# Anticipatory Prescribing at End of Life (Adults)

| | |
|---|---|
| Document Reference No. | MM046 |
| Status | Final |
| Version Number | Revision of v3 Draft 5 |
| Replacing/Superseded policy or documents | Kent & Medway<br>Anticipatory Prescribing at End of Life (Adults) v3 |
| Target audience/applicable to | Kent & Medway |
| Author | Lead Pharmacist, Adult Services<br>Kent Community Health NHS Foundation Trust |
| Acknowledgements | Authors of previous documents<br>Clinical Nurse Specialist, Central and North West London NHS Foundation Trust |
| Equality Initial Screening Tool / full Equality Analysis (state which) | Equality Analysis |
| Contact Point for Queries | Local organisations |
| Date Ratified | October 2022 |
| Date of Implementation/distribution | November 2022 |
| Review date | October 2024 |
| Has this document been adopted? | No |
| Where has this document been adopted from? | N/A |

Author: Heather Having Ridout
Approved by: IPMO and Ratified by Kate Langford
Approval Date: Oct 2022
Review Date: Oct 2024

## EXECUTIVE SUMMARY

The purpose of this policy is to improve anticipatory care to help more people with palliative care needs and at the end of their life to be cared for and die in the place of their choice. Improved anticipatory care will ensure patients receive timely symptom assessment and management. Facilitating improved anticipatory care has the potential to enhance patient care and aid the prevention of unnecessary crises and unscheduled hospital admissions.

This document applies to all practitioners caring for a patient at home who is either involved in anticipatory prescribing or administering medicines. It also applies to registered nurses in care homes. The principles also apply when discharging a patient from an acute hospital.

In the previous version of this policy, subcutaneous drug administration by carers stated that the request for a carer to be involved in the subcutaneous administration of medicines should be initiated by the patient and not suggested by a health professional. In this revised version, the scheme should now be offered by the Healthcare Professional (HCP) if certain criteria are met.

## CONTENTS

## 1.0 INTRODUCTION

1.1 The National End of Life Strategy aims to ensure the delivery of high quality palliative care to everyone in the UK on the basis of clinical need not diagnosis, and according to established principles of equity and personal dignity. It sets out an agenda for improving the quality and effectiveness of services.

1.2 This policy supports anticipatory prescribing and access to palliative care medicines for patients in the dying phase. Common symptoms in the terminal phase e.g. pain, anxiety, breathlessness, nausea and respiratory secretions may be anticipated. Adequate quantities of the appropriate medicines are prescribed for the patient and stored in the patient's home. Carers and patients are reassured that the prescribed medicines have been prescribed 'just in case,' and may not be needed. Patients and carers have a range of contact numbers (including Community Nursing and out-of-hours services) to ensure timely access to symptom assessment and management. These will be detailed in the patient care record which is left with the patient.

1.3 The aims of the policy are to:

- promote procedural uniformity and assist practitioners in anticipatory prescribing.
- promote procedural uniformity and assist practitioners who are administering medicines.
- support safe and accountable practice when providing symptom relief for those patients who require prescribed medicines.
- provide a robust framework for carers to administer subcutaneous medicines.
- clarify roles and responsibilities.

## 2.0 ROLES AND RESPONSIBILITIES

### 2.1 Trust Board

It is the responsibility of the respective Trust Boards to acknowledge the importance of the Policy for the use of this policy and to ensure that their staff understand its importance.

### 2.2 Directors

It is the responsibility of the respective Directors to acknowledge the importance of the Policy for the use of this policy and to ensure that their staff understand its importance.

### 2.3 Committees

Kent & Medway. Anticipatory Prescribing at End of Life Group.

### 2.4 Heads of Service / Managers

It is the responsibility of the respective Heads of Service to acknowledge the importance of the Policy for the use of this policy and to ensure that their staff understand its importance.

### 2.5 Staff

Staff providing care under this scheme are required to be aware of the content of this policy and practice within the scope of their professional competency.
It is the responsibility of staff to ensure that the Policy for the use of this policy is read, understood and applied by staff. It is their responsibility to ask if there is any aspect which they do not understand.

### 2.6 Specialist Role

A registered medical practitioner or independent prescriber, who has access to the patient's current medical record will prescribe medicines for the individual patient.

A registered medical practitioner, a first level registered nurse or a registered paramedic or another health professional will administer the prescribed medicines.

## 3.0 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. The patient's own GP, hospice team, Community Nursing team or hospital doctor will identify potential patients ahead of need. Ensure that suitable anticipatory medicines and routes are prescribed as early as possible.

Discuss any prescribing needs with the dying person, those important to them and the multi-professional team. A copy of a Patient Information Leaflet should be provided to the patient and their carers. They should also be given time to discuss any concerns prior to implementation.

In situations where a staff member believes it is not safe to leave Controlled Drugs (CDs) in a patient's home e.g. where there is a history or suspicion of drug misuse among carers or visitors to the home, a risk assessment should be undertaken. Community Nursing Teams should take measures to prevent diversion of the CDs. A senior nursing manager should be involved in risk managing the situation and the organisation's Controlled Drugs Accountable Office (CDAO) should be informed. Options could include the temporary storage of CDs at a local Community Hospital.

All arrangements must be discussed, agreed, documented and implemented.

### 3.1 Prescribing

A registered medical practitioner or independent prescriber, who has access to the patient's current medical record, will prescribe the anticipatory medicines for the individual patient.

Refer to: National Institute for Health & Care Excellence. *Care of dying adults in the last days of life. NG31*. Published 16 December 2015

#### 3.1.1 Choice of medicines

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 take into account:

- 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 the medicine prescribed is appropriate to the individual. For example, it is essential to be aware of the renal function of the individual to avoid a medicine which could cause patient harm such as opioid toxicity.

3.1.2 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.

3.1.3 Dose

*See: Organisational policies for Controlled Drugs*
*See also: Symptom Control and Care of the Dying Patient: Palliative Care Guidelines. 6th Edition. Kent Palliative Medicine Forum.*

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.

## 3.2 Supply of Medicines

Medicines may be supplied from a Hospital (either acute setting or Community Hospital), a Hospice or a GP (on an FP10 prescription). For end of life medicines it is desirable that the expiry date is at least six months from the date of supply.

## 3.3 Documentation

Bedded Units

Each organisation will have their own charts for use in bedded units.

Community Hospitals

The Kent & Medway 'Palliative Care' charts are intended to be used seamlessly between a Community Hospital environment and a domiciliary environment. As such they can be used together with the usual hospital drug chart.

Domiciliary

In some localities, printed Kent & Medway 'Palliative Care' charts are available.
GPs also have the option of electronic forms which can be completed and sent electronically.

## 4.0 ADMINISTRATION OF MEDICINES

4.1 Anticipatory medicines prescribed for an individual patient should never be administered to any other patient.

4.2 Anticipatory medicines can be administered as needed by a registered nurse, a registered medical practitioner or paramedic. For administration by a carer or family member see Section 5.0.

4.3 Before anticipatory medicines are administered, review the dying person's individualised symptoms and adjust the individualised care plan and prescriptions as necessary.

4.4 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.

4.5 All persons administering medicines will record the Controlled drugs (CD) on the Medicines Record Form and record a running balance.

4.6 Inform the GP and persons involved in the patient's care if there is a change in the situation. Note that a syringe pump may be considered when a patient needs it and not just in response to the number of doses given of subcutaneous medicines. When a syringe pump is anticipated or commenced a prescription for further medicines will be required.

## 5.0 SUBCUTANEOUS DRUG ADMINISTRATION by CARERS

Please refer to the NICE guidelines on 'Supporting adult carers' which describes support for carers during end of life care and after the person dies.
Supporting adult carers (nice.org.uk)

In line with these NICE guidelines, this policy adopts the same terminology for 'carer'.

A carer is defined as 'an adult (aged 18 or over) who provides unpaid care and support to a family member, partner or friend (aged 16 or over) because of a disability, health condition, frailty, mental health problem, addiction or other health or social care need'[1].

5.1 Decision process for carer to administer medicines
The extension of the carer role to include administration of as-needed subcutaneous medicines in the management of common breakthrough symptoms in the last days of life of people who expressed a wish to be at home when they die, has several potential benefits: it can improve time to symptom control for the dying, and empower carers to support a wish to die at home. It has been shown to be safe when practiced in the context of a carefully constructed programme.

[1] National Institute for Health and Care Excellence. *Supporting adult carers.* NG150. Published 22 January 2020. Supporting adult carers (nice.org.uk) (accessed 05 May 2022)

**IMPORTANT:**

**Patients and their carer(s) may be asked by the Healthcare Professional whether they would consider administering medicines by the subcutaneous route to the patient.**

**The initial discussion will depend on the following:**

- **all criteria are met for subcutaneous administration by carers (see below)**
- **the prescriber of the anticipatory medicines agreeing and**
- **the wider multidisciplinary team (e.g. Community Nursing Staff, Hospice staff) agreeing**

5.2 Eligibility criteria:

- The patient is aged over 18 years.
- Patients who have unpredictable symptoms where PRN subcutaneous medicines maybe/is required.
- Patients where stat medicines, in the event of an emergency such as fitting, is required.
- The patient will have a subcutaneous cannula.
- There is potentially a carer, aged 18 years or over, who could undertake this role.

5.3 Potential Exclusion Criteria:

All of the following are subject to risk assessment by the prescriber and MDT.

- The patient or carer has a history of illicit drug use or there is someone with a known history of illicit drug use who has access to the property.
- Relationship or safeguarding issues between the patient and carer.
- If there is a complex drug regime which has been discussed at Complex Patient meeting and where it would not be appropriate for the carer to administer subcutaneous medicines.
- If it is not possible for the registered staff member to be able to ascertain if the carer is competent to administer.
- The patient or the carer is deemed unable to cope (physically, emotionally or cognitively) with the procedure.

5.4 Risk Assessment

5.4.1 A risk assessment, taking into account the inclusion criteria and exclusion criteria as above and following organisational guidance on risk assessments, should be prepared and presented to the MDT. It is best practice to do this before the patient and carers are informed of the scheme.

5.4.2 If a patient and/or carer ask about the scheme before being approached by the HCP, the HCP should make the process clear i.e. that the request will be taken to a multidisciplinary meeting to be discussed.

5.4.3 Where there is more than one potential carer, a risk assessment should be completed for each.

5.4.4 If the person acting as a carer is a healthcare professional holding current registration, they should be aware that although this is a legal practice, some colleagues or managers may feel hesitant about them taking on such a role. They need to know that there is a risk (likely low) that they will be reported to their registering body, but that this will not lead to disciplinary action as long as they have been trained to competency and acted within the parameters of the policy.

It is the responsibility of any registered HCP to check with their professional body e.g. General Medical Council (GMC), Nursing & Midwifery Council (NMC), General Pharmaceutical Council (GPhC) and/or defence organisation prior to undertaking the role to seek advice.
*For example, the GMC guidance states 'wherever possible you should avoid providing medical care to anyone with whom you have a close personal relationship'.*

Correspondence with the professional body an/or defence organisation should form part of the risk assessment.

There must be clear understanding that the HCP acting as a carer should only administer the medicines and doses prescribed.

5.5 Identify the lead healthcare professional who will be responsible for the patient and their care. The named person will be responsible for actively participating in shared decision-making on the person's end of life care. This includes liaising with the patient and the carer; liaising with all the health professionals involved; for ensuring that the correct process is followed; that the carer is trained and is competent to administer medicines and that all decisions and actions are documented.

5.6 Discussion with the carer
Clinical judgement should be used to determine if the discussion is more appropriate with patient and carer(s) together or separately to avoid coercion from either party.

Verbal and written information should be provided to the potential carer(s).

*Example leaflet, which could be adapted locally*:
Carer administration of as-needed subcutaneous medicines (helixcentre.com)

Carers should understand that even if they agree, they can discontinue this arrangement at any time if they wish.

Proceed to a more in-depth discussion if the patient would like their carer to administer medicines and the carer agrees to undertake a training and competence programme.

Appendix 7: Administration of medicines by a carer (informal): Responsibilities of Medical and Nursing Staff.

5.7 Consent
The patient must give informed consent for their named family member carer to administer subcutaneous medicines, in writing where possible.

Appendix 5: Consent Form – Administration of subcutaneous injections by a carer

Where this form is used, an electronic copy must be uploaded to the electronic patient record.

It is acceptable for the patient to give verbal consent if they are unable to provide a signature; this must be recorded in the patient's clinical notes.

Informed consent requires the patient and/or family member carer to:

- have an adequate explanation of the procedure
- have an adequate explanation of the risks and benefits
- understand the information given
- understand the existing services available to them, including out-of-hours
- feel free from pressure or coercion

5.8 Training and Competence Programme

A training checklist is available which may be used to support the decision of the team allowing the administration by a carer. The healthcare professional delegating the task of the administration of medicines must give full details in the medical notes regarding competence.

See Appendix 6: Administration of medicines by a carer (informal): Training checklist
See Appendix 8: A guide for carers (informal) to administer subcutaneous injections

Once the carer has completed the training programme and is deemed competent, the HCP should make a record both on the organisation's patient record and also on the Kent & Medway Clinical Record (KMCR) to say that the patient is on the 'carer-administration of EOL medication scheme'.

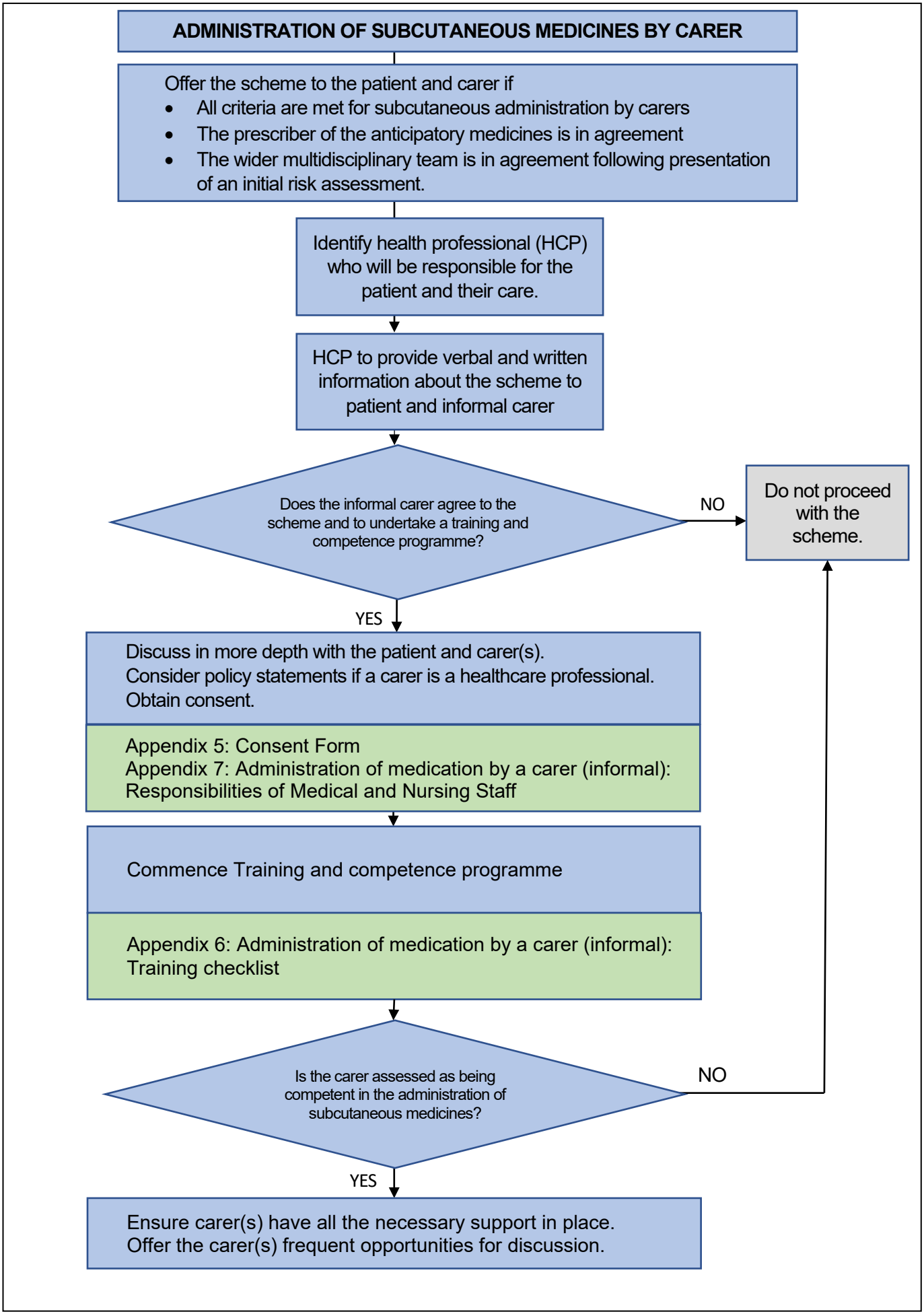
5.9 Commencing the scheme:

The carer should be given a contact telephone number (e.g. of the KCHFT Community Nursing Team, Hospice Community Team) so that the management of the patient may be discussed prior to administration of drugs by subcutaneous injection. The clinician should be involved in the decision when to administer drugs by subcutaneous injections by the informal carer and what dose to administer. The clinician should take into account the ability of the carer to cope emotionally with the current situation and advise accordingly. Management options may also include non-pharmacological care e.g. change in position of the patient or alternative prescribing e.g. an antibiotic for a chest infection.

The carer will make records of administration on the drug chart and also make records in the paper notes held in the patient's home.

5.10 Case Review

Where this policy has been used for the administration of medicines by carers, it is recommended that each case is reviewed. The focus on the review is on meaningful learning and sharing ways to improve care, so areas of good practice are highlighted as well as areas for improvement.


ADMINISTRATION OF SUBCUTANEOUS MEDICINES BY CARER
Offer the scheme to the patient and carer if
All criteria are met for subcutaneous administration by carers
The prescriber of the anticipatory medicines is in agreement
The wider multidisciplinary team is in agreement following presentation of an initial risk assessment.
Identify health professional (HCP) who will be responsible for the patient and their care.
HCP to provide verbal and written information about the scheme to patient and informal carer
Does the informal carer agree to the scheme and to undertake a training and competence programme?
NO
Do not proceed with the scheme.
YES
Discuss in more depth with the patient and carer(s).
Consider policy statements if a carer is a healthcare professional.
Obtain consent.
Appendix 5: Consent Form
Appendix 7: Administration of medication by a carer (informal): Responsibilities of Medical and Nursing Staff
Commence Training and competence programme
Appendix 6: Administration of medication by a carer (informal): Training checklist
Is the carer assessed as being competent in the administration of subcutaneous medicines?
NO
YES
Ensure carer(s) have all the necessary support in place.
Offer the carer(s) frequent opportunities for discussion.

## 6.0 MONITORING AND REVIEW OF TREATMENT

6.1 28-day review recommendation
In order to make sure that the prescription is still appropriate and the medicines remain in date, a 28-day check by an identified member of the MDT is recommended.

6.2 **There is no legal requirement for revalidation of the documentation at 28 days.**

6.3 Separate 'drug charts' are available for syringe pump authorisations ('prescriptions') and 'when required PRN medicines' if changes are required. These drug charts are available electronically. All authorisations must be printed and held together in a designated folder; any authorisations on the existing chart(s) must be marked as superseded.

## 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.

## 8.0 REPORTING SUSPECTED INCIDENTS OR DEFECTS

Any errors or incidents in relation to anticipatory prescribing 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.

## 9.0 EXCEPTIONS

Children under the age of 18 are excluded from this policy.

## 10.0 GLOSSARY AND ABBREVIATIONS

**Anticipatory medicines**
Medicines prescribed in anticipation of symptoms, 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.

**Carer**
An adult (aged 18 or over) who provides unpaid care and support to a family member, partner or friend (aged 16 or over) because of a disability, health condition, frailty, mental health problem, addiction or other health or social care need.

## 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. Royal Pharmaceutical Society and the Royal College of Nursing (2019). Professional Guidance on the Administration of Medicines in Healthcare Settings.
3. GSF (2006) *The Gold Standards Framework. Examples of Good Practice Resource Guide. Just in Case Boxes.* Place: Publisher.
4. NHS Lanarkshire (2013) *Policy for the Use of Just in Case Boxes:* NHS Lanarkshire
5. Kent Palliative Medicine Forum (2019). *Symptom Control and Care of the Dying Patient: Palliative Care Guidelines. 6th Edition.*
6. National Institute for Health and Care Excellence (NICE) (2019). *End of life care for adults: service delivery.* NG142. NICE.
7. National Institute for Health and Care Excellence (NICE) (2016). *Palliative care for adults: strong opioids for pain relief.* CG140. NICE.
8. NHS. (2021) *Ambitions for Palliative and End of Life Care: A national framework for local action 2021 – 2016.*

## 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** | 2 years from ratification |
| **Review criteria** | This document will be reviewed prior to review date if a legislative change or other event dictates. |

## KEY REFERENCES


| |
|---|
| National Institute for Health and care Excellence (NICE) (2015). *Care of dying adults in the last days of life.* NICE guidelines NG31. |
| National Institute for Health and care Excellence (NICE) (2017). *Care of dying adults in the last days of life.* Quality Standard QS144 |

## DOCUMENT TRACKING SYSTEM

| Version | Status | Date | Issued to/Approved by | Comments/Summary of Changes |
|---|---|---|---|---|
| 0.1 | Draft | 14 April 2016 | JIC group | Minor amendments throughout |
| 0.2 | Draft | 12 June 2016 | | |
| 1.0 | Final | 18 August 2016 | Medicines Management Governance Group | New Policy |
| 1.1 | Final | 01 December 2016 | Staff intranet | Minor amendment regarding the audit tool to ensure that the medication listed matches the recommended medication for West Kent. |
| Second Version<br>Draft 1 | Draft | 25 March 2018 | EOL group, KCHFT.<br>EOL consultant, Nicola<br>Le Prevost | Amendments as listed. |
| 2.0 | Draft | 12 April 2018 | Medicines Management Governance group | Amendments as listed. |
| 2.0 | Final | 18 September 2018 | Quality Committee | |
| 3.0 | Draft | | | Change of name of Policy<br>Amendments as listed |
| 3.0 | Final | 31 March 2020 | Medicines Optimisation SubCommittee | Minor changes from draft only. |
| | | | | |

## SUMMARY OF CHANGES

### *Summary of Changes from Version 3.0*

| | | |
|---|---|---|
| | | Presented as Kent & Medway Policy. |
| | | Syringe driver changed to Syringe Pump throughout. |
| | | Management of 'Just in Case boxes' removed.<br>This information will be in local SOPs. |
| 3.0 | ANTICIPATORY PRESCRIBING | Statement added when unsafe to leave CDs in a patient's home. |
| 3.1 | Prescribing | Reminder added to<br><br>Refer to: National Institute for Health & Care Excellence. *Care of dying adults in the last days of life. NG31*.<br>Published 16 December 2015 |
| 5.0 | SUBCUTANEOUS DRUG ADMINISTRATION by CARERS | The previous version of this policy stated that the request for a carer to be involved should be initiated by the patient and not suggested by a health professional. In the revised version, the Healthcare Professional should offer the scheme to patients and their carer(s).<br><br>Throughout section 5 the process is revised to reflect this change.<br><br>Charts and forms revised.<br><br>A flow chart describing the process has been added. |
| Appendix 4 | | Legal Framework Added |

### *Summary of Changes from Version 2.0*

Just in Case Box Policies for each of West Kent and East Kent amalgamated.
Significant revision of content
Addition of process for the administration of medication by carers.
Glossary added
Removal of Appendix regarding Audit.
New KCHFT Policy Template

## EQUALITY ANALYSIS

| **Has an Equality Analysis (EA) been completed?** |
|---|
| No ☐<br>The document will have no impact on people with any of the nine protected characteristics |
| Yes ☑<br>*Include summary of any reasonable adjustments or actions required to avoid significant impact on patients, patients' families and employees and volunteers with protected characteristics.*<br><br>The Equality Analysis for this policy is available upon request by contacting the Engagement Team via kchft.equality@nhs.net. |
| ***NOTE:***<br>*Kent Community Health NHS Foundation Trust is committed to promoting and championing a culture of diversity, fairness and equality for all our staff, patients, service users and their families, as well as members of the public.*<br><br>*Understanding of how policy decisions, behaviour and services can impact on people with 'protected characteristics' under the Equality Act 2010 is key to ensuring quality and productive environments for patient care and also our workforce.*<br><br>***Protected characteristics:*** *Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief, Sex, Sexual Orientation.*<br><br>*An equality analysis should be completed whilst a policy is being drafted and/or reviewed in order to assess the impact on people with protected characteristics. This includes whether additional guidance is needed for particular patient or staff groups or whether reasonable adjustments are required to avoid negative impact on disabled patients, carers or staff.*<br><br>***Equality Analysis*** *Liaise with the Engagement Team if support is required at kchft.equality@nhs.net* |

## MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY

Audits will be defined and undertaken at intervals.

## GOVERNANCE AND OWNERSHIP OF DOCUMENTS

This policy has been written in collaboration with members of the Kent & Medway End of Life Group.

Recommendations for change should be brought to the attention of the lead author.

Appendix 1

## Anticipatory Prescribing Process

**Identification of need**

- Anticipatory care planning process identifies that patient would benefit from having anticipatory end of life medicines available – (GP, hospice team, Community Nursing team or hospital doctor).
- Discuss reason for anticipatory prescribing with patient and carers. Provide guide for patients – Anticipatory Care Medicines

**Prescription of medicines**

- Prescriber or Independent Prescriber to prescribe anticipatory medicines and complete the Community Prescription chart. (The healthcare professional who identifies the need for anticipatory medicines should prescribe it and complete the chart, however the GP must be informed).
- GP to ensure that anticipatory prescribing is read coded in the patient notes.

**Recommended Anticipatory End of Life Medicines:**

Morphine Sulphate injection 10mg in 1ml – 10 ampoules
Midazolam **10mg in 2ml** injection – 10 ampoules
Glycopyrronium 200mcg in 1ml injection – 10 ampoules
Antiemetic of choice
Water for injection 10ml – 10 ampoules

**Dispensing of Medicines**

- Hospital or Community Pharmacy to dispense anticipatory medicines ensuring all items have at least a 6 month expiry.
- Pharmacy to deliver medicines or carer / patient to collect.

**Setting up in patient's home**

- GP, hospice or hospital to contact Community Nursing team to notify them that medicines will be prescribed and to arrange for supply of sundries if appropriate.
- Community Nursing Team to confirm patient and carers have received the guide for patients and add patient to their caseload for review at least every 28 days.
- Where 'Just in Case' boxes are used to store the anticipatory medicines, Community Nursing Team to follow local Standard Operating Procedure.

**Patient review**

- Community Nursing Team to review the patient at least every 28 days; complete the "check of contents" form

**Medicines administration**

- The anticipatory medicines can be administered as needed by a registered medical practitioner, a registered nurse or paramedic.
- Inform the GP and persons involved in the patient's care if there is a change in the situation. Note that a syringe pump may be considered when a patient needs it, not in response to the number of doses given of subcutaneous medicines.
- If appropriate utilise anticipatory medicines as part of this treatment.

**Disposal of medicines**

- Following a change in treatment or death, the anticipatory medicines should be returned to a Community Pharmacy by the family or carer.
- Any box and/or sundry items should be returned with the documentation to the Community nursing base.

**Audit**

- Audits will be defined and undertaken at intervals.

Appendix 2

NHS
Kent Community Health
NHS Foundation Trust

A guide for patients about

# anticipatory care medication, called a *just in case box*

## Why have I been given this advice sheet?

A healthcare professional looking after you may have left a *just in case box* in your home. This box contains some medicines which have been prescribed for you just in case you need them, especially during the night or at the weekend when your GP practice or local pharmacy is closed. These medicines are usually given by injection to help relieve pain, sickness, anxiety and other symptoms that may be experienced towards the end of life. Your healthcare professional or GP will talk to you and your family and/or carer about the box when they bring it to the house.

## What's in the box?

The box contains some injections that a healthcare professional or doctor may give, if needed, to relieve symptoms you may experience. A prescription chart will be left with the box. The box also contains items such as needles and syringes which are required to give these injections.

## What happens if someone uses the medicine in the box?

The healthcare professional or doctor will only give you what has been prescribed for you. They will keep a record of any medicines that are given to you. The box contains enough medication to last until more can be supplied if needed.

## Where should I leave the box?

Remember to keep the box in a safe place. Your healthcare professional will advise you on the best place.

**The *just in case box* should be stored out of sight and out of the reach of children.**

## What do I have to do now?

You don't need to do anything. You and your family and/or carer can relax, knowing that you won't have to worry about trying to get hold of medicines if you need them outside of normal working hours.

If you start to have any symptoms you should continue to take your usual medicines, for example, painkillers usually taken by mouth to see if this helps. If they do not help, you, your family or carer can phone your GP, community nurse or the out-of-hours service for advice. The GP or community nurse will discuss your symptoms with you, your family and/or carer to decide the best treatment for you. If you're unable to swallow your medication or are being sick, then the GP or community nurse may give you an injection from your *just in case box* of medicines.

## Useful contacts

we care Our values Compassionate Aspirational Responsive Excellent www.kentcht.nhs.uk

## Notes

### Do you have feedback about our health services?

**Phone:** 0300 123 1807
8am to 5pm, Monday to Friday
**Text:** 07899 903499
**Email:** kentchft.PALS@nhs.net
**Web:** www.kentcht.nhs.uk/PALS

**Patient Advice and Liaison Service (PALS)**
Kent Community Health NHS Foundation Trust
Unit J, Concept Court
Shearway Business Park
Folkestone
Kent CT19 4RG

If you need communication support or this leaflet in another format, please ask a member of staff or contact us.

Donate today, and help the NHS go above and beyond.
Visit www.kentcht.nhs.uk/icare

i care...

**Appendix 3**

## First Line recommended 'standard' medicines

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

Dose recommendations for a syringe pump are outside the scope of this policy. An individualised approach is advocated.

***NB: Medicines should have a minimum of 6 months shelf life at the date of issue.***

| Drug | Indication | Example dose | Quantity |
|---|---|---|---|
| **Morphine Sulphate Injection** 10 mg in 1ml | Pain | 2.5mg to 5mg every 2 hours PRN | 10 (TEN) ampoules |
| **Midazolam Injection** 10mg in 2ml | Agitation | 2.5mg to 5mg every 2 hours PRN | 10 (TEN) ampoules |
| **Glycopyrronium Injection** 200 micrograms in 1ml | Secretions | 200 micrograms every 2 hours PRN Maximum 1.2mg in 24 hours (including syringe pump). | 10 ampoules |
| **Antiemetic of choice** | Nausea & Vomiting | | |
| **Water for Injection** 10ml | Diluent | | 10 ampoules |

***Additional items:*** *1ml and 2ml syringes, subcutaneous safety needles, needles for drawing up, occlusive dressing, community sharps bin, KCHFT Community Prescription chart*

**Appendix 4**

## Legal framework for the administration of subcutaneous medicines to a patient by a carer or family member

A lay carer can legally administer medicines individually prescribed for a third party, including controlled drugs such as morphine, as long as the carer has been appropriately trained and assessed as competent, specifically in medicines management. This is true even if the medicines are given to a patient lacking capacity, and/or if the medicine is administered via injection. At present, injections are prepared immediately before administration (and not in advance, requiring relabelling). Carers should be trained to assess symptoms and should have access to dedicated support.

In support of this statements, the relevant sections from UK legislation and guidance are detailed below:

The Misuse of Drugs Regulations 2001[2] Section 7(3) states:

- *'Any person other than a doctor or dentist may administer to a patient, in accordance with the directions of a doctor or dentist, any drug specified in Schedule 2, 3 or 4.*

'Good Medical Practice guidelines' written by the General Medical Council (GMC) [3] Paragraph 45 states:

- *'When you do not provide your patients' care yourself, for example when you are off duty, or you delegate the care of a patient to a colleague, you must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient'.*

'Delegation and referral' guidelines written by the GMC[4] state:

- *'You are not accountable to the GMC for the actions (or omissions) of those to whom you delegate care or make referrals. You will be accountable for your decisions to transfer care and the steps you have taken to make sure that patient safety is not compromised. You must be prepared to explain and justify your decisions and actions. Only serious or persistent failure to follow our guidance that poses a risk to patient safety or public trust in doctors will put your registration at risk.'*

The Nursing & Midwifery Council (NMC) describes the delegation of tasks from one individual to another in the document, 'Delegation and accountability'[5]. This includes a registered or unregistered person to a carer or family member.

*These expectations are that people on the NMC register:*

- *only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand the instructions.*
- *make sure that everyone they delegate tasks to are adequately supervised and supported so they can provide safe and compassionate care.*
- *confirm that the outcome of any task delegated to someone else meets the required standard.*

[2] Misuse of Drugs Regulations

[3] General Medical Council. *Good medical practice*. Published March 2013 and updated November 2020. Good medical practice - ethical guidance - GMC (gmc-uk.org) (accessed 03 May 2022)

[4] General Medical Council. *Delegation and referral.* Delegation and referral - ethical guidance - GMC (gmc-uk.org) (accessed 03 May 2022)

[5] Nursing & Midwifery Council. *Delegation and accountability. Supplementary information to the NMC Code*. delegation-and-accountability-supplementary-information-to-the-nmc-code.pdf (accessed 03 May 2022)

**Appendix 5**
**Consent Form – Administration of subcutaneous injections by a carer**

| Patient Name<br><br><br>NHS Number:<br>Date of Birth: | Address |
|---|---|
| Carer name | |

The patient and carer give consent for the carer to undergo the necessary training and competence programme to administer medicines to the patient through a subcutaneous cannula.

The patient and carer give consent for the carer to proceed with the delegated responsibility to administer medicines through a subcutaneous cannula if deemed competent to do so. The patient and carer do so in the knowledge that they have access to specialist advise and support from the Community Nursing Team and that they can relinquish this role at any time. The carer agrees that they will adhere to the agreed management plan.

The carer agrees to proceed in the knowledge that the Community Nursing Team may decide that in the best of interests of everyone concerned, the carer will not continue to administer subcutaneous medicines and the patient will continue with care provided by the Community Nursing Team.

**Multi-professional team members** who considered and agreed for the carer to administer subcutaneous medicines:

| Name | Role | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Training delivered by**:

| Name | Role | Date |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Patient signature……. Printed Name…… Date……

Carer signature…….. Printed Name…… Date……

## Appendix 6: Administration of medicines by a carer (informal): Training checklist

| |
|---|
| Name of patient: |
| Name of carer administering medicines: |
| Name and role of the Healthcare Professional: |

| | **Discuss, demonstrate and feedback** | | **Observe procedure** | | **1st Perform with supervision assessment** | | **Competent doing the procedure** | |
|---|---|---|---|---|---|---|---|---|
| The carer is able to:- | Healthcare professional signature and date | Informal carer signature and date | Informal carer signature and date | Healthcare professional signature and date | Informal carer signature and date | Healthcare professional signature and date | Informal carer signature and date | Healthcare professional signature and date |
| Describe why prescribed medicines are being used, the expected aim of symptom control, potential side effects | | | | | | | | |
| Demonstrate handwashing and is able to discuss the importance of effective handwashing | | | | | | | | |
| Identify the equipment required to administer subcutaneous injections | | | | | | | | |
| Describes the reason for flushing before and after administering subcutaneous medicines | | | | | | | | |
| Demonstrate administration of subcutaneous injections and the safe disposal and recording of stock balance | | | | | | | | |
| Describes how to document medicines given and stock balance | | | | | | | | |
| Demonstrates how to store safely all medicines and how to discard equipment | | | | | | | | |

**Appendix 7: Administration of medicines by a carer (informal): Responsibilities of Medical and Nursing Staff**

| Discussed/ completed | Responsible person | Signature | Designation | Date |
|---|---|---|---|---|
| To establish if the patient and family member/ informal carer agrees to administer subcutaneous injections | | | | |
| To complete a risk assessment which is scanned into the patient's electronic medical records | | | | |
| To ensure that the patient/carer meets the eligibility criteria and that they are not excluded for any reason | | | | |
| To obtain written consent that the patient and carer agree to the administration of subcutaneous injections | | | | |
| To ensure that a nurse has cannulated the patient prior to the carer administering subcutaneous medicines | | | | |
| To provide the carer with the necessary training and support and to ensure that the carer has been assessed as competent to administer subcutaneous injections | | | | |
| To ensure that the family member/informal carer has all the contact details for in and out of hours | | | | |
| To ensure all staff are aware that a family member/informal carer is administering subcutaneous injections | | | | |
| To ensure that the patient is assessed daily to provide support to the carer and to ensure symptom control is monitored | | | | |
| To feedback at the multidisciplinary meeting including any concerns | | | | |

## Appendix 8: A guide for Informal Carers to administer subcutaneous injections

As your loved one becomes increasingly unwell it becomes more difficult for them to swallow oral tablets and liquids. Medicines used to control symptoms such as pain, are given via a syringe pump. This is managed by your community nurses. However, there may be times that your loved one may require additional medicines to control troublesome symptoms such as pain or nausea. This is done by a small subcutaneous injection which can be given at any time of the day or night. Informal carers can be taught how to do this. Your hospice nurse, doctor or paramedic will be able to support you and teach you how to do this. If at any time you no longer want to do this then please let your hospice nurse/paramedic know.

**Check the community drug chart to see the time of when the last dose of medicines was given to see if it is safe to give a further dose**

1. **Wash and dry hands thoroughly**

2. **If using a cannula (needle) check that the site is not**
   a. red or inflamed
   b. showing signs of leakage
   c. discomfort is not reported

3. **Prepare the equipment**
   a. Have prescription chart available
   b. Medicines required
   c. Stock balance sheet
   d. Needles and syringes
   e. Sharps bin

4. **Preparing the medicines**
   a. Check the prescription chart for when medicines was last given to see if it is safe to give a further dose
   b. Draw up prescribed medicines as prescribed on the drug chart
   c. Dispose of used needles and unused mediciness into the sharps bin

5. **Administering subcutaneous medicines**
   a. If giving an injection through a line, remove the cap from the line, attach the syringe and gently push the plunger until the syringe is empty, detach the syringe and then attach second syringe (containing water for injection) and flush the line
   b. Secure the cap onto the line
   c. If administering injection subcutaneously, select either the upper thigh or upper arm
   d. Using your writing hand remove the needle sheath and insert the needle at an angle of 90° or 45°.
   e. Gently push the syringe plunger and the medicines will be injected
   f. Remove the needle and syringe and dispose in the sharps bin
   g. Do NOT re-sheath the needle

6. **Disposal and completion**
   a. Dispose of used syringes and needles into the sharps bin
   b. Document the drugs used, drugs discarded, stock balance on the stock balance chart
   c. Complete the drug chart with the date, time, dose of drug and signature
   d. Wash and dry hands
   e. Store all equipment and medicines as advised by your Hospice nurse/paramedic