NHS
Kent and Medway

NHS Kent and Medway Integrated Care Board

Guidelines for the use of the Kent and Medway Palliative Care Community Prescription Chart

Version:	V2.0
Approved by	Kent and Medway ICB - IMOC
Date Approved	Feb 2025
Name of the responsible committee	Kent and Medway ICB - IMOC
Reviewed by	Acacia Sooklal, NHS Kent and Medway ICB Swapna Thummala, NHS Kent and Medway ICB Heather Habing-Ridout, Kent Community Health NHS Foundation Trust
Effective from	Feb 2025
Review date	Feb 2028
Target audience:	All organisations using the Kent and Medway Palliative Care Community Prescription Chart

Document History

Version	Created by	Date	Main changes/comments
1	Lead Pharmacist, Adult Services Kent Community Health NHS Foundation Trust	August 2021	
2	Kent and Medway ICB		The document's statements are rephrased to clarify that they are authorised for use by the Community Providers of Kent & Medway. 2.5 and 4.2: A statement was added that the dose should not be started at zero in a syringe driver. 6.0 included a statement regarding the patients' review interval. This document aligns with other ICB documents for consistency.

EXECUTIVE SUMMARY

These guidelines on using the Kent & Medway (K&M) Palliative Care Community Prescription Chart aim to reduce the risk of patient harm by ensuring a standardised practice of prescribing and administering the medication on a standardised drug chart.

The ICB team has updated the guidelines with agreement and engagement with community providers across Kent and Medway: Kent Community Health NHS Foundation Trust (KCHFT), Medway Community Trust (MCT), Ellenor Hospice, Pilgrim Hospice, The Heart of Kent Hospice, Maidstone, and Tunbridge Wells NHS Trust, and HCRG Care Group Community Services

1.0 INTRODUCTION

1.1 These guidelines provide an overview of the use of the K&M Palliative Care Community Prescription Chart, but staff members should refer to local policy for details, e.g. Syringe Pump Policy, Medicines Policy, End of Life Care Policy.

1.2 These guidelines provide an overview of the K&M Palliative Care Community Prescription Chart, including prescribing, supplying medication, using syringe pumps, administering medication, monitoring and reviewing 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
- Symptom Control and Care of the Dying Patient: Palliative Care Guidelines. 7th Edition. Kent Palliative Medicine Forum.
- https://www.pallcare.info/
- Scottish Palliative Care Guidelines | Right Decisions

2.2 Anticipatory Prescribing

Prescribe anticipatory medicines individually for people likely to need symptom control in the last days of life. Discuss 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 and that a Treatment Escalation Plan (TEP) and Advance Care plan are in place for each individual patient.

A registered medical practitioner or non-medical prescriber who has access to the patient's current medical record must prescribe the anticipatory medication for each 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 the 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 are used to ensure that the medication prescribed is appropriate for the individual. It is essential to be aware of the individual's renal function to avoid medication that could cause harm, such as opioid toxicity.

The drug chart provides space for prescribing an antiemetic, and advice is given about choice. Each locality or organisation may have its 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, ability to swallow safely, and 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 using 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 Community Prescription Chart may not be used to obtain supplies.

Medication must be prescribed according to local policy, e.g., on an FP10 or a hospital discharge letter. See Appendix 1 for guidance on the first line of 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.' However, 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 patient's suitability for inclusion in the scheme
- Informing patients and carers of the scheme
- Action to be taken if a patient declines inclusion in the scheme.
- The process for setting up the scheme, including Care Homes

4.0 SYRINGE PUMPS

Follow the Syringe Pump Policy for your organisation.

4.1 A syringe pump will take several hours to reach therapeutic levels, so giving a 'stat' dose of necessary medicines is good practice when starting one.

However, a patient does not need to have had a certain number of 'stat' doses before starting one**. A syringe pump should only be set up when the patient needs it and should be individualised.**

4.2 A range of doses can be prescribed to allow dosing flexibility; however, an excessively wide range is unacceptable.

A range starting at zero is not recommended. A person setting up the syringe pump may omit medicines following patient assessment. Use a relevant omission code to document why a dose is omitted.

4.3 Calculating a 'breakthrough dose'. The PRN dose will need to be reviewed when starting a syringe pump. A guidance PRN dose would be 1/6th of the total daily opioid dose; however, 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 opioids.

5.0 ADMINISTERING MEDICATION

5.1 Anticipatory medication 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, a 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 the local policy.

5.3 Before administering anticipatory medicines, review the dying person's individualised symptoms and adjust the individualised care plan and prescriptions as necessary. A person may omit medicines following patient assessment, e.g. those in a syringe driver. Use a relevant omission code to document why a dose is omitted. 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 circumstances and frequency of multidisciplinary meetings.

There is no legal requirement to revalidate the documentation at 28 days. A review interval of no more than 6 months is recommended. Please individualise the review interval for the patient if needed.

7.0 PROCESS FOLLOWING DEATH OF THE PATIENT

All remaining anticipatory medicines no longer required for treatment following a change in regimen 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 related to using the K&M Palliative Care Community Prescription 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 Kent and Medway ICB so that action may be taken, including 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.

GLOSSARY AND ABBREVIATIONS

Anticipatory medicines

Medication is prescribed in anticipation of symptoms and designed to enable rapid relief at whatever time the patients develop 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. 7th Edition.*
6. https://www.pallcare.info/
7. Scottish Palliative Care Guidelines | Right Decisions

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 (patients on already opioids should have individualised prescription)	Pain/Breathlessness	2.5mg to 5mg	2 hourly	10 ampoules 10mg in 1ml
Midazolam Injection	Anxiety/Panic/ Agitation/Sedation	2.5 to 5 mg (increased to10mg if necessary)	2 hourly	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, including syringe pump)	2 hourly	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

PALLIATIVE MEDICINES TO BE GIVEN AS REQUIRED – Prescribe pro-actively
Refer to page 4 for guidance

There is variation across organisations regarding the choice of ant-emetic. Many of the antiemetic drugs prolong the QT interval – check individual drugs before prescribing if concerned. Seek specialist advice in patients with Parkinson's Disease.

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 *Patients already on opioids should have individualised prescription	2.5mg to 5mg	SC	every 2 hours		09.01.25	A. Doctor A.DOCTOR
NAUSEA AND/ OR VOMITING	CYCLIZINE	50 mg	SC	every 8 hours	Total max 150mg in 24 hours (including syringe pump)	09.01.25	A. Doctor A.DOCTOR
ANXIETY / SEDATION/ AGITATION	MIDAZOLAM	2.5mg to 5mg Increased to 10mg if necessary	SC	every 2 hours		09.01.25	A. Doctor A.DOCTOR
RESPIRATOTY SECRETIONS	GLYCOPYRRONIUM	200 micrograms	SC	every 2 hours	Total max 1.2mg in 24 hours (including syringe pump)	09.01.25	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:

Reason for use	Drug	Dose range	Route	Frequency	Maximum dose per 24 hours	Start Date	Signature & printed name
PAIN / BREATHLESSNESS	MORPHINE SULPHATE *Patients already on opioids should have individualised prescription	2.5mg to 5mg	SC	every 2 hours		09.01.25	A. Doctor A.DOCTOR

Reason for use	Drug	Dose range	Route	Frequency	Maximum dose per 24 hours	Start Date	Signature & printed name
PAIN	MORPHINE SULPHATE *Patients already on opioids should have individualised prescription	5mg to 10mg	SC	every 2 hours		15.01.25	A. Doctor A.DOCTOR

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 the 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 / MN	JK / MN	JK / MN	/	/
Signature and printed name *A.Doctor* **A.DOCTOR**	Date **24 June 2021**	Syringe pump checks completed	JK	JK	JK		