VOMITING	CYCLIZINE	50mg	SC	every 8 hours	Total max 150mg in 24 hours (including syringe pump)	24.06.21	A.Doctor A.DOCTOR
ANXIETY / SEDATION	MIDAZOLAM	2.5mg to 5mg	SC	every 2 hours		24.06.21	A.Doctor A.DOCTOR
RESPIRATOTY SECRETIONS	GLYCOPYRRONIUM	200 microgram	SC	every 2 hours	Total max 1.2mg in 24 hours (including syringe pump)	24.06.21	A.Doctor A.DOCTOR

Where an amendment is necessary, cross through the pre-printed section and re-prescribe on the next page where there are blank spaces:

Guidelines for the use of the K&M Palliative Care Drug Chart





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SYRINGE PUMP: Medicines to be administered over 24 hours by SC infusion

In addition to the drugs, doses and reasons for use, indicate the diluent by crossing through the inappropriate diluent.

Remember to sign, print name and write the date of prescribing.

Drugs	Dose range	Reason for use	Dose given	Dose given	Dose given	Dose given	Dose given
MORPHINE SULPHATE	**60mg to 90mg**	**Pain**	60mg	60mg	60mg		
LEVOMEPROMAZINE	**6.25mg**	**Nausea**	6.25mg	6.25mg	6.25mg		
MIDAZOLAM	**10mg**	**Anxiety**	10mg	10mg	10mg		
Water for Injection or ~~Sodium Chloride 0.9%*~~	***Delete as appropriate. Check compatibility using references.**	Diluent	WFI	WFI	WFI		
Special Instructions e.g. with respect to dosage changes: ***Commence with 60mg Morphine Sulphate. Notify GP if/when increased dose is required***		Date	25.6.21	26.6.21	27.6.21		
		Time set up	1600hrs	1600hrs	1600hrs		
		Set up by	JK / MW	JK / MW	JK / MW		
Signature and printed name *A.Doctor* **A.DOCTOR**	Date **24 June 2021**	Syringe pump checks completed	JK	JK	JK		