

Examples of Good Practice Resource Guide No 5

Anticipatory Prescribing for Crisis
Management in Primary Palliative Care
'Just in Case' Boxes

August 2006

Gold Standards Framework Anticipatory Prescribing for Crisis Management in Primary Palliative Care: 'Just in Case' Boxes

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Just in Case Boxes Resource

1. Introduction

Many areas nationally have developed a system of 'Just in Case' boxes to support anticipatory prescribing and access to palliative care medications for patients in the dying phase. These patients often experience new or worsening symptoms outside of normal GP practice hours. The development of 'Just in Case' boxes in local areas seeks to avoid distress caused by poor access to medications in the Out of Hours (OOHs) period, by anticipating symptom control needs and enabling availability of key medications in the patient's home.

Access to palliative care medications and proactive management of symptom control for patients are key components of GSF, within C3 Control of Symptoms and with anticipatory prescribing in C7 Care in the dying phase. The introduction of 'Just in Case' boxes can support proactive symptom control

This information resource contains information to support you in developing 'Just in case' boxes in a local area and examples of 'Just in Case' boxes form a number of different PCTs.

Anticipation of need

The key message is to encourage GPs and accredited non medical prescribers to think proactively about medication:

- Anticipate the key symptom control problems that can be experienced by patients in the dying phase: pain, nausea/vomiting, restlessness, moist secretions
- Sufficient supplies of anticipatory medications to cover OOHs period
- Nurse administration of prescribed anticipatory medications. This would be according to local protocols and appropriate authorisation to administer documentation

Examples of good practice

The information included in this resource includes examples of good practice that have been notified to the GSF team. It is not an exhaustive list. Many specialist palliative care services have developed protocols and guidelines to support anticipatory prescribing and management of patients with palliative care needs in the community. It is recommended when developing local guidelines for 'Just in Case' boxes, local specialist palliative care providers are involved.

Some of the examples included may suit some geographical areas and local resources, but it is hoped that the information can support existing good practice or enable development of good practice in other local areas. Examples of templates detailed in this resource can only be useful if they are amended to contain locally relevant information on palliative care services, local palliative care formulary, etc.

The contact details for each example of good practice, are as accurate as possible for August 2006. All the examples included have indicated that they are keen to share their information and expertise with others.

2. Gold Standards Framework guidance on developing Just in Case boxes in a local area

This is a potential checklist for developing 'Just in case Boxes' in your area, to enable a process of clinical governance in moving forward a new initiative.

1. Set up local working group. Membership should include GP, DN, Specialist Palliative Care, Long Term Conditions Case Manager Community Pharmacist, Clinical Governance representative, Out of Hours representative
2. Audit current anticipatory prescribing in the dying phase and access to medications. This could be through retrospective audit of patient records and / or audit survey of clinicians
3. Agree local approved list of medications for the 'Just in Case Boxes' from local palliative care formulary
4. Agree local algorithms / guidelines for anticipatory prescribing in the dying phase
5. Agree quantities of medications to be prescribed for the 'Just in Case Boxes'
6. Agreed protocols and guidelines for the process of anticipatory prescribing and use of the 'Just in Case Boxes'
7. Ensure 'Just in Case Boxes' endorsed by the Trust Clinical Governance and Medicines Management Committees
8. Agree on funding, supply / purchase of 'Just in Case Boxes'
9. Pilot 'Just in Case Boxes'
10. Audit anticipatory prescribing and access to medications in the dying phase
11. Following evaluation agree roll out of new initiative across the Trust

3. Gold Standards Framework guidance on contents for 'Just in Case' boxes in a local area

This is a potential checklist of 'Just in case Box' contents used for anticipatory prescribing in the dying phase.

1. Information label for the 'Just in case Box' stating:
 - a. Patient name
 - b. Date of supply of the 'Just in Case Box'
 - c. Earliest expiry date of the medicines contained within the box
2. Local authorisation document to administer medications
3. Prescribing algorithms / guidelines for the dying phase
4. Information leaflet for patients and carers
5. Contact details for advice and specialist palliative care
6. Syringes 2ml
7. Needles for drawing up medications from the ampoules
8. Needles for sc injection
9. Medications to include:
 - a. SC medication for pain
 - b. SC medication for nausea and vomiting
 - c. SC medication for terminal restlessness and agitation
 - d. SC medication for moist secretions
10. Additional medication could include:
 - a. Rectal diazepam for possible seizure or marked anxiety

Example of Good Practice

Mount Vernon Cancer Network

- I. 'Just in Case' box guidance document
- II. 'Just in Case' box audit tool
- III. Article from The Pharmaceutical Journal
- IV. Authorisation documentation front and back sheet

Best practice guideline for anticipatory prescribing for patients with a terminal illness

Patients with a terminal illness often experience new or worsening symptoms outside doctors' normal working hours. Since "out of hours" involves more hours than normal working time, this guideline seeks to avoid distress caused by poor access to out of hours medicines by anticipating need. **This document provides some guidance for sites to enable them to develop a local procedure**

Purpose

1. To ensure that:
 - Common symptoms in the terminal phase (e.g. pain, secretions and agitation) are anticipated
 - Small quantities of appropriate medicines are prescribed for the patient and stored in a special container, the "**Just In Case**" at the patient's house
 - Carers and patients are re-assured that the prescribed medicines have been prescribed "just in case", and may not be needed
2. To formalise and encourage good practice that is already taking place in many areas
3. To provide a safe framework for the use of palliative care medicines in the home
4. To provide data relating to usage, costs and wastage, by using an audit trail to follow the administration of medicines from the **Just in Case**

Scope

The scheme will include:

- Patients with a terminal illness registered withSurgery, who are supported by District Nurses and/orSpecialist Palliative Care Nurse, (subject to referral), who are assessed as suitable to be included in the scheme. This will include almost all patients with a terminal diagnosis, but will exclude:
 - Patients where there is a history or suspicion of drug misuse among carers or visitors to the house
 - Patients who are themselves unwilling to participate, or with carers who are unwilling to participate (although nurses and doctors may be able to provide re-assurance in most cases)
- Doctors fromSurgery
- Specialist Palliative Care Nursing team
- District Nurses attached toSurgery
- Medical Director and/or Clinical PharmacistHospice
- Pharmacists and dispensing staff at.....Pharmacy

Known Risks

Few, since healthcare professions will be working together but:

- As with all drugs open to abuse, medicine supplies in patients' houses may be subject to misuse
- Patients and/or carers may misinterpret anticipatory prescribing as provision for euthanasia, or cause increased anxiety that death is near. However good communication and the explanatory leaflet should allay fears

Process

- District Nurses, Specialist Palliative Care Nurses, or GPs identify relevant patients ahead of need
 - Patient's GP will prospectively prescribe appropriate medications on form FP10, which are likely to include
 - diamorphine for pain
 - cyclizine, haloperidol or levomepromazine for nausea and vomiting
 - midazolam for agitation
 - glycopyrrolate/glycopyrronium or hyoscine hydrobromide for respiratory secretions
 - oral lorazepam tablets
 - Prescriptions and the medicines supplied will reflect the individual needs of each patient
 - Patient's GP will also write these anticipatory medicines up in the patient's notes, on the administration sheet used only for anticipatory or PRN medicines given as *s/c stat* doses or oral prn doses, with clear instructions, and signing and dating the entry. Preferably, to avoid errors or discrepancies, the writing of the FP10 and the administration sheet should take place at the same time during a joint home visit with the District Nurse or Specialist Palliative Care Nurse
 - It is usually inappropriate to anticipate syringe driver doses routinely. Predicting starting doses is often difficult and can often only be sensibly done when nausea, coma, or inability to swallow is imminent. When appropriate, doses should be written on the administration sheet used for Continuous Subcutaneous Infusion (CSCI) drugs
 - The quantity of ampoules of prescribed Schedule 2 Controlled Drugs (usually diamorphine) in the **Just in Case** box must be entered on the relevant record sheet according to local policy (which may be clearly defined following the outcome of the Shipman Inquiry), and counted and deducted from numbers when used, along with any non-anticipatory Schedule 2 CDs
 - GP, District Nurse or Specialist Palliative Care Nurse will explain the purpose of the **Just In Case**, and that all items are for professional use only, apart from lorazepam tablets which can be used in accordance with the written leaflet supplied
 - The prescription will be dispensed by supplying pharmacy, dispensing the medicines in the usual way:
 - Adding the expiry dates of drugs and the batch numbers of all injections to each medicine container
 - Including Patient Information Leaflets for each medicine, together with ampoules of Water for Injection with diamorphine ampoules
 - The dispensed medicines may be collected from the pharmacy by the patient's carer and subsequently packed into the **Just in Case** at the patient's home by the identified nurse
- or
- Medicines may be packed into the **Just in Case** by the community pharmacist and delivered by the identified nurse. Although the NMC recommends that nurses should not routinely carry medicines to patients, the nursing team may use discretion for a nurse to collect medicines if that is deemed to be in the best interest of the patient, particularly in relation to the sensitive circumstances involved
 - The **Just In Case** should be labelled externally at the pharmacy or in the patient's home with:

- Patient's name
- The date of supply
- Earliest expiry date of the medicines contained within it

The kit also contains a brief carer leaflet explaining use of kit and use of lorazepam tablets. A summary of symptom control guidelines can be held either in the **Just in Case** in a sealed envelope identifying it as for professional use, or in the patient's notes

- Each site will need to use an audit tool for the District Nurse or Specialist Palliative Care Nurse to record the medicines supplied in the box and the details of usage
- Receipt of the **Just In Case** must be recorded by the District Nurse or Specialist Palliative Care Nurse:
 - In the patient's general notes to inform other visiting nurses and doctors
 - On any patient information board at the GP surgery
 - By placing a sticker on the patient notes held at the surgery, to indicate that a **Just in Case** is held at the patient's home, with a record of the first expiry date of the medicines involved
- The medicines in the **Just in Case** are prescribed for the named patient only and should **never** be used for any other patient
- Care should be taken to avoid the medicines going out of date. This is unlikely to happen but may occur if the patient's condition improves before deteriorating. A designated, named nurse must be responsible for checking the expiry date of the medicines held within the **Just in Case** and recording in the patient notes that the check has taken place
- It is the responsibility of the District Nurse or Specialist Palliative Care Nurse to also check the contents of the **Just in Case** at agreed intervals to ensure that nothing has been removed from the case, without a record being made in the patient's notes. If any drugs cannot be accounted for, the nurse must inform the police, after appropriate enquiry of the family and health care team
- Patient's anticipatory needs may change during the course of the illness. An identified doctor or nurse must be responsible for ensuring that regular review of required drugs takes place (at least once a month, and/or after any known change in circumstances). This will help to ensure that drugs in the **Just in Case** are appropriate and relevant both in terms of strength and type. Some patients may need stronger drugs, while others may need less potent drugs because they have subsequently undergone palliative radiotherapy or surgery to reduce tumour size. Where circumstances change in this way, a separate sheet should be included in the **Just in Case** to provide an adequate record of the drugs added or removed
- If items are used:
 - The nurse must record this in the patient notes identifying the source as the **Just In Case**
 - The drugs and quantities used, batch numbers and expiry dates may need to be recorded on the administration sheet, according to local district nurse policy
 - Any use of medicines by out of hours doctors must also be recorded
 - The GP must be informed of the use of the palliative care medicines, re-assess need and prescribe appropriate replacements where relevant via form FP10
 - A review of patient symptoms will be required at this stage as a change in dosage or medicines supplied may be needed

- Once items have been used from the **Just in Case**, a regular prescription for palliative care medicines for symptom control must be considered
- The GP must be aware that any new instructions for administration will be needed on the administration sheet
- An audit tool should be completed when items are used from the **Just in Case**. This will provide information for the surgery to determine any benefits gained for patients by the use of the **Just In Case**
- The pharmacist must dispense further supply according to the new FP10 (including expiry dates, product information leaflets etc)
- Following the patient's death, any Scheduled 2 Controlled Drugs from the Just in Case should be handled according to local district nurse policy (which may change in the light of the Shipman Inquiry)
- The GP practice or community nurse should inform the pharmacy of the death of the patient
- All other drugs should be returned to the community pharmacy for destruction as soon as possible, preferably by the relative
- If patients are admitted to the hospice or hospital and do not return home before their death, the patient's family is responsible for returning the empty **Just In Case** to..... surgery, having returned all medicines to the community pharmacy as stated above.
- So that it can be retained for future use, a printed label on the **Just in Case** will state that the empty box should be returned to the surgery
- If any drugs are not accounted for at the patient's house, the nurse must inform the police, after appropriate enquiry of the family and health care team

Responsibilities

Pilot leads: Medical DirectorHospice
 Dr.....GP.....Surgery
District Nurse
Specialist Palliative Care Nurse
Pharmacist

Acknowledgement is given to
 Mary Allen, Palliative Care Pharmacist, Hospice of St Francis, Berkhamsted
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Mount Vernon Cancer Network

PRACTICE NAME

AUDIT OF 'JUST IN CASE' BOXES FIRST PILOT STUDY

Date when case issued

Auditor's name
(BLOCK CAPITALS)

RIP date

Aims of the audit

- To ascertain the use of JUST-IN-CASE boxes
- To ascertain the wastage of drugs in the JUST-IN-CASE boxes
- To discover whether the JUST-IN-CASE boxes improve patient care

Instructions

- An audit form is to be completed for each patient who has JUST-IN-CASE box
- YES/NO questions. Please circle / tick the correct answer to each question

Questionnaire

- Which drugs were in the JUST-IN-CASE box to start with'

Drug name	Drug strength	Number of ampoules / tablets etc.
Diamorphine		
Midazolam		
Glycopyrronium bromide		
Antiemetic		
Lorazepam		
Any others		

- Was the 'just in case' box used

YES NO

- If you answer to question 2 is YES, please record which drugs were used.

Drug	Day of the week	Time	Given by (*see code)

* Code

GP – General practitioner
MacN – Macmillan nurse

OOH – Out of hours doctor
HN – Hospice nurse

DN – District nurse
P – Patient

R – Relative

4) Were the most appropriate drugs included in the JUST-IN-CASE box?

YES NO

If you answer to question 3 is NO, please state which drugs should have been included?

Drug name	Drug form (tablet / injection / suppository etc.)

5) Was any medicine prescribed outside NICE guidance for supportive and palliative care?

YES NO

6) Did the JUST-IN-CASE box prevent?

An out of hours call to a doctor?

YES NO

An admission to hospital?

YES NO

An admission to a hospice?

YES NO

A call-out to an out of hours pharmacist?

YES NO

7) Was there resistance to the introduction of the JUST-IN-CASE box in the box?

	Was there resistance?		If there was resistance, was the cause identified?		Identify the cause of the resistance, if known
	YES	NO	YES	NO	
By the patient					
By the patient's relatives					
By any other person (please identify)					

Audit site ...Letchworth and Bedfordshire.....

Number of 'Just in case' boxes issued

Number of 'Just in case' boxes used

Drug name

Drugs in box

Drugs used

Cyclizine injection

Diamorphine injection

Glycopyrrolate / glycopyrronium injection

Haloperidol injection

Hyoscine hydrobromide patch / injection

Lorazepam tablets

Midazolam injection

Yes

No

Resistance to Just in case in the home

Did the Just in case box prevent:

Yes

No

out of hours call to the doctor

an admission to hospital

an admission to the hospice

a call-out to the out-of-hours pharmacist

Yes

No

Was any medicine in the Just in Case box prescribed outside of NICE Guidance for Palliative Care

Medication Sheet for 'Just In Case box'

Individual patient details.....

<i>Date</i>	<i>Drug</i>	<i>Dose</i>	<i>Route</i>	<i>Frequency</i>	<i>Signature Prescriber</i>	<i>Print name</i>
	Diamorphine (for pain)	2.5 - 10mgs	S/C	PRN		
	Cyclizine (for sickness)	50mgs (up to max of 150mg / 24hrs)	S/C	PRN		
	Glycopyrronium (to dry bronchial secretions)	200mcg	S/C	PRN		
	Midazolam (for agitation)	2.5mg – 10mg	S/C	PRN		
	Rectal Diazepam (in the event of a seizure or for marked anxiety)	5-10mgs. (In the event of a seizure, the dose can be rpt after 15 min if necessary to achieve control).	Rectal	PRN		

Example of Good Practice

Shropshire PCT

- I. 'Just in Case' box guidance document
- II. Authorisation documentation

**Shropshire County PCT
Palliative Care Emergency Medicine Pack Service Protocol – Pilot Proposal**

Background:

The Gold Standards Framework for Palliative Care¹ is already widely in use across Shropshire, and the Liverpool Care Pathway for care of the dying is in the pilot phase. These frameworks help to develop and implement a standard of quality care, including anticipatory prescribing for distressing symptoms. Ready and easy access to palliative care medicines is essential for the successful implementation of these pathways.

Despite the fact that up to 90% of all palliative care occurs in a patient’s home environment and the majority of patients and their carers wish for a home death, most people who are suffering from terminal malignancy die in an institution. Breakthrough symptom control and lack of anticipatory palliative care are a contributory factor to high hospital death rates and patients being unable to die in their place of choice.

The Department of Health document published in December 2004, “Securing proper access to medicines in the Out-of-Hours period” recommends prompt and easy access to palliative care medicines in the out of hours period (action points 8 and 9).²

This pilot scheme supports anticipatory prescribing and rapid access to medicines commonly prescribed in palliative care by ensuring a Palliative Care Emergency Medicine Pack has been prescribed and placed in the patient’s home. The packs are targeted at patients reaching the terminal phase of their illness. It also supports effective team working between doctors, nurses and pharmacists, both in and out of normal working hours.

The Scheme:

The Palliative Care Emergency Medicine Packs will be available from PCT approved community pharmacies. A general practitioner and a district or Macmillan nurse in liaison with the general practitioner, will identify **adult** patients requiring palliative care support in their home. If it is anticipated that the patient’s medical condition may deteriorate into the terminal phase of illness and with the patient and carer’s agreement, the prescriber can initiate and prescribe an Emergency Medicine Pack. The practice will arrange for the chosen community pharmacy to receive the prescription and supply the pack. The pack will be kept at the patient’s home for rapid administration of medicines commonly prescribed for breakthrough symptom control. All medicines will need to be authorised (prescribed doses, indication, directions, signed and dated) in the patient’s community nursing notes by the prescriber, in order to enable a community nurse to administer the prescribed medication.

The Contents of the Palliative Care Emergency Medicine Pack:

Medicine	Strength	Quantity
Diamorphine Injection*	10mg	2 ampoules
Diamorphine Injection*	30mg	2 ampoules
Hyoscine Butylbromide Injection	20mg/ml	3 x 1ml ampoules
Levomepromazine Injection	25mg/ml	2 x 1ml ampoules
Midazolam Injection	10mg/2ml	4 x 2ml ampoules
Water for Injection BP	BP	2 x 10ml

¹ www.goldstandardsframework.nhs.uk

² Guidance for PCTs and Organised Providers, Gateway no 4107, DoH

* Or equivalent dose of morphine or oxycodone if diamorphine unavailable, see Appx 1

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The Process:

Suitable Patients:

1. A patient is identified as appropriate for a Palliative Care Emergency Medicine Pack by a prescriber. Patients will have a terminal diagnosis and will have been appropriate for a DS1500 i.e. a prognosis of 6 months or less. Usually the pack is introduced in the last two to three months of life. Some patients may be unwell and in the last few weeks of life but others may be relatively well at the time of initiation of the pack.

Patient Consent:

1. The provision of a Palliative Care Emergency Medicine Pack must be discussed with the patient and where appropriate the family and carers, in order to explain its function and acceptability. The patient's written consent must be gained by the prescriber initiating the pack prior to taking part in the scheme. If the patient agrees to take part in the pilot project, the last page of the PCT Patient Consent Form must be signed and kept in the patient's medical records. The patient should keep the top pages of the consent form containing the explanation of the scheme.
2. A patient must wish to participate in the service and it should be explained to the patient by a healthcare professional that it will be necessary for information about their care to be shared with the chosen approved community pharmacy. The healthcare professional will be required to contact the pharmacist and order a Palliative Care Emergency Medicine Pack and the pharmacist will need to communicate with the patient or their carer regarding the delivery or collection and refilling of the pack.
3. In cases where an adult is found not to be competent to give their consent to understanding and joining the scheme due to the severity of their illness, advice needs to be sought elsewhere. If the prescriber believes inclusion in the pilot project would be in the individual's best interests, relatives, carers or friends may be best placed to advise on the individual's preferences.

Communication with other Teams:

1. The patient must be referred to the community nursing team for assessment and the introduction of Community Nursing notes into the home.
2. Communication with the Out-of-Hours teams must occur in the usual manner. The provision of a Palliative Care Emergency Medicine Pack should be identified on the flagging notice.

Prescription Requirements:

1. A normal FP10 prescription is generated for the medicines contained in the Palliative Care Emergency Medicine Pack and signed by the GP caring for the patient. The correct quantities must be specified and the prescription for parenteral diamorphine is subject to DDA requirements.
2. It may be possible to incorporate this into a computer template, taking care to identify any patient specific issues e.g. allergies or interactions.
3. The Home Office has expressed the view that a dose of "as directed" or "as required" is not acceptable for a controlled drug prescription but "one to be taken as directed" is acceptable. For the Palliative Care Emergency Medicine Pack, a prescription for diamorphine should contain the following dosage instructions:
Diamorphine 10mg Injection: 10mg to be administered for pain as directed
Diamorphine 30mg Injection: 30mg to be administered for pain as directed

Prescription Collection & Delivery Arrangements:

1. The General Practice is responsible for arranging the prescription, contacting the chosen approved community pharmacy and arranging for the prescription to reach the pharmacy.
2. The completed Palliative Care Emergency Medicine Pack should either be collected by the patient or their nominated carer and this process will be arranged by the pharmacy, or the pack could be delivered to the patient's home using the pharmacy's delivery service where feasible.

Authorisation and Administration of Medication from the Emergency Pack:

1. Drugs from the pack cannot be administered by the community nursing team unless the medicines are authorised (prescribed doses, indication, directions, signed and dated) by a prescriber in the patient's community nursing notes.
2. In some situations, clinical scenarios can be anticipated and the medicines can be 'written up' in advance when the pack is organised for the patient.
3. The pack will be sealed to prevent tampering and this seal should only be broken by a healthcare professional when a medicine is required. The seal should not be broken by a nurse/ doctor to check the contents of the pack, as the details of the contents can be found on the audit toolkit in the plastic pouch attached to the pack and the pharmacist has carried out the final check before sealing the pack.
4. The name of the medicine, batch number and expiry date should be checked prior to administration in the usual manner.
5. When a doctor or nurse administers a medicine from the pack, the individual must complete the audit tool sheet and place back in the plastic pouch attached to the box. The audit sheet must be kept in the pouch at all times. Completion of the audit tool is vital to the review of the pilot project and tracking the usage of the medicines.

Using & Refilling the Emergency Medicine Pack:

1. The packs will be delivered with a black tamper proof seal from the Pharmacy. Only a healthcare professional caring for the patient may break the seal in order to administer a medicine from the pack. Once any medicine from the pack is used, the community nurse and the patient's general practice should organise for the pack to be refilled by the same community pharmacy who issued the pack originally.
2. The healthcare professional should ensure the practice generate a new prescription, only for the medicines used.
3. The pack cannot be refilled by another approved pharmacy as the audit cycle needs to be maintained and the patient has signed their consent for personal information to be shared with the named pharmacy only.
4. When a pack needs refilling, the Practice should contact the pharmacy by telephone to allow the pharmacy time to arrange collection or delivery of both the prescription from the Practice and the pack from the patient's home. The pharmacy may arrange for a relative to deliver the pack to the pharmacy or collect the pack directly from the patient's home if they operate a delivery service and it is feasible to do so.
5. If the Pack is opened and some of the medicines are administered, details should be recorded in the patient's community nursing notes as usual and the Palliative Care Emergency Medicine Pack Audit Tool (found in the plastic pouch attached to the pack) should be completed immediately and placed back in the pouch.
6. The box should be resealed with the spare (red) seal found in the pack ready for returning to the Pharmacy.
7. If the pack is used by the out-of-hours team, the co-op doctor or community nurse is responsible for informing the practice by telephone/fax or computer link the next day that the pack has been opened and needs to be refilled.
8. Once the patient has died, the practice should inform the pharmacy and the out-of-hours agencies. The Pharmacy will be responsible for ensuring the Palliative Care Emergency Medicine Pack with the unused contents is returned by the patient's relatives. It is recognised there may be a delay in obtaining the packs due to the circumstances and the pharmacist may wish to contact the family after 2 weeks rather than immediately after death. The community nursing team may be able to help with the removal and return of the pack to the Pharmacy. The patient consent form does explain the need to return the packs to the Pharmacy once no longer required by the patient.

Pack Found to be Open:

1. If a GP or community nurse find the pack open in the patient's home, the contents should be examined to check they match the details in the audit tool sheet. If the audit tool sheet has not been completed, the community nurse should attempt to identify who opened the box by checking the nursing notes or checking with the practice. The Audit tool sheet should be completed retrospectively and the pack should be refilled.
2. If the healthcare professional cannot identify who opened the pack, or suspect the patient or a relative of tampering with the pack, the pack should be removed from the patient's home immediately and the GP informed.

The Community Pharmacy Team's Role:

- 1) The PCT will provide all approved Community Pharmacies with the outer plastic boxes (not the white dispensing boxes) seals, plastic wallets and copies of the audit sheets.
- 2) The Practice will provide the FP10 prescription either for the entire contents of the pack, or in the case of refilling, the medicines which need to be refilled.

The Pack:

- 1) Medicine labels should be generated as usual for each medicine to include the following details:
 - a) Patient's name
 - b) Pharmacy details
 - c) Date of dispensing
 - d) Directions for use
 - e) Keep out of the reach of children
 - f) Name of the medicine and directions for use
 - g) The medication ampoules should be packed as usual in a white dispensing box for each product and the medicine label attached as usual
- 2) The labelled medicines should be placed in the Emergency Medicine Packs together with symptom control guidelines and a spare red seal tag and the pack should be sealed shut with a black tag.
- 3) The packs will be given a unique number by the PCT on the outside of the box and the pharmacy will need to attach or complete labels with the following:
 - a) The pharmacy should complete the label on the outside of the box stating " The contents of this Pack Expire on" and the expiry date chosen should correspond to the earliest expiry date of the medicinal products within the pack.
 - b) The contact name and details of the pharmacy.

The cost of the ampoule cases will be sponsored by Link Pharmaceuticals for the duration of the pilot project, and the ampoule cases will be supplied to the participating pharmacies.

The Plastic Pouch:

A plastic pouch is attached to one side of the box. The pouch must contain an audit tool sheet

- 1) The following details should be completed by the Pharmacy on the Audit Tool Sheet when preparing a new box or refilling a box:
 - a) Patient's name
 - b) The name of the prescribing GP
 - c) The corresponding emergency medicine pack number (found on the outside of the ampoule case)
 - d) Expiry dates of the medicines
 - e) The Batch or Lot numbers of the medicines

Record Keeping:

It is good practice and a requirement of the service level agreement, for the pharmacy to keep a copy of the audit tool sheet for their records and the following details:

- a) The expiry date placed on the ampoule case in order to monitor when a box needs recalling.
- b) The date the box was supplied. The Pharmacy should request the practice to review any boxes remaining in a patient's home for more than 3 months having never been used.
- c) The above details must be kept securely and confidentially in the pharmacy. The PCTs advise Pharmacists to keep copies for a period of 5 years

Patient Information leaflets/ Box Inserts:

Each pack should be provided to the patient with the medicinal product's patient information leaflets. The leaflets can be folded to fit inside the box and the healthcare professional administering the medicine can ensure the patient has access to the relevant leaflet.

Delivery & Collection:

1. The pharmacy should arrange with the patient or their relative to either collect the pack from the pharmacy or deliver directly to their home if the pharmacy is able to offer a delivery service.
2. The pack will be delivered sealed and will remain sealed until the healthcare professional opens the box to administer a medicine.

Refilling the Pack:

1. The pack will require refilling once opened and any of the contents used. The practice or community nurse will contact the pharmacy regarding a pack requiring refilling.
2. It is the responsibility of the pharmacy to ensure the pack is returned to the pharmacy for refilling. The pharmacy may request the patient's carer to bring the pack to the pharmacy for refilling or use their delivery driver if possible.
3. The pack should be returned to the pharmacy sealed with a red tag and the pharmacy should query any packs returned unsealed with the appropriate GP or nurse.
4. The completed audit tool will be returned with the pack to the pharmacy in the plastic pouch and the form must be matched to the contents of the pack being returned.
5. Where the audit tool has not been completed or it does not correspond to the box, the pharmacy should contact the patient's practice to ensure completion by the appropriate healthcare professional. Completion of the audit tool sheet is vital to allow the pilot project to be reviewed and completion of this is required to trigger the pharmacy audit payment.
6. The medicines requested on prescription to refill the box should be dispensed and the expiry and batch/LOT numbers should be recorded on a new audit tool sheet- refer to record keeping section above.
7. Medicines that have not been used remain in the pack.
8. The pack should be resealed with a black seal and a spare red seal placed in the pack.
9. The expiry date of the pack should be altered to reflect the earliest expiry date.

Pack No Longer Required:

When the patient has died, the pharmacy will be responsible for ensuring the Palliative Care Emergency Medicine Pack is returned to them for safe and appropriate drug waste disposal and audit completion. The box should be retained for future use. It is recognised there may be a delay in obtaining the packs due to the circumstances and the pharmacist may wish to contact the family after 1 to 2 weeks rather than immediately after death. The community nursing team may be able to help with the removal and return of the pack to the Pharmacy.

Completion of the Audit Data Collection Sheet:

The completed audit tool sheet will provide all the information required to complete the Project Audit Data Collection Form. The Pharmacy is expected to chase the healthcare professionals for the details needed to complete the audit data collection form and will receive a payment for this role.

Payment Details:

The approved pharmacies will be paid £120 for the 12 month period, with agreement that the service will be reviewed again in February 2007. The payment is for the completion of the audit data collection form which must be provided to Shropshire County PCT twice a year. Pharmacies will be paid in advance on signing up to the pilot project.

Clinical Governance Issues:

Shropshire County PCTs Approved Community Pharmacies:

In order for a community pharmacist to become approved by the PCTs, they must first satisfy the following criteria:

- a) The Pharmacies have an established link with Practices participating in Gold Standards Framework
- b) Pharmacists taking part in the scheme should undergo Palliative Care Emergency Medicine Pack Training where possible.
- c) Every pharmacy wishing to take part in the pilot scheme must sign the PCT pilot project agreement before commencing.
- d) Pharmacists will be responsible for their continuing professional development in the area of palliative care.

Patient Complaints:

Pharmacies and Practices should follow in-house complaints procedures and if unresolved, a patient may be directed to the PCT Complaints Manager for further advice.

Problem Solving:

The pilot project problem sheet can be completed and sent to Trish Campbell at SCPCT for future discussion and shared problem solving. Common queries can be acted upon and lessons learnt shared in future newsletters or meetings. The contents of the problem sheet are strictly private and confidential and the individuals completing the sheet may remain anonymous if preferred.

Audit:

The PCT will review the data collection forms twice a year to assess the uptake of the pilot scheme. The healthcare professionals and where deemed appropriate, the carers involved with the scheme will be asked to complete a pilot project satisfaction questionnaire.

Scheme Contact Details:

Palliative Care Lead GP:

Dr Wendy-Jane Walton

C/o Severn Hospice

Bicton Heath

Shrewsbury

SY3 8HS

Tel: 01743 236565 ext 569

wendy-jane@nhs.net / wendy-jane@doctors.org.uk

Community Pharmacist Advice:

Martin Lunt

General Advice about the Scheme:

Mrs Trish Campbell, SCPCT Medicines Management team

01743 492195

trish.campbell@shropshirepct.nhs.uk

Sponsorship for the ampoule cases:

Link Pharmaceuticals Ltd

Bishops Weald House

Albion Way

Horsham

W.Sussex

RH12 1AH

Tel: +44 (0) 1403 272451

Fax: +44 (0) 1403 272455

chris.bubb@linkpharm.co.uk

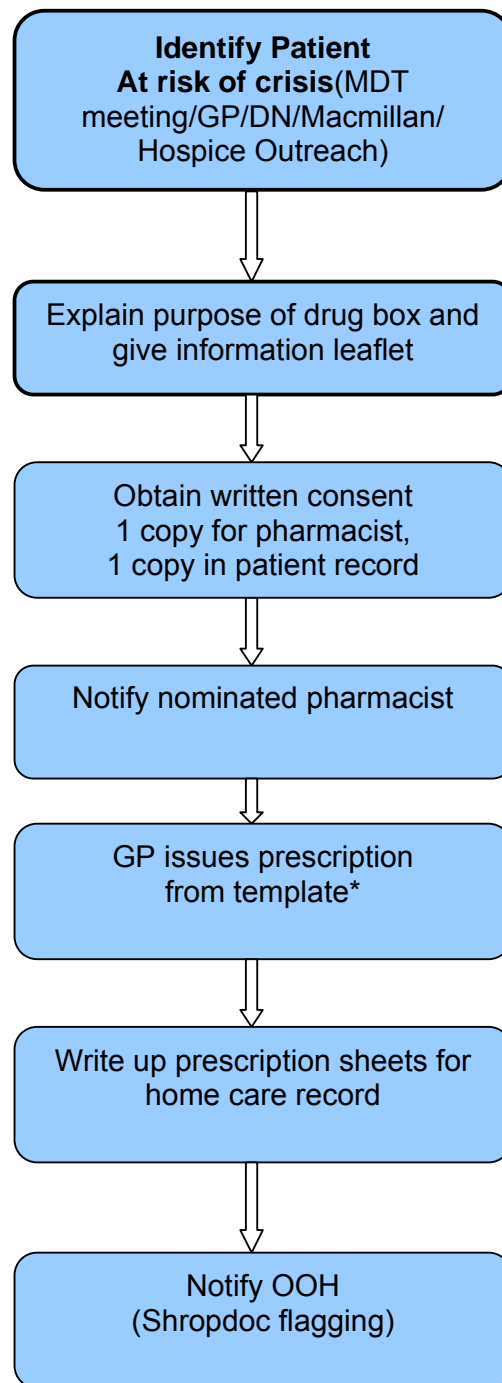
Administrative support

Carole Lawrence

Carole.Lawrence@shropdoc.nhs.uk

01743 285600

Checklist for Emergency Drug Box Prescribing



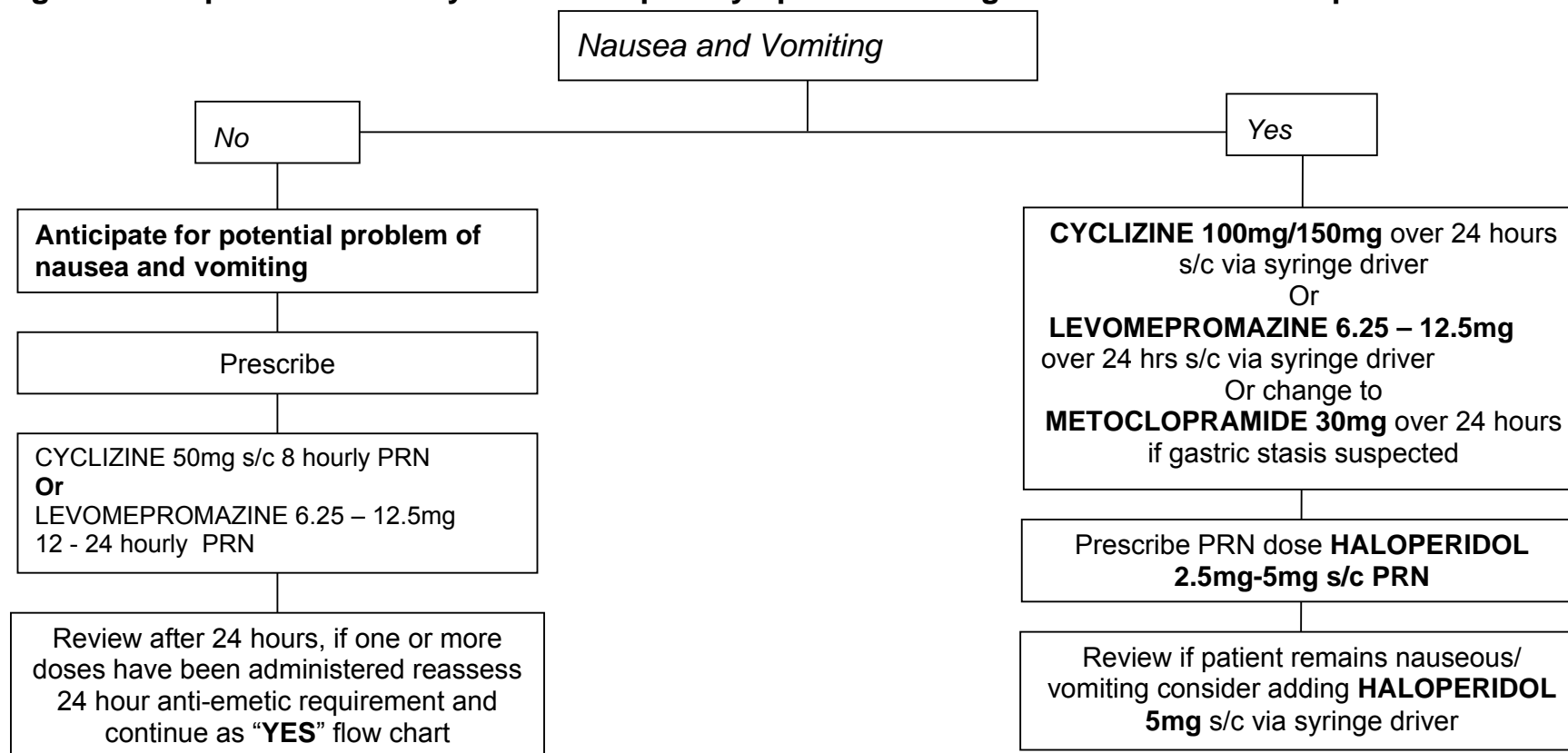
- Template available from SCPCT IT dept Nicki.littleford@shropshireha.wmids.nhs.uk
- 01743 261300

Example of Good Practice

Mendip PCT

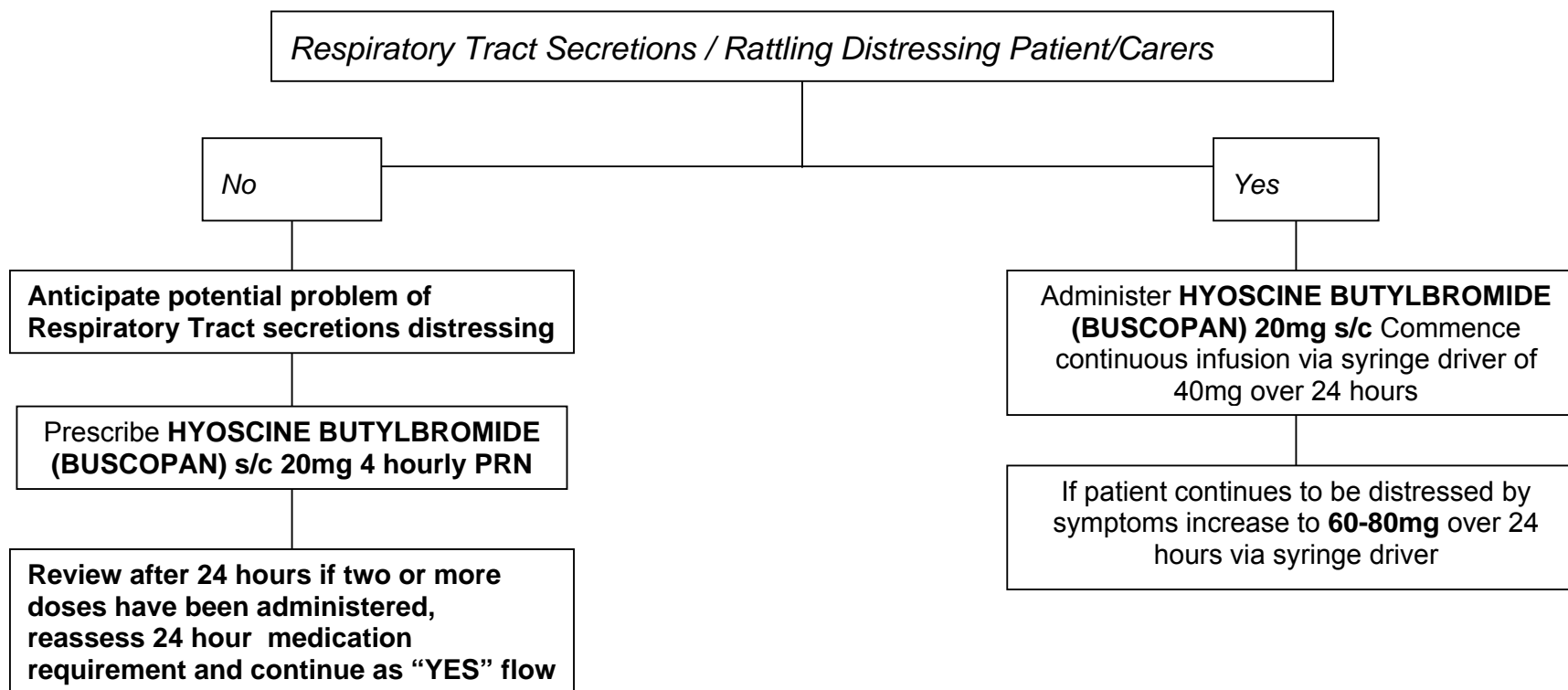
- I. Guidance for anticipatory prescribing
- II. Patient information leaflet

St Margaret's Hospice and Dorothy House Hospice symptom control guidelines for the Liverpool Care Pathway



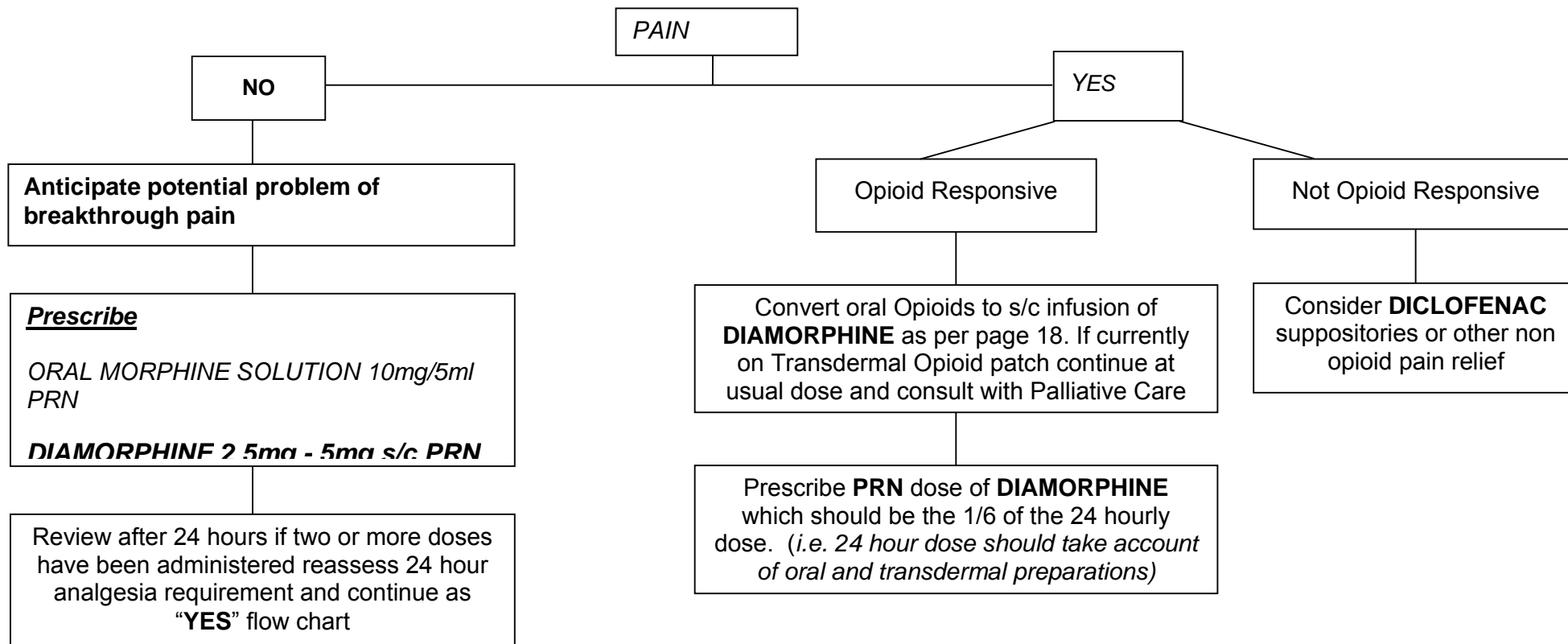
If symptoms persist contact your Palliative Care Team 24 hour advice line:
 St Margaret's Hospice: 01823 345914 for Street, Glastonbury, Wells and Bruton
 Dorothy House : 01225 722999 for Beckington, Frome, Oakhill, Shepton, Coleford and Evercreech

St Margaret's Hospice and Dorothy House Hospice symptom control guidelines for the Liverpool Care Pathway



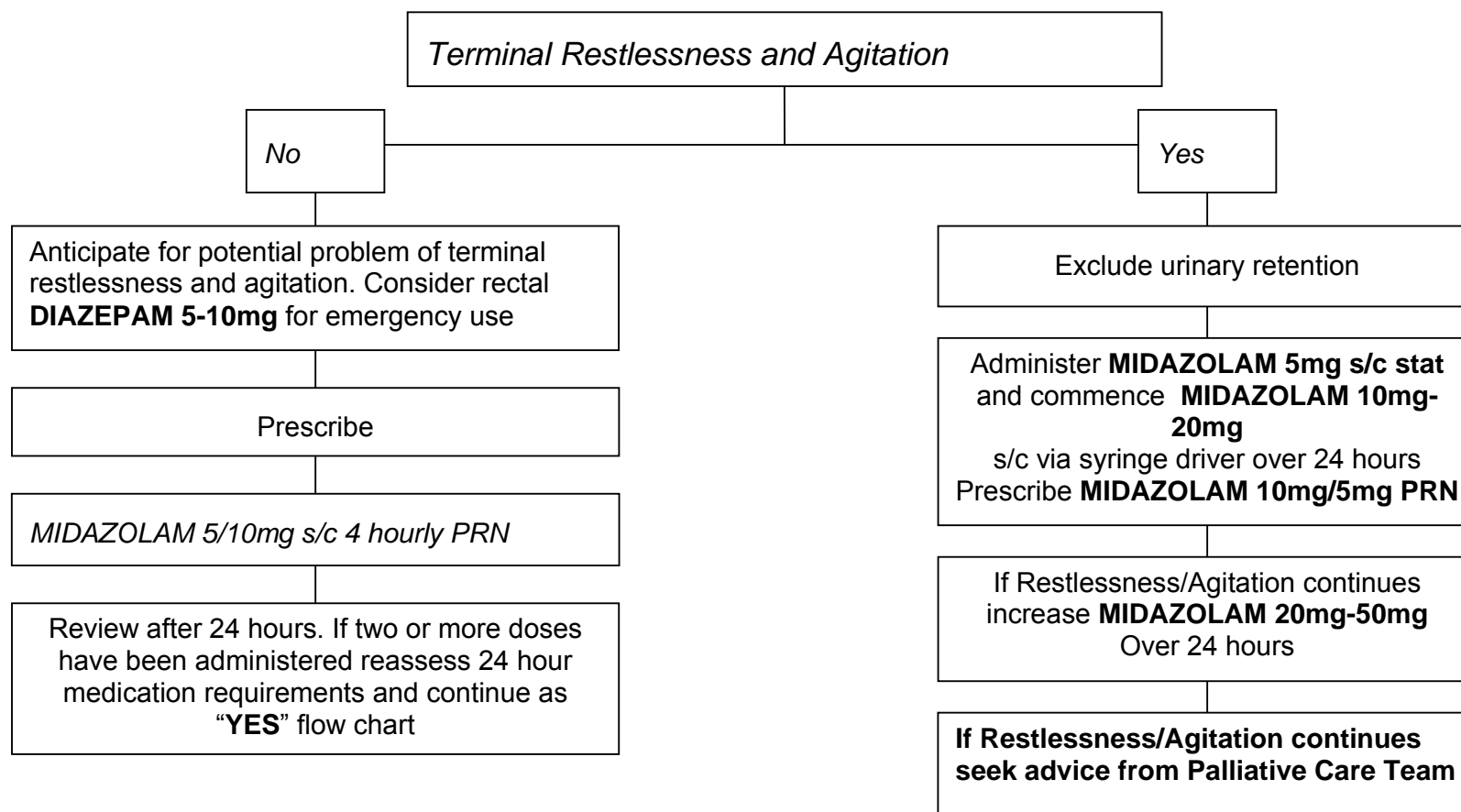
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St Margaret's Hospice and Dorothy House Hospice symptom control guidelines for the Liverpool Care Pathway

Conversion of Oral Opioid Based Analgesia into Diamorphine for use in a Syringe Driver

Oral Opioid Drug	Daily Dose	Conversion to Diamorphine	Example
MORPHINE <i>e.g</i> <i>Zomorph</i> <i>Sevredol</i> <i>Oramorph</i>	Calculate the 24 hour oral mg dose	Divide 24 hour dose by 3	60mg Morphine Divide by 3 = 20mg Diamorphine
OXYCODONE <i>Oxynorm / Oxycontin</i> <i>(modified release)</i>	Calculate the 24 hour dose NB Twice as potent as morphine	Oxycodone - 10mg = 20mg Morphine Multiply Oxycodone dose by 2 then divide this dose by 3	Oral Oxycodone 30mg is equivalent to 60mg of Morphine 60mg Morphine is equivalent to 20mg s/c Diamorphine
FENTANYL	Continue as prescribed. <i>(However a patient may need</i> <i>Diamorphine for breakthrough</i> <i>pain.)</i>	Divide the transdermal dose by 5 to calculate the 4 hourly s/c Diamorphine dose	75mcg patch per hour divided by 5 = 15mg of s/c Diamorphine 4 hourly breakthrough dose

Diluents

Water for injection is the diluent of choice in most instances *(Should you have any concerns in respect of diluent, please contact the Palliative Care Team)*

If symptoms persist contact your Palliative Care Team 24 hour advice line:
 St Margaret's Hospice: 01823 345914 for Street, Glastonbury, Wells and Bruton
 Dorothy House : 01225 722999 for Beckington, Frome, Oakhill, Shepton, Coleford and Evercreech

St Margaret's Hospice and Dorothy House Hospice symptom control Guidelines for the Liverpool Care Pathway

Conversion of S/C Diamorphine to S/C Oxycodone, and Oral Oxycodone to S/C Oxycodone

With the ongoing shortage of diamorphine, oxycodone is a useful alternative. Some combinations are incompatible (for example cyclizine is incompatible with oxycodone and precipitation occurs). Oxycodone is less soluble than diamorphine, so the volume of infusion may be larger. This can be managed in several ways, depending on the volume required and the type of syringe driver being used. It may be possible to use a larger syringe (e.g. 20mls rather than 10mls) or alternatively it may be possible to run the syringe over 12 hours rather than 24 hours. In some cases two syringe drivers might be needed in parallel. **It is recommended that advice be sought from your local specialist palliative care team**

S/C Diamorphine	Conversion to S/C Oxycodone	Example
	1mg diamorphine is equivalent to 1mg of s/c oxycodone	Diamorphine 20mg over 24hrs via syringe driver = oxycodone 20mg over 24 hours via syringe driver
Oral Oxycodone	Conversion to S/C Oxycodone	Example
	2mg of oral oxycodone is equivalent to 1mg of s/c oxycodone	Oxycodone 40mg orally over 24 hrs = oxycodone 20mg over 24 hours via syringe driver

Important Points to Consider

<i>Steroids</i>	Continue with steroids if considered essential for symptom control, otherwise reduce and discontinue. Steroids may be given via a second syringe driver, or as a single daily s/c dose (Oral dose of DEXAMETHASONE is the same as by injection).
<i>Anticonvulsants</i>	If no longer able to take oral anticonvulsants consider MIDAZOLAM 30mg s/c via syringe driver over 24 hours (increasing if necessary to maximum of 100mg).
<i>Bowel Obstruction</i>	Total cessation of nausea/vomiting may be impossible in complete obstruction. Consider HYOSCINE BUTYLBROMIDE (BUSCOPAN) 60mg-120mg in 24 hours s/c via syringe driver to maximise antispasmodic and anti-secretory actions.
<i>Fentanyl Patch (Durogesic)</i>	If patient using FENTANYL PATCH but requires additional pain relief, continue with patch at usual dose and consider use of DIAMORPHINE in syringe driver as per guideline for pain.

If symptoms persist contact your Palliative Care Team 24 hour advice line:
St Margaret's Hospice: 01823 345914 for Street, Glastonbury, Wells and Bruton
Dorothy House : 01225 722999 for Beckington, Frome, Oakhill, Shepton, Coleford and Evercrech

If you would like this information in another language or format, please ask us.

Se deseja obter informação noutra idioma ou formato, diga-nos.

Se desiderate ricevere informazioni in un'altra lingua o in un altro formato, siete pregati di chiedere.

Informationen können auch in anderen Sprachen oder Formaten angefordert werden.

Jeżeli chcieliby Państwo uzyskać informacje w innym języku lub w innym formacie prosimy dać nam znać.

如欲索取以另一语文印制或另一格式制作的资料，请与我们联系。

☎ 01749 836500

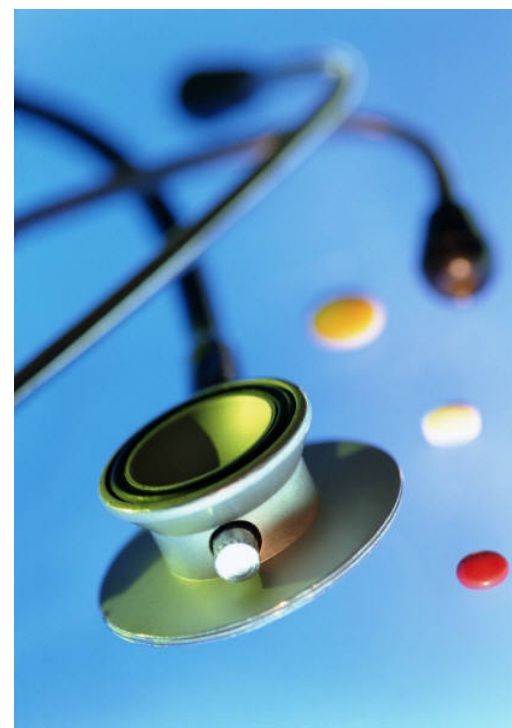
📠 01749 836699

📍 Mendip PCT, Priory House, Priory Health Park, Glastonbury Road, Wells BA5 1XL

✉ headquarters@mendip-pct.nhs.uk

Originated Review

Guide to your “Just in Case” box



What is a Just in Case box?

A Just in Case box is what it says – it contains a small supply of medication that may well not be needed, but is kept in your home just in case you will need it one day. Sometimes it can be difficult to get these drugs in a hurry, especially at night or at weekends, so it is very helpful to have them ready – just in case. The medicines can only be given by a nurse or doctor.

What is in a Just in Case box?

In your Just in Case box there are some small boxes containing ampoules of several different medicines, and some information for the nurses and doctors. There may also be a medicine administration sheet, authorising your District Nurse to give you medication by injection if you need it.

What are the different medicines for?

The medicines in the box will vary from patient to patient, you may not need any of them, but just in case, the common ones are:

Diamorphine	for pain and shortness of breath
Cyclizine	for sickness
Levomepromazine	for sickness
Hyoscine	for secretions in the throat
Midazolam	for restlessness

How do I look after my Just in Case box?

The medicines in your box have been prescribed for you, and should not be given to anyone else. They don't need to be kept in the fridge, but should be kept in a safe place, out of the reach of children. If the medicines are not required, they should be returned to your chemist, or given to your District Nurse.

Any questions?

If you have any questions about your Just in Case box, do feel free to ask your District Nurse or GP.

Example of Good Practice

Solihull PCT

- I. Protocol for 'Just in Case' box
- II. Guidance for anticipatory prescribing

Gold Standards Framework

Stock list for the Just in Case Box

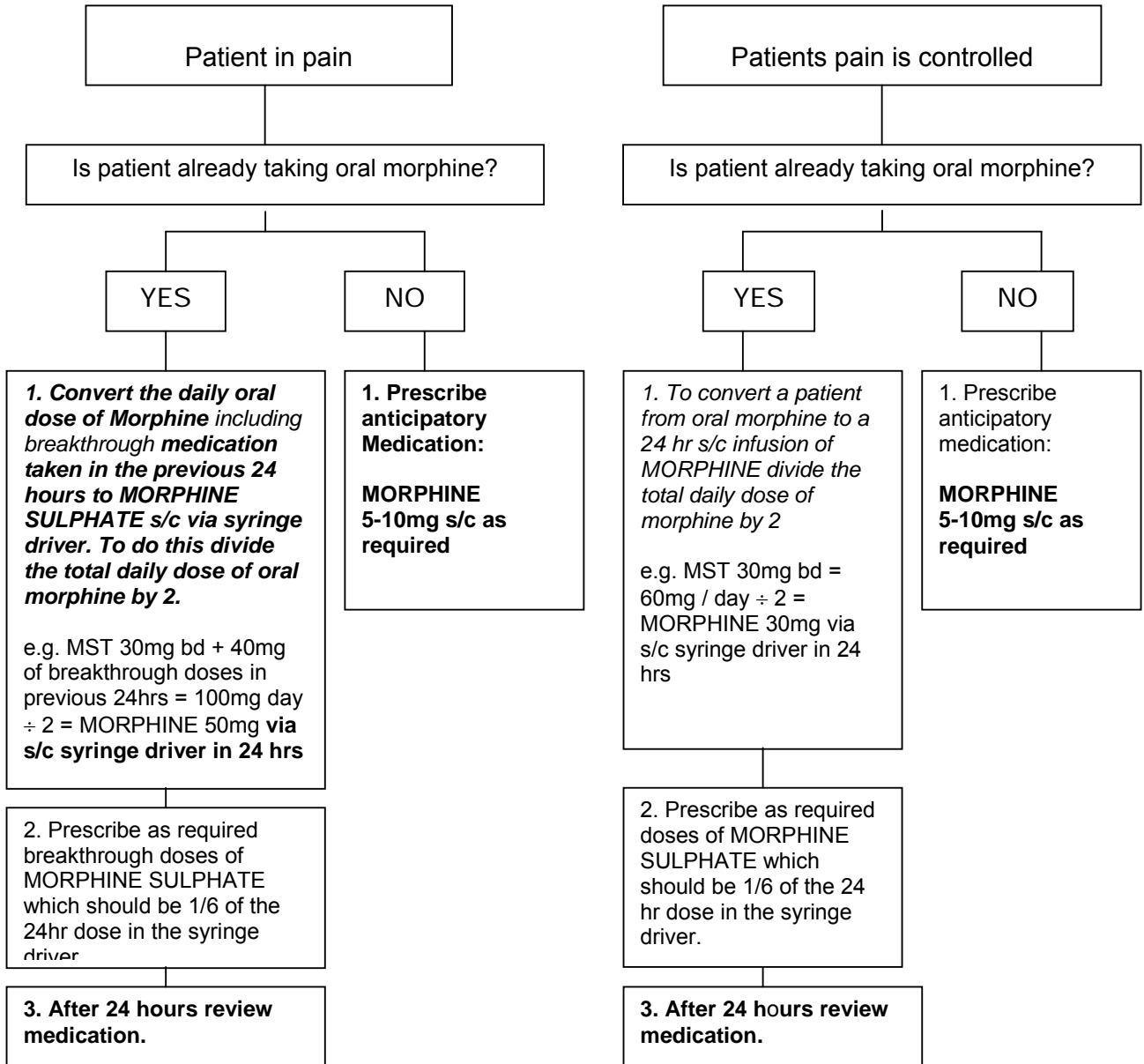
Item
Small sharps box
Green needles
Blue / orange needles for sc injection
2 ml syringes
Copy of anticipatory prescribing algorithms

Protocol for Use of the Comfort Care Box

1. The Just in Case Box will be used for patients on the Core Care Plan for Comfort Care. When taken out to a patient the box should be stocked with the agreed list in the table above, plus anticipatory medications.
2. Once the box has been issued to a patient, all subsequent medications for breakthrough symptoms or syringe driver management should be kept in the Just in Case Box.
3. Please ensure the patient and their family / carer knows who to contact in hours and out of hours, should any symptom problems develop.
4. The patient's care plan should be kept with the Just in Case box. The care plan should include the following:
 - Documentation for authorisation of administration of medications (blue and purple cards)
 - Orange sheet to record administration of medications by injection
 - Record of medication stock numbers for CD drugs
5. The DN team is responsible for:
 - Delivery and collection of the 'Just in Case Box'
 - Cleaning of the box in accordance with PCT policy for cleaning and maintaining equipment
 - Restocking of the box with new stock supplies ready for future use
 - Recording delivery, location and collection of the box

**Prescribing Algorithm for Pain in the DYING PHASE
using MORPHINE SULPHATE SC for injections**

If the patient is not in the dying phase then please consult the West Midlands Guidelines for symptom control in palliative care and follow the WHO analgesic ladder. Remember to assess for reversible causes of pain and discomfort: for example constipation. If patient has Fentanyl patch, please refer to guidance on the back of this algorithm.



If advice is needed then please contact specialist palliative care:
 Contact details for specialist palliative care in hours Mon - Fri:

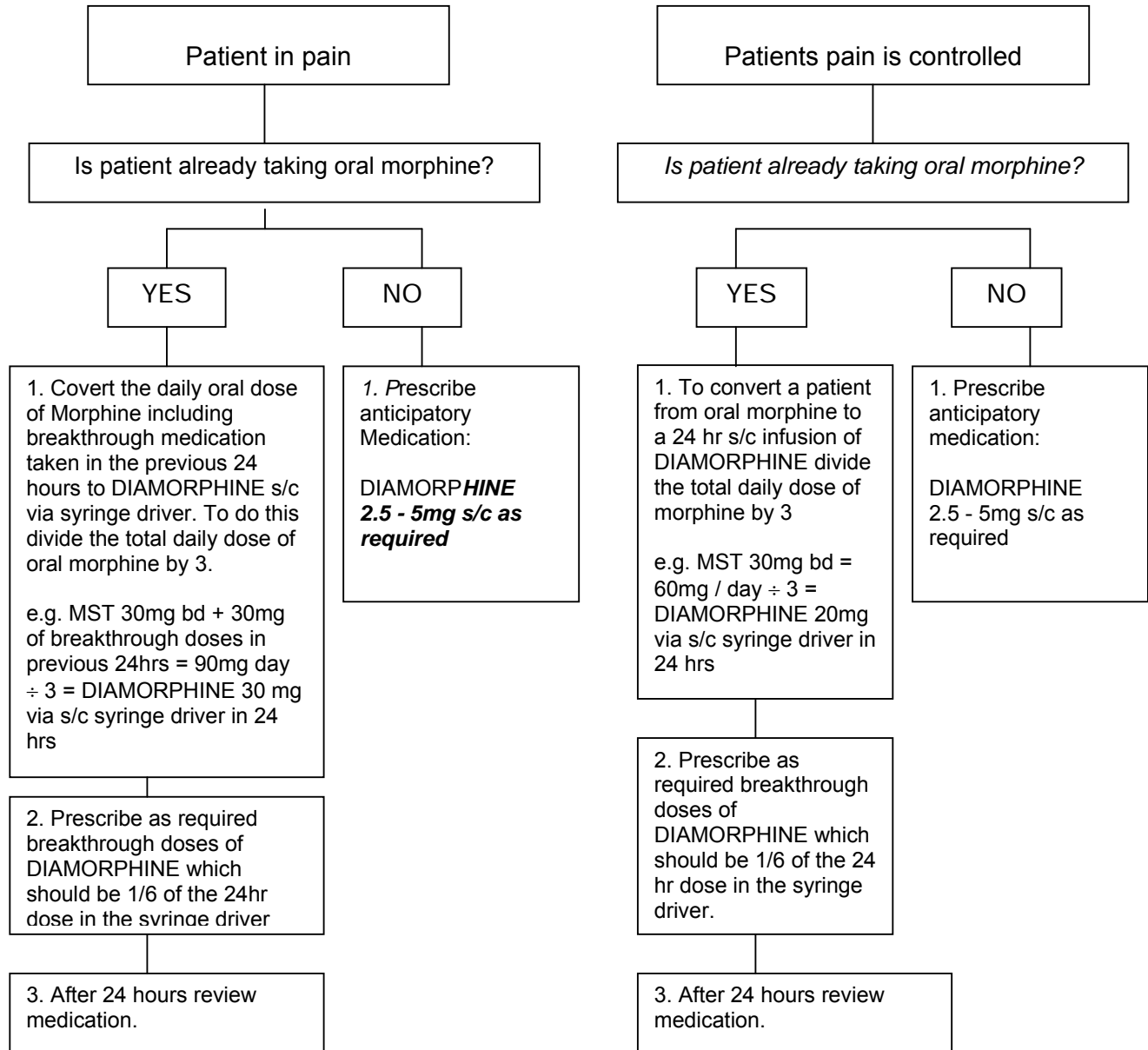
- PCT Macmillan CNS Palliative care team – 01564 732804 9-5pm
- Marie Curie Hospice Palliative Care Advice Line – 07919 598643 9-4pm
- Marie Curie Hospice Solihull CNS team – 0121 254 7800 9-5pm

Contact details for specialist palliative care out of hours:

- Marie Curie Hospice inpatient unit – 0121 254 7800

Prescribing Algorithm for Pain in the DYING PHASE using **DIAMORPHINE** for SC injections

If the patient is not in the dying phase then please consult the West Midlands Guidelines for symptom control in palliative care and follow the WHO analgesic ladder. Remember to assess for reversible causes of pain and discomfort: for example constipation. If patient has Fentanyl patch, please refer to guidance on the back of this algorithm.



If advice is needed then please contact specialist palliative care:

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- PCT Macmillan CNS Palliative care team – 01564 732804 9-5pm
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- Marie Curie Hospice inpatient unit – 0121 254 7800

Guidance on the Prescribing, Dispensing and Administration of Fentanyl Patches

Currently there are three transdermal fentanyl preparations available in the UK

	Active Drug	Delivery Mechanism	Cost for five 25 microgram patches ¹	Cost of five 100 microgram patches	Additional Information
Durogesic DTrans	Fentanyl	Matrix	£27.52	£88.32	New 12mcg Patch available
Durogesic Patch (Parellel Import)	Fentanyl	Reservoir	£27.52	£88.32	Not a UK product
Tilofyl Patch	Fentanyl	Reservoir	£27.00	£88.00	No identifiable markings

The Royal Pharmaceutical Society is recommending prescribing by brand name for all patches containing a strong opiate due to the possibility of variability between different formulations.

Examples:

- Tilofyl **Patches- Fentanyl reservoir patch (Tilofyl)**, 25 micrograms per hour. Apply every third day. Supply five (5) patches.
- **Durogesic DTrans- Fentanyl matrix patch (Durogesic DTrans)**, 25 micrograms per hour. Apply every third day. Supply five (5) patches.
- **Durogesic Patches- Fentanyl reservoir patch (Durogesic)**, 25 micrograms per hour. Apply every third day. Supply five (5) patches.

Dispensing and Administration

Before dispensing or administering a fentanyl patch please ensure the correct delivery mechanism of patch is prescribed. Cases of toxicity or pain have been reported on changing the delivery mechanism in some patients.²

References

1. Drug Tariff, January 2006
2. www.palliativedrugs.com
3. Durogesic DTrans SmPC Nov 2005

Guidance on use of Fentanyl patches in the dying phase

The options listed below provide general guidance only. The patient should always have a pain assessment. If in doubt regarding pain management then seek advice from specialist palliative care.

In the last days of life it is acceptable practice to continue with fentanyl patch administration if the patient has previously been pain controlled, ensuring that an appropriate breakthrough dose of SC analgesia (see tables below) is prescribed.

If 2 or more doses of breakthrough analgesia are required over 24 hrs consider continuous infusion via a syringe driver. The total of previous 24 hr breakthrough analgesia doses should be set up in the syringe driver and continue the fentanyl patch (change patch every 72 hours). Ensure continued use of the fentanyl patch is documented.

Please note: ensure future breakthrough analgesia is 1/6 equivalent fentanyl dose plus syringe driver dose.

It may be necessary to discontinue the fentanyl patch and commence a syringe driver infusion with total analgesic dose. In this case remove the fentanyl patch. Calculate the equivalent diamorphine dose and divide by 2. Round this up to the equivalent diamorphine ampoule size and give as SC infusion over 24 hours. After 24 hrs give the whole previous patch strength as diamorphine/24hrs, following assessment of pain relief.

(Based on recommendations from Sir Michael Sobel House, Oxford)

Fentanyl and Morphine Sulphate sc information

Fentanyl patch dose	Equivalent Morphine Sulphate sc / 24 hrs	Morphine Sulphate sc 1/6 breakthrough dose
25mcg / hr	45mg / 24 hrs sc	7.5mg sc
50mcg / hr	90mg / 24 hrs sc	15mg sc
75mcg / hr	135mg / 24 hrs sc	22.5mg sc
100mcg / hr	180mg / 24 hrs sc	30mg sc

Fentanyl and Diamorphine sc information

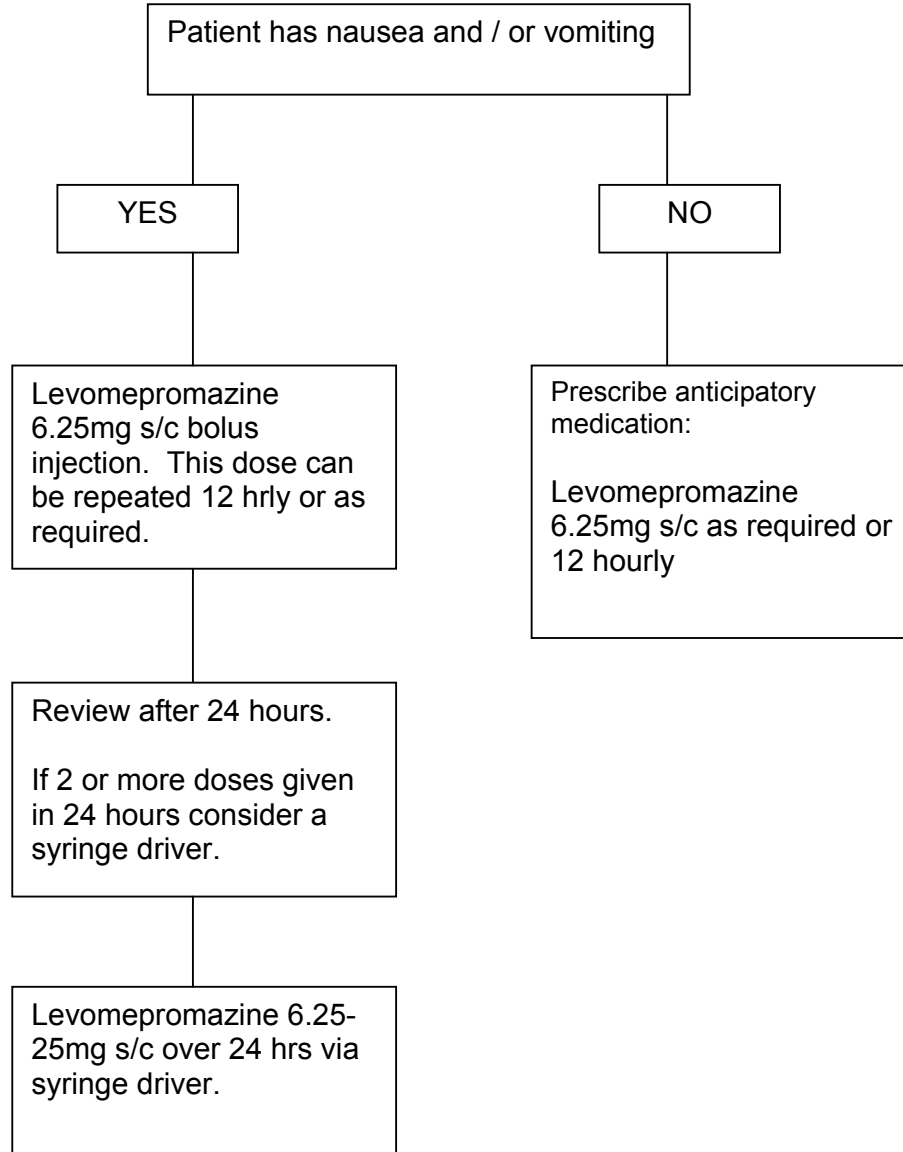
Fentanyl patch dose	Equivalent Diamorphine sc / 24 hrs	Diamorphine sc 1/6 breakthrough dose
25mcg / hr	30mg / 24 hrs sc	5mg sc
50mcg / hr	60mg / 24 hrs sc	10mg sc
75mcg / hr	90mg / 24 hrs sc	15mg sc
100mcg / hr	120mg / 24 hrs sc	20mg sc

Solihull PCT Guidance on Fentanyl - Abi Jenkins: Palliative Care Pharmacist Pan-Birmingham Cancer Network and Helen Meehan: Lead Nurse Palliative Care Solihull PCT 2006

Solihull PCT Pain algorithm for anticipatory medication March 2006: adapted from LCP J. Ellershaw 2004

Prescribing Algorithm for Nausea and Vomiting in the DYING PHASE

Please refer to the West Midlands Guidelines for symptom control in palliative care if the patient has a current prescription for anti emetics but is not on the maximum therapeutic dose or if the patient is not in the dying phase.



If symptoms persist or if advice is needed then please contact specialist palliative care:

Contact details for specialist palliative care in hours Mon - Fri:

- PCT Macmillan CNS Palliative care team – 01564 732804 9-5pm
- Marie Curie Hospice Palliative Care Advice Line – 07919 598643 9-4pm
- Marie Curie Hospice Solihull CNS team – 0121 254 7800 9-5pm

Contact details for specialist palliative care **out of hours:**

- Marie Curie Hospice inpatient unit – 0121 254 7800

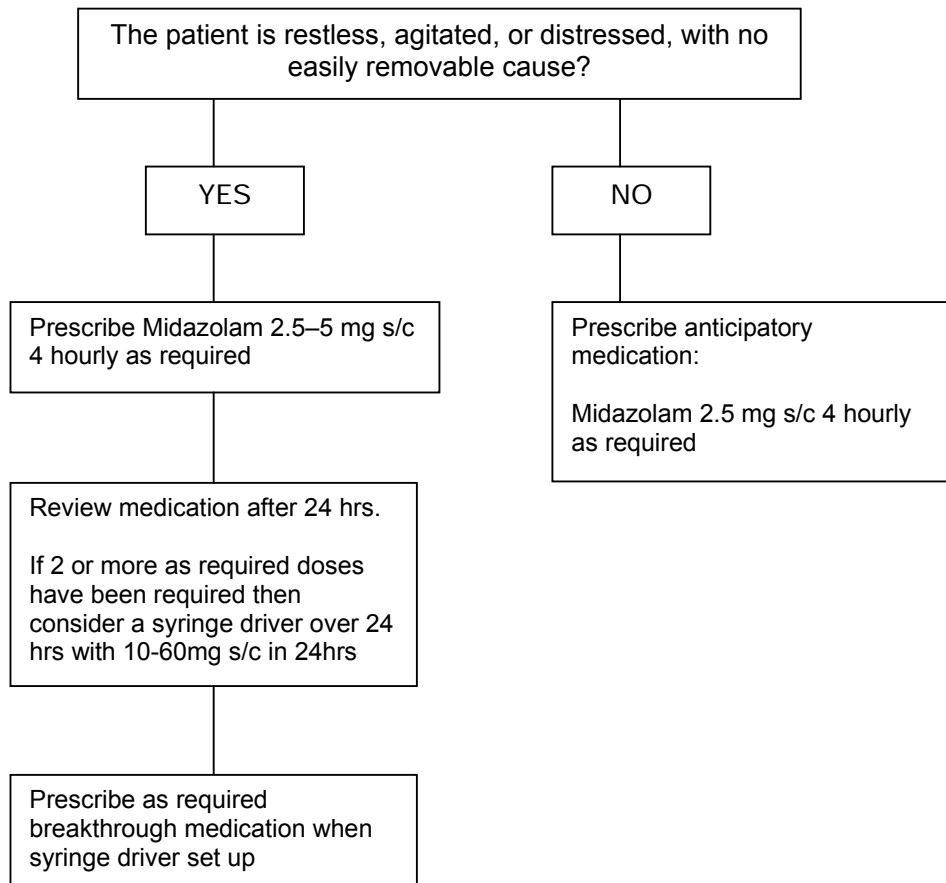
Prescribing algorithm for Restlessness in the DYING PHASE

Before initiating drug treatment, assess the patient for reversible causes of agitation or restlessness:

- Urinary retention
- Constipation
- Pain
- Drug toxicity eg, opioids, phenytoin, digoxin
- Biochemical abnormalities e.g Ca, Na
- Hypoxia
- Spiritual distress

The information for this algorithm is taken from the West Midlands Palliative Care Symptom Control Guidelines.

Note: if patient is at risk of fitting, an increase in dose may be necessary.



If symptoms persist or if advice is needed then please contact specialist palliative care:

Contact details for specialist palliative care in hours Mon - Fri:

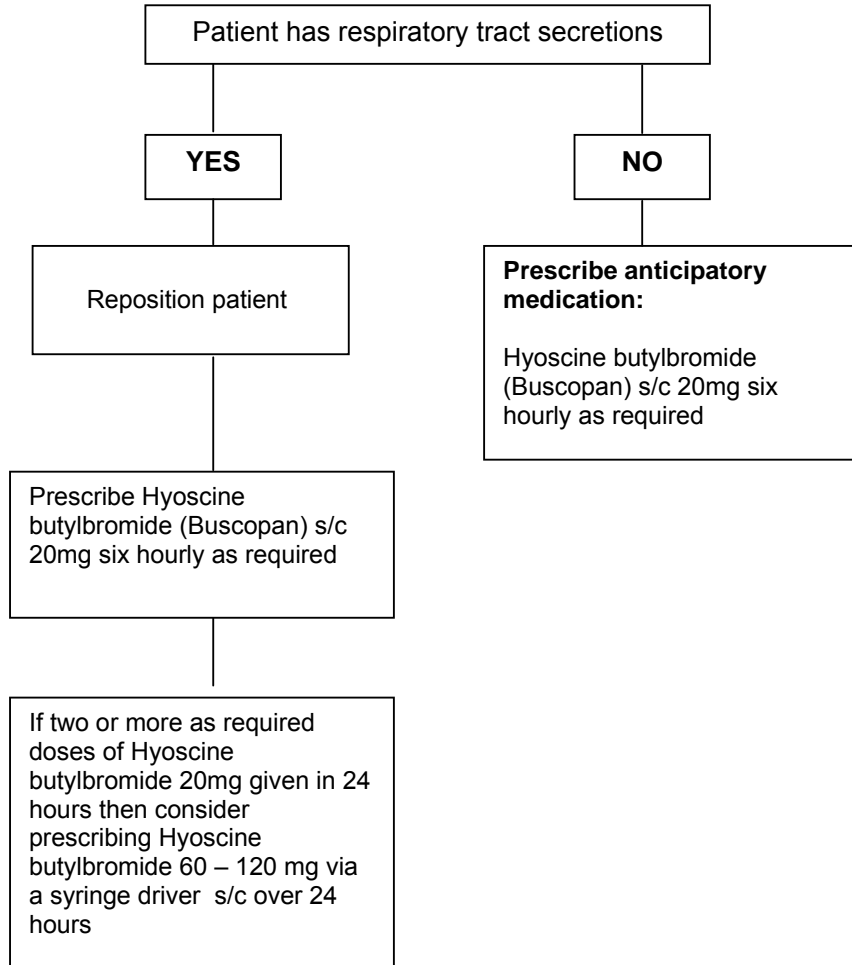
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| • PCT Macmillan CNS Palliative care team | – 01564 732804 | 9-5pm |
| • Marie Curie Hospice Palliative Care Advice Line | – 07919 598643 | 9-4pm |
| • Marie Curie Hospice Solihull CNS team | – 0121 254 7800 | 9-5pm |

Contact details for specialist palliative care **out of hours:**

- | | | |
|--------------------------------------|-----------------|--|
| • Marie Curie Hospice inpatient unit | – 0121 254 7800 | |
|--------------------------------------|-----------------|--|

Prescribing algorithm for Excessive Respiratory Secretions in the DYING PHASE

Secretions are often more distressing to the family and carers than to the patient themselves. If the patient is not distressed careful explanation of this may avoid the need for drugs.



It should be remembered that drug treatment does not reduce the quantity, or cause re-absorption of secretions already produced. It will only reduce the production of further secretions. Furthermore, drying up secretions will cause a dry mouth, which some patients may find uncomfortable.

If advice is needed then please contact specialist palliative care:

Contact details for specialist palliative care in hours Mon - Fri:

- PCT Macmillan CNS Palliative care team – 01564 732804 9-5pm
- Marie Curie Hospice Palliative Care Advice Line – 07919 598643 9-4pm
- Marie Curie Hospice Solihull CNS team – 0121 254 7800 9-5pm

Contact details for specialist palliative care out of hours:

- Marie Curie Hospice inpatient unit – 0121 254 7800