

**GUIDELINE**: **Anticipatory injectable prescribing guidance for the community.**

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| Role responsible: | Medical Director |
| Reviewed by: | Medical Director, Community Palliative Care and EOL Care Leads, Mohammed KANJI, Prescribing Adviser, Havering |
| Date created: | March 2022.Lead: Dr San San Vijeratnam Saint Francis Hospice |
| Date of review: |  |
| Next review: | February 2025 unless change in Medication Authorisation and Administration Records charts |
| Approved by: | Medicines Management Group Saint Francis Hospice |
| Ratified by Chief Executive Officer: |  |

Saint Francis Hospice is regulated by the Health & Social Care Act 2008 and the Care Quality Commission (CQC) Regulation 2009

This policy relates to the following CQC standard set of key lines of enquiry (KLOEs)

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| SAFE | People are protected from abuse and avoidable harm | S2 S4 |
| EFFECTIVE | Care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible | E1 |
| CARING | Staff involve and treat people with compassion, kindness, dignity and respect | C1 |
| RESPONSIVE | Services are organised so that they meet people’s needs | R3 |
| WELL-LED | Leadership, management and governance of the organisation assures the delivery of high-quality person-centered care, supports learning and innovation, and promotes an open and fair culture |  |

In consultation with: Saint Joseph’s Hospice, Mohammed Kanji, Prescribing Adviser, Havering, BHR EOL Steering Group. Adapted, with thanks, from Pan London, NELFT and St Joseph’s Hospice Guidance

**Guideline summary:**

This guideline contains guidance for anticipatory injectable prescribing in the community for people with advanced, progressive illness, vulnerable to rapid change, who need such medication to be readily available.

**The guidance covers three situations:**

* opioid naïve with egfr >30
* opioid naïve and frail, with egfr >30
* opioid naïve with renal impairment egfr <30. Seek advice if egfr <10.

If an individual is already taking an opioid then doses for PRN injections and syringe drivers may be different – please seek advice from the Saint Francis Hospice Advice Line, **01708 758643.**

If a patient is on a transdermal opioid patch then leave the patch on.

If the patient may require a syringe driver in the next 48 hours a syringe driver should be prescribed in addition to PRN injections.

If a patient requires 2-3 PRN doses in 24 hours then a syringe driver should usually be started.

However, if the patient is very symptomatic or imminently dying they may need a syringe driver straight away.

Please be aware that in some nursing homes syringe drivers cannot be used as nursing staff are not trained. In this event 4 hourly regular injections may need to be prescribed, please seek advice.

In patients with nausea and vomiting consider the underlying cause; another antiemetic may be moresuitable.

**IN ALL SITUATIONS SEEK ADVICE IF UNSURE ABOUT RECOMMENDATIONS OR PRESCRIBING.**

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| **\*\* For patients already on opioids, please refer to NELFT Palliative Cate EOL Quick Reference Guide V4 P6** [www.sfh.org.uk/mint-project/uploads/831325987.docx](http://www.sfh.org.uk/mint-project/uploads/831325987.docx)***Anticipatory Injectable Prescribing Guidance: Opioid Naïve + eGFR >30*** |
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|  | **AS REQUIRED PRN SUBCUT MEDICATION** | **24-HOUR SUBCUT PUMP** | **AMPOULE STRENGTHS** |
|  |  | ***Medication*** | ***Dose Range*** | ***Max Frequency /24 hr dose*** |  | ***Medication*** | ***Dose Range*** |
|  |  |  |  |  |  |  |  |
| **PAIN / SOB** |  | Morphine Sulfate | 2.5mg to 5mg | 1 hourly/ Max 30mg/24hour |  | Morphine Sulfate | 10mg to 20mg / 24hrs | 10mg/1ml amps Supply 10 ampoules |
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| **NAUSEA / VOMITING** |  | Levomepromazine | 6.25mg to 12.5mg | 4 hourlyMax 25mg / 24hrs |  | Levomepromazine | 6.25 to 12.5mg/ 24hrs | 25mg/1ml amps Supply 10 ampoules |
| *\* The choice of medication for use in nausea and vomiting will depend on the underlying cause for the symptom and the medications the patient is already taking. If the cause of the symptom is unclear or prescribing entirely in anticipation then use levomepromazine 1st line.* ***NOTE:*** *haloperidol, metoclopramide and levomepromazine MUST NOT BE USED in Parkinson’s disease, and cyclizine can only be used with caution. Cyclizine should not be used in severe heart failure. Metoclopramide should not be used in mechanical bowel obstruction. Please seek advice from specialist palliative care for these patients or if you are unsure what anti-emetic to use.* |
| **AGITATION / DISTRESS** |  | Midazolam | 2.5mg to 5mg | 1 hourly/ max 30mg/24hour |  | Midazolam | 10mg to 20mg /24hrs | 10mg/2ml amps Supply 10 ampoules |
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| **RESPIRATORY SECRETIONS** |  |  |  | 4 hourly Max 1.2mg/ 24hrs |  | Glycopyrronium |  |  |
|  | Glycopyrronium | 200micrograms to 300micrograms |  |  | 600microgram to1.2mg/ 24hrs | 200 micrograms/1ml ampsSupply 10 ampoules |

**If a patient requires more than 2 to 3 PRN doses in 24 hours, then a syringe driver should usually be started.**

**Please contact SFH 24 hour specialist advice line on 01708 758643 if unclear, this is guidance only. Please seek advice on drugs and doses for patients with an eGFR of <10.**