Community **PRN** Medication Authorisation

"AS REQUIRED" DOSES ONLY

Southern Health NHS Foundation Trust | Solent NHS Trust | NHS

Patient's Name: _____

D.O.B: _____ NHS No: _____

Address: _____

_____

GP: _____

Practice: _____

Latest eGFR: Date:

Allergies / Sensitivities:

Special Instructions: Document any analgesic patch (type, strength & location).

Adjustments within dose ranges should be justified by symptoms and any current or previous medicines administered. Please record changes and reasoning in the patient's clinical record.

NB. ONLY PRESCRIBE AND ADMINISTER THOSE MEDICATIONS CLINICALLY INDICATED

Date author-ised	Name & Form of Drug		PRN Dose or Range *	Route	Minimal Interval	Seek advice before exceeding	**Sign EACH prescribed drug.** Print name & GMC / NMC number once
	MORPHINE SULFATE INJ. (Check vial strength prior to administering)	Opioid naïve	1.25 - 2.5mg	SC	1 hour	If titrating 6 doses in 24hrs	
	Pain, breathlessness, cough			SC	1 hour	If on driver or patch 4 doses in 24hrs	
	HALOPERIDOL INJ. 5mg / ml Nausea, vomiting, delirium		0.5 - 1.5mg	SC	4hrs	4 doses in 24hrs	
	HYOSCINE BUTYLBROMIDE INJ. [Buscopan®] 20mg / ml Distressing oral or chest secretions, or abdominal colic		20mg	SC	4hrs	4 doses in 24hrs	
	MIDAZOLAM INJ. 10mg / 2ml Anxiety, agitation, breathlessness		2.5 - 5mg	SC	1 hour	4 doses in 24hrs	
	WATER FOR INJECTION To flush line		0.5ml	SC	None		

HOSPITAL DISCHARGES: For End of Life Care discharges (likely prognosis days to short weeks) please provide at least 7days supply of SC meds & a copy of the hospital medicines administration record. Contact patient's GP on day of discharge via an email flagged "Urgent", & if prognosis is days also telephone, to ensure a safe transfer of care.	Hospital Clinical Pharmacist Check:	Initials & Date:

Delete discontinued medicines with a single line, sign & date, using a pen

For Specialist Palliative Care Advice Out of Hours contact the team covering the patient's GP practice			
Countess of Brecknock, Andover	01264 835288	Oakhaven Hospice, Lymington	01590 670346
Mountbatten Hospice, Hampshire	02382 548860	Rowans Hospice, Portsmouth	02392 250001
St Michael's Hospice, Basingstoke	01256 844744	Salisbury Hospice	01722 425113
The Beacon Centre (9am-5pm) Phyllis Tuckwell Hospice (24 hour)	01252 729440 01252 729400	Macmillan Unit, Christchurch Hospital (Out of hours	01202 705470 01202 705291)
St Wilfrid's Hospice, Chichester	01243 775302	Midhurst SPC Team (8.30am – 8.30pm)	01730 811121
Winchester Hospice	01962 825344		

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Golden Rules

- Assess and diagnose the cause of symptoms before planning symptom management.
- Treat potentially reversible causes, where appropriate e.g. constipation, retention or dressing a pressure ulcer.
- Always consider non-drug approaches e.g. positioning, a calm environment, information for patient, carers &/or family. They are as important as the use of drugs.

Recording

- Record drug, dose given and "**reason for use**" in the electronic clinical record.
  - Record a description of where, when, how bad and your reasoning, particularly for patients unable to communicate §. Writing solely "pain" or "agitation" is poor record keeping and is not clinically helpful.

General Points

- Generally injections do not work any better than oral medication. Cases where oral medications are not absorbed are rare, though this may happen towards the end of life alongside swallowing becoming more difficult.
- Appropriate opioid use at the end of life does not shorten life, but uncontrolled pain can. Rarely, dying patients may experience distress when symptoms cannot be controlled, despite expert palliative care advice / involvement. In these rare circumstances, some patients may require sedating medication to diminish awareness of their discomfort.
- Medicines with a sedating effect: monitor the dose to ensure that it is the minimum required to relieve distress. Medication used in this way does not shorten life.

Pain assessment in cognitive impairment §

- Patients may be slower to express pain, less able to localise it, or express it differently (e.g. aggression towards themselves or others). If so, use an observational scale such as the PAINAD (particularly for patients with dementia) which can be found here.
- For further advice speak to a local end of life dementia CNS or Learning Disability team.

Opioid Conversion Chart **Wessex Palliative Physicians Handbook of Palliative Care 9th edition 2019**

'Strong' opioids													Patches		'Weak opioids'	
Morphine					Oxycodone					Diamorphine		Alfentanil		Fentanyl	Buprenorphine	Tramadol	Codeine Phosphate
Oral (mg)			Subcutaneous (mg)		Oral (mg)			Subcutaneous[1] (mg)		Subcutaneous (mg)		Subcutaneous[2] (mg)		Transdermal Patch (mcg/hr) *Stable pain only*	Transdermal patch (mcg/hr) *Stable pain only*	Oral (mg)	Oral (mg)
4 hr dose (IR)	12 hr dose (MR)	**24 hr total dose**	4 hr dose	**24 hr total dose**	4 hr Dose (IR)	12 hr Dose (MR)	**24 hr total dose**	4 hr dose	**24 hr total dose**	4 hr dose	**24 hr total dose**	4 hr dose	**24 hr total dose**	**Change every 72 hours**	**Change at intervals indicated**	**24 hr total dose**	**24 hr total dose**
1.25		**10**													5 *7 days*	100	120
2.5	10	**20**	1.25	**10**	1.25	5	**10**	1.25	**5**	1.25	**5**	0.125	**0.5**		10 *7 days*	200	240
5	15	**30**	2.5	**15**	2.5	10	**20**	1.25	**10**	1.25	**10**	0.125	**1**	6-12	15 *7 days*	300	
7.5	20	**40**	5	**20**	5	10	**20**	2.5	**10**	2.5	**15**	0.25	**1.5**	12	20 *7 days*	400	
10	30	**60**	5	**30**	5	15	**30**	2.5	**15**	2.5	**20**	0.25	**2**	12-25	35 *72 hrs*		
15	45	**90**	7.5	**45**	7.5	25	**45**	3.75	**25**	5	**30**	0.5	**3**	25-37	52.5 *72 hrs*		
20	60	**120**	10	**60**	10	30	**60**	5	**30**	7.5	**40**	0.75	**4**	37-50	70 *72 hrs*		
30	90	**180**	15	**90**	15	45	**90**	7.5	**45**	10	**60**	1	**6**	50-75			

[1]Some units recommend a 1:1 conversion from CSCI morphine to CSCI oxycodone rather than the 2:1 conversion in the table above

[2]Some units recommend an 18:1 conversion from PO morphine to CSCI alfentanil rather than the 30:1 conversion above

***Seek specialist advice when doses are greater than the equivalent of 120- 200mg of oral morphine in 24hours.**

Exceptions to Normal Anticipatory Meds (www.FuturePlanning.org.uk/EoLmedsworksheet)

- Renal Failure: if eGFR is below 30 drug accumulation, particularly of morphine, may lead to increased side effects. Please seek advice as necessary.
- If previously taking oral oxycodone use SC oxycodone (10mg/1ml at ½ oral dose) where possible.
- The same applies for Levetiracetam (100mg/ml at same dose). Where this is not available, and for replacement of other oral anticonvulsants, CSCI midazolam should be considered.
- Patients with intra-cranial pathology (brain metastases, CVA, dementia) appear more sensitive to Haloperidol CNS side effects, in these cases lower doses or use alternative medications e.g. cyclizine, metoclopramide or levomepromazine depending upon the cause of nausea
- Anti-psychotics are best avoided in patients with Parkinson's disease or PSP. Use cyclizine 1st line for N&V in these patients.