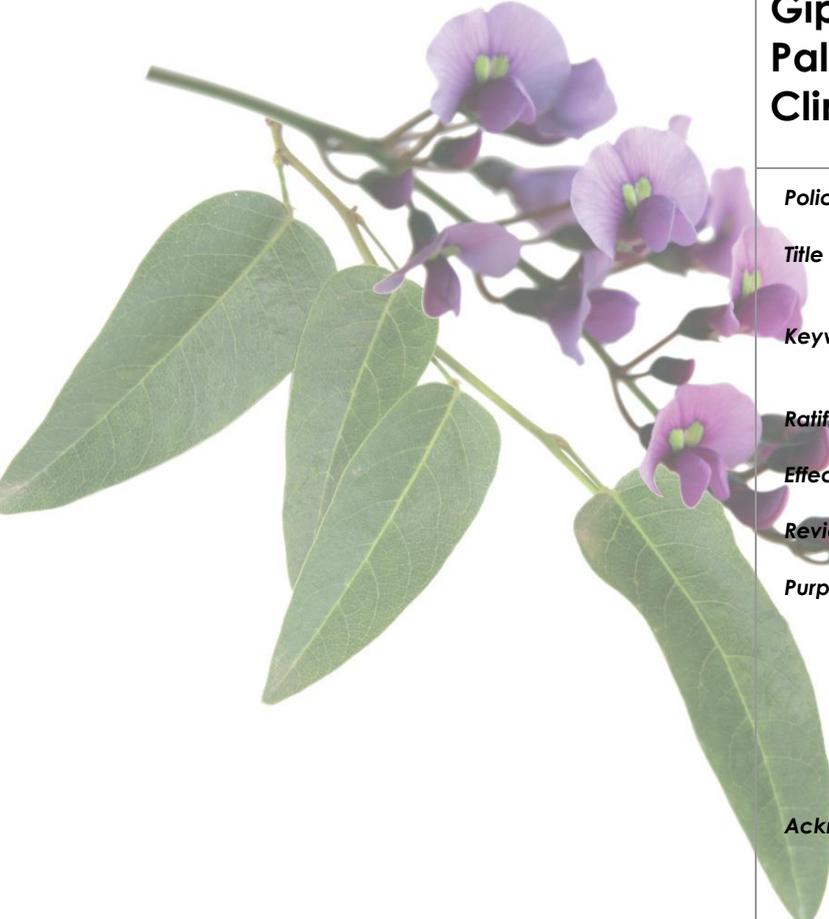


Palliative Care Anticipatory Prescribing Guidelines

June 2016

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



Policy No.	GRPCC-CPG008_1.1_2016
Title	Anticipatory Prescribing Guidelines & Templates
Keywords	Palliative Care, Anticipatory Prescribing, Guidelines
Ratified	GRPCC Clinical Practice Group
Effective Date	June 2014
Review Date	May 2018
Purpose	This guideline has been endorsed by the GRPCC Clinical Practice Group and is based on current evidence-based practice. The intent of this document is to promote region adoption of best practice. Enquiries can be directed to GRPCC by email enquiries@grpcc.com.au or phone 03 5623 0684.
Acknowledgement	Some of the information contained in this document was taken from Melbourne City Mission Palliative Care.
Pages	8

Background

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

The Gippsland Regional Palliative Care Consultancy Service (GRPCCS), which now operates from Latrobe Regional Hospital, provides specialist consultancy and face to face reviews to people living with a life limiting illness. The GRPCCS also offers after-hours support and advice to palliative care community services and general practitioners across the region.

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 needs².

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 environment³. 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.

Access to after-hours medical support

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

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

³ *Strengthening palliative care: Policy and strategic directions 2011-2015*

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 medications⁴.

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.

This guidelines contains:

1. Appendices 1 and 2: clinical notes on breakthrough and incident pain medication and cautionary notes on the current use of metoclopramide; and
2. Template letter and prescribing forms: 1, 2 and 3, which are designed to assist GPs in their decision making and writing of anticipatory prescribing.

⁴ Gippsland Region Palliative Care Consortium Emergency Medication Audit and Report, September 2011

1. Clinical notes

Breakthrough and incident pain medication

Breakthrough pain is a heterogeneous pain state. The term has been used widely to describe a phenomenon whereby pain intensity suddenly increases to “break through” the background pain that is otherwise controlled by a fixed schedule around-the-clock opioid regime². Breakthrough pain occurs between regular analgesic doses and reflects an increase in the level of pain beyond the control of baseline analgesia⁵.

Incident pain occurs with, or is exacerbated by, activity. It is a common occurrence in patients with metastatic bone disease or wounds requiring dressing⁶.

Breakthrough Dose (BTD) is an additional dose used to control breakthrough pain. BTD dose is also known as rescue dose⁷.

The usual management of advanced illness related breakthrough pain is with supplemental doses of analgesics (commonly opioids) at a dose proportional to the total around-the-clock (ATC) opioid dose⁸.

In addition to the ATC dose, breakthrough doses of the order of one-sixth to one twelfth (1/6-1/12) of the total daily dose should be prescribed and/ or recommended.

A widespread drug treatment is to give an extra dose of the regular analgesic, e.g. a p.r.n. dose of immediate-release **morphine** for patients taking ATC morphine⁹. A traditional practice, dating from before morphine related opioid products were available, was to give an extra dose of the regular q4h dose of oral **morphine** (i.e. one sixth of the total daily dose). However, many breakthrough pains are short-lived and this approach effectively doubles the patient's opioid intake for the next 4h¹⁰.

Accordingly, many specialist centres now recommend that the patient initially takes, as an immediate-release formulation, 10% of the total daily regular dose as the p.r.n. dose.

However, a standard fixed-dose is unlikely to suit all patients and all pains, particularly because the intensity and the impact of breakthrough pain vary considerably. Thus, when patients have been encouraged to optimize their rescue dose, the chosen dose varies from 5–20% of the total daily dose.

⁵ Oxford Handbook of Palliative Care 2011. Oxford University Press

⁶ Therapeutic Guidelines: Palliative Care Version 3, 2010. Therapeutic Guidelines Limited

⁷ Palliative Care Formulary Wilcock & Twycross Eds. 2014, Fifth Edition

⁸ *Ibid*, pages 362-371

⁹ *Ibid*, pages 362-371

¹⁰ Australian Medicines Handbook Ed. 2015

2. Cautionary notes

Current use of metoclopramide

Metoclopramide is a widely used antiemetic and gastroprokinetic drug, particularly in palliative care clinical practice¹¹. Metoclopramide has been used since the 1960s for nausea and vomiting of various causes and gastrointestinal motility disorders¹². Metoclopramide works on the upper gastric system: stomach and proximal small bowel but has little effect on colonic motility. Metoclopramide:

- possesses parasympathomimetic activity as well as being a dopamine-receptor (D2) antagonist with a direct effect on the chemoreceptor trigger zone;
- has serotonin-receptor (5-HT3) antagonist properties; and
- as a consequence it has a wide range of nonselective effects¹³.

Recent information from CareSearch alerts clinicians working in palliative care of the Therapeutic Goods Administration (TGA) recently updated product information (PI) for metoclopramide that includes a new contraindication and changes to metoclopramide dosing and duration of use to reduce the risk of neurological adverse events¹⁴. A survey of palliative care clinicians/ palliative medicine doctors in Australia in 2014 indicated that metoclopramide is the predominant first-line agent (69%) used by palliative care clinicians, followed by haloperidol. Dosing varying from 40-240 mg per day to a median maximal dose of 80 mg¹⁵.

Because of the risks of neurological (extrapyramidal effects- EPE) adverse effects the TGA made recommendations with regard to metoclopramide dose and duration of therapy. The risk of acute neurological effects is higher in children and the risk of EPE i.e. tardive dyskinesia appears to be more frequent in the elderly, especially with high doses or long term treatment¹⁶. Recommended changes:

- metoclopramide is contraindicated for children under one year of age;
- for young adults (under 20 years old) and children over one year of age, metoclopramide is only indicated as second-line therapy;
- the total daily dose, especially in children and young adults, should not exceed 0.5mg/bodyweight, with a maximum of 30 mg daily independent of route of administration;
- the maximum dose for adults is 10 mg three times daily; and
- the maximum recommended treatment duration is five (5) days in all age groups¹⁷.

Expert opinion on the current use of metoclopramide

Palliative care physicians and specialist clinicians are and have been, over the years, cautious on the use of metoclopramide in regards to length of treatment and dosages, particularly in the elderly, children and young people. Specialist palliative care require impeccable assessment of symptoms and their aetiology so the appropriate antiemetic regime can be recommended and instigated. Clinicians can then be confident that choosing metoclopramide is based on appropriate clinical reasoning i.e. as a prokinetic agent and/or for early satiety. Clinicians must also ensure timely evaluation of dosages and length of metoclopramide treatment occurs to ensure less likelihood of adverse effects¹⁸

It is important to acknowledge also that all other antiemetic options have additional limitations therefore there is no easy alternative and that the risk of neurological adverse effects are likely to be higher when metoclopramide is

¹¹ Medicines Safety Update, Therapeutic Goods Administration-Australian Government Department of Health, Volume 6, Number 1, February 2015

¹² CareSearch https://www.caresearch.com.au/caresearch/Portals/0/Documents/PROFESSIONAL-GROUPS/Nurses%20Hub/NHN_Pharmacy_Nov2015.pdf

¹³ Palliative Care Formulary Wilcock & Twycross Eds. 2014, Fifth Edition

¹⁴ *Ibid*, pages

¹⁵ Agar M, Yates P, Currow DC. Prescribing for nausea in palliative care: a cross sectional national survey of Australian Palliative medicine doctors. *Journal of Palliative Medicine*. 2014; 17 (9):1032-6

¹⁶ Oxford Handbook of Palliative Care 2nd Edition Oxford University Press 2010: Gastrointestinal symptoms, pages 309-313

¹⁷ Therapeutic Guidelines: Palliative Care Version 3, 2010: pages 131-132, 165, 238-256. Therapeutic Guidelines Limited

¹⁸ Associated Professor Mark Boughey, Deputy Director of Palliative Medicine St Vincent's Hospital, Fitzroy Melbourne, Victoria & Dr Scott King Clinical Director of Palliative Medicine Calvary Bethlehem, Caulfield Melbourne, Victoria. Clinical discussions, 24 May 2016.

prescribed with other dopamine antagonists i.e. haloperidol, promethazine¹⁸. Finally, in suspected bowel obstruction unrelated to constipation, the use of metoclopramide is contraindicated.

«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 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/or NP or NPC»
<<NameofOrganisation/Company>>

Template 2

Client Name:
Date:
Date:

<<Organisation Logo>>

Drug	Use	Recommended Dose*	Route	Frequency	Signature	Date
*Morphine mixture Strengths on PBS 2mg/mL 5mg/mL 10mg/mL Script 200/mL bottle	Oral breakthrough Medication for pain and/or breathlessness		Oral	p.r.n.		
Morphine sulfate Strengths on PBS 10mg/mL Script for 5 (five) ampoules/box or authority script required for one month's supply 30mg oral morphine= 10mg SC morphine	Subcutaneous (SC) breakthrough Medication for pain and/or breathlessness		SC	p.r.n. or 6 (six) doses 24 hourly		
Metoclopramide 10mg/2mL Script 10 ampoules/box	Nausea and vomiting	10 mg	SC	** 6-8 hourly p.r.n.		
Haloperidol 5mg/mL Script 10 ampoules/box	Nausea and vomiting and/or delirium	0.5mg-2.5mg	SC	6 hourly p.r.n.		
Midazolam (not on PBS) Script 5mg/5mL	Agitation, restlessness and/or fitting	2.5mg-5mg	SC	2-3 hourly p.r.n.		
Clonazepam drops 2.5mg/mL 20 drops per mL (each drop= 0.1 mg) Script 10mL bottle	Restlessness and risk of fitting	It is recommended that with the benzodiazepine naïve and the elderly patient always start with 2-4 drops	Oral or sublingu al (SL)	1-2 hourly p.r.n.		
*Glycopyrrolate (not on PBS) 0.2mg/1mL Script 5 ampoules/box	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.

** See page 4

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 <<NameofOrganisation/Company>> on <<faxnumber>>. 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>*Morphine sulfate Strengths on PBS 10mg/mL Script for 5 (five) ampoules/box or authority script required for one month's supply</p> <p>30mg oral morphine= 10mg SC morphine</p>	Subcutaneous (SC) breakthrough Medication for pain and/or breathlessness		SC	p.r.n. or 6 (six) doses 24 hourly		
<p>Metoclopramide 10mg/2mL Script 10 ampoules/box</p>	Nausea and vomiting	10 mg	SC	**6-8 hourly p.r.n.		
<p>*Clonazepam drops 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 2-4 drops	Oral or sublingu al (SL)	1-2 hourly p.r.n.		

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.
- *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.
- ** See page 4

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.