Community Anticipatory Medication Administration Order
"AS REQUIRED" PRN DOSES ONLY

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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).

[1]Consider previous oral meds, syringe driver & patch strength when calculating doses

***Adjustments within dose ranges should be justified by symptoms and any previous medicines administered. Please record these in the Electronic Clinical Record.**

NB. ONLY PRESCRIBE AND ADMINISTER THOSE MEDICATIONS CLINICALLY INDICATED

Delete medicines not clinically indicated or discontinued with a single line, signature & date

Date author-ised	Name, Form & Strength of Drug		PRN Dose or Range *	Route	Minimal Interval	Seek advice before exceeding	**Sign each prescribed drug** + PRINT once legibly.
	MORPHINE SULFATE INJ. 10mg / ml	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 / 2mls 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: Please contact patient's GP on day of discharge to ensure a safe transfer of care. For end of life care discharges (0-10days?), or if limiting the duration of this Order, please provide at least 7days supply of SC meds and a copy of the hospital medicines administration record.						Hospital Pharmacist Clinical Check	Initial & Date

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, Southampton	02380 475528	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)	07867 780538 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

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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 SC 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 180mg of oral morphine in 24hours.**

Exceptions to Normal Anticipatory Meds

- 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 mets, CVA, dementia) appear more sensitive to haloperidol CNS side effects, in these cases use lower doses or 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.