



# Palliative Care Anticipatory Prescribing Guidelines

**Gippsland Region  
Palliative Care Consortium  
Clinical Practice Group**



<i>Policy No.</i>	GRPCC-CPG008
<i>Title</i>	Anticipatory Prescribing Guidelines
<i>Keywords</i>	Palliative Care, Anticipatory Prescribing, Guidelines
<i>Ratified</i>	GRPCC Clinical Practice Group
<i>Effective Date</i>	June 2014
<i>Review Date</i>	Every two years from effective date.
<i>Purpose</i>	This guideline has been endorsed by the GRPCC Clinical Practice Group and is based on current evidence-based practice. The intent of the guideline is to promote region wide adoption of best practice. Enquiries can be directed to GRPCC by email <a href="mailto:enquiries@grpcc.com.au">enquiries@grpcc.com.au</a> or phone 03 5623 0684.
<i>Acknowledgement</i>	Some of the information contained in this document was taken from Melbourne City Mission Palliative Care.
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## Background

*Strengthening palliative care: Policy and strategic directions 2011–2015*<sup>1</sup> identifies after-hours support for clients and carers in their homes, particularly in rural areas, as a key priority.

Specialist palliative care services, where medical consultants, specialist palliative care nurses and allied health services are provided from the same service, do not currently exist in Gippsland. Nurse Practitioners (NP), NP Candidates and Clinical Nurse Consultants are available in some areas. Service hours vary greatly from a minimum of 8.00 am until 4.00 pm to a maximum of 7.00 am until 9.30 pm, Monday to Friday. Nine of 12 services also have scheduled visits on the weekend. The after-hours time frame therefore differs considerably between services.

The first of the six key elements identified in the *After-hours palliative care framework* is *best practice care planning*. This element includes the core input of *advocacy for improving access to medications* which describes, among others, two important components:

- Palliative medicine specialists support GPs not confident with prescribing palliative medications;
- Working in conjunction with the client's primary and tertiary doctors, supply timely and appropriate medication in the client home, or arrange alternatives where these are not available, based on actual and potential symptoms and care needs<sup>2</sup>.

## Anticipatory prescribing

International research has found that up to 90 per cent of people with a life-threatening illness would like to die at home or in a home-like environment<sup>3</sup>. Enabling people to be cared for and to have a good death at home are vital components of modern palliative care practice. However, they present unique challenges for the primary care team, especially out-of-hours when access to the client's own general practice and regular pharmacy are usually not possible.

Timely access to medications is critical to enabling people to stay at home. Symptoms in individuals with advanced illness can change rapidly due to sudden deterioration, exacerbation of existing symptoms, poor absorption or simply that the oral route is no longer viable. Inability to control symptoms is the most frequent reason for unplanned hospital admissions.

Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the client develops distressing symptoms.

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<sup>1</sup> Victorian Government Department of Health, *Strengthening palliative care: Policy and strategic directions 2011-2015, Implementation Strategy*, 2012.

<sup>2</sup> Victorian Government Department of Health, *After-hours palliative care framework*, 2012, page 5

<sup>3</sup> Strengthening palliative care: Policy and strategic directions 2011-2015

## Access to after-hours medical support

Access to after-hours medical support is dependent on the availability of the client's GP, confirmed on admission to the palliative care service. If the GP is not available, access to medical support is through the nearest hospital or via the ambulance service.

The *Gippsland Region Palliative Care Consortium (GRPCC) Emergency Medication Audit and Report* shows there is little consensus among GPs and nursing staff, from the different health services, regarding approaches and protocols to anticipatory prescribing and obtaining supplies of emergency medications<sup>4</sup>.

The community nurse's capacity to respond to a client's rapidly changing needs is constrained by difficulties in accessing appropriate medications, particularly injectable medications. Challenges include:

- Clients discharged home from the inpatient setting without appropriate injectable medications;
- Clients who upon discharge have been switched to medication known to have been ineffective in the past, i.e. *cyclizine in hospital versus metoclopramide in the home*;
- Inability to contact the client's GP\*;
- Understandable reluctance of GPs to prescribe injectable medication in the absence of sufficient information about the client's condition;
- Locum GP has limited knowledge of the client's recent illness trajectory; and
- Difficulty accessing the community pharmacy.

\*Where GPs are not available to prescribe emergency medications, the primary care team may need assistance from the palliative care specialist (in working hours) and/ or the NP.

In summary, anticipatory prescribing of medications for the most frequently occurring symptoms in the deteriorating and/or end of life phases often prevents crises and unplanned admissions to hospitals and promotes dying at home for those clients and their caregivers whose choice this is.

The attached letter and templates are designed to assist GPs in their decision making regarding anticipatory prescribing.

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<sup>4</sup> Gippsland Region Palliative Care Consortium Emergency Medication Audit and Report, September 2011

**Template 1**

«Title» «Firstname» «LastName»  
«JobTitle»  
«Company»  
«Address1»  
«City» «PostalCode»

Dear «FirstName»,

This is to inform you that we have admitted.....into our palliative care program.

Anticipatory (emergency) orders are standard palliative care practice for:

- Managing the acute onset and/or exacerbation of distressing symptoms for clients in their homes;
- Caring for clients when they are no longer swallowing, close to death and wanting to die at home.

Timely access to appropriate medications, including injectable medications, is crucial to relief of symptoms and supporting clients to be at home.

Nursing staff will endeavour to consult with you as soon as possible after the event if implementation of your anticipatory (emergency) orders is required.

These recommendations are in line with current best practice within the Pharmaceutical Benefits Scheme (PBS) prescribing regulations. There could also be individual variations that need to be taken into account when prescribing anticipatory medications, e.g. ongoing medication dosages, known drug allergies and known concerns about placing injectable medication, such as opioids, in the home setting.

We welcome your call on <<Organisationphonenumber>> to discuss any questions or queries.

Please refer to attached template.

We appreciate your collaboration.

**«Referral/triage Coordinator/and/orNP or NPC»**  
**<<NameofOrganisation/Company>>**

**Template 2**

Client Name:  
Date:  
Date:

<<Organisation Logo>>

Drug	Use	Recommended Dose*	Route	Frequency	Signature	Date
<p><b>*Morphine mixture</b> Strengths on PBS 2mg/mL 5mg/mL 10mg/mL Script 200/mL bottle</p>	Oral breakthrough Medication for pain and/or breathlessness		Oral	p.r.n.		
<p><b>Morphine sulfate</b> Strengths on PBS 10mg/mL Script for 5 (five) ampoules/box or authority script required for one month's supply</p> <p><b>30mg oral morphine= 10mg SC morphine</b></p>	Subcutaneous (SC) breakthrough Medication for pain and/or breathlessness		SC	p.r.n.  or  6 (six) doses 24 hourly		
<p><b>Metoclopramide</b> 10mg/2mL Script 10 ampoules/box</p>	Nausea and vomiting	10 mg	SC	6 hourly p.r.n.		
<p><b>Haloperidol</b> 5mg/mL Script 10 ampoules/box</p>	Nausea and vomiting and/or delirium	0.5mg-2.5mg	SC	6 hourly p.r.n.		
<p><b>Midazolam</b> (not on PBS) Script 5mg/5mL</p>	Agitation, restlessness and/or fitting	2.5mg-5mg	SC	2-3 hourly p.r.n.		
<p><b>Clonazepam drops</b> 2.5mg/mL 20 drops per mL (each drop= 0.1 mg) Script 10mL bottle</p>	Restlessness and risk of fitting	It is recommended that with the benzodiazepine naïve and the elderly patient always start with <b>2-4 drops</b>	Oral or sublingual (SL)	1-2 hourly p.r.n.		
<p><b>*Glycopyrrolate</b> (not on PBS) 0.2mg/1mL Script 5 ampoules/box</p>	Excessive chest secretions	400mcg-1-2mg	SC	4 hourly		

**Anticipatory Prescribing orders are standard practice in palliative care when the patient is in the deteriorating or terminal phase of their illness.**

**Cautionary notes**

\*When opioid analgesia is indicated, morphine remains the drug of choice. Other opioids should be considered if there is known renal and/or liver impairment.

\* Other medication such as Hyoscine hydrobromide (not on PBS) or Hyoscine butylbromide can also be used to reduce gastrointestinal and respiratory secretions at the end of life.

When prescribing opioids and/or benzodiazepines; the number of tablets/ampoules must be written in words on the script e.g. five ampoules.

When prescribing clonazepam drops ensure the right number of drops is written on the script.

Please review the attached orders, complete and sign them if you think they are appropriate.

Fax them back as soon as possible to <<Name of Organisation/Company>> on <<fax number>>. Please also give the relevant prescription to your patient and/or carer or their pharmacist.

**Template 3**

Client Name:  
Date:  
Date:

<<Organisation Logo>>

Drug	Use	Recommended Dose*	Route	Frequency	Signature	Date
<p><b>*Morphine sulfate</b> Strengths on PBS 10mg/mL Script for 5 (five) ampoules/box or authority script required for one month's supply</p> <p><b>30mg oral morphine= 10mg SC morphine</b></p>	Subcutaneous (SC) breakthrough Medication for pain and/or breathlessness		SC	p.r.n.  or  6 (six) doses 24 hourly		
<p><b>Metoclopramide</b> 10mg/2mL Script 10 ampoules/box</p>	Nausea and vomiting	10 mg	SC	6 hourly p.r.n.		
<p><b>*Clonazepam drops</b> 2.5mg/mL 20 drops per mL (each drop= 0.1 mg) Script 10mL bottle</p>	Restlessness and risk of fitting	It is recommended that with the benzodiazepine naïve and the elderly patient always start with <b>2-4 drops</b>	Oral or sublingu al (SL)	1-2 hourly p.r.n.		

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