<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Anticipatory Prescribing Guidelines &amp; Templates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Keywords</strong></td>
<td>Palliative Care, Anticipatory Prescribing, Guidelines</td>
</tr>
<tr>
<td><strong>Ratified</strong></td>
<td>GRPCC Clinical Practice Group</td>
</tr>
<tr>
<td><strong>Effective Date</strong></td>
<td>October 2018</td>
</tr>
<tr>
<td><strong>Review Date</strong></td>
<td>October 2020</td>
</tr>
<tr>
<td><strong>Purpose</strong></td>
<td>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 <a href="mailto:enquiries@grpcc.com.au">enquiries@grpcc.com.au</a> or phone 03 5623 0684.</td>
</tr>
<tr>
<td><strong>Acknowledgement</strong></td>
<td>Some of the information contained in this document was taken from Melbourne City Mission Palliative Care and Peninsula Home Hospice</td>
</tr>
<tr>
<td><strong>Companion Document</strong></td>
<td>GRPCCS Symptom Management Guidelines</td>
</tr>
</tbody>
</table>
Disclaimer

The intent of the GRPCC Clinical Practice Group endorsed clinical guidelines is to make them available to health services and clinical staff across the Gippsland region to promote evidence-based practice when delivering palliative care.

Clinical guidelines are intended to provide general advice to the medical, nursing, and allied health staff working with clients with a life limiting illness. These endorsed clinical guidelines are not a substitute to comprehensive assessment and critical thinking relevant to the particular patient’s individual clinical circumstances and degree of symptom burden. There may also be strong clinical evidence for choosing a therapeutic intervention that may be different to what is recommended in these guidelines. Timely consultation and advice from the palliative care service is always recommended, if appropriate, when using these guidelines.

When developing clinical guidelines, the GRPCC ensures the guidelines content is accurate and based on evidence. The GRPCC takes no responsibility for new clinical evidence or information that become available or be published following guideline distribution or nominated review date.

The GRPCC guidelines may be used by providers to develop similar protocols and procedures that can be customised according to the organising clinical context and requirements. Health organisations must also ensure that utilisation of these guidelines complement their organisational governance structure including health professional palliative care delivery scope of practice.
Background/Context

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\(^1\). 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.

The Victorian Government’s ‘end of life and palliative care framework, 2016’\(^2\) identifies after-hours support for clients and carers in their homes, as a key aspect in enabling people to be cared for, and die in their place of choice.

The Gippsland Regional Palliative Care Consultancy Service (GRPCCS) which 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 telephone 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\(^3\). This element includes the core input of advocacy for improving access to medications which describes, among others, two important components:

- Working in conjunction with the client’s primary and tertiary doctors, and community pharmacy, to facilitate the timely supply of appropriate medication in the client home, or arrange alternatives where these are not available, based on actual and potential symptoms and care needs\(^4\).
- Palliative medicine specialists support GPs who are not confident with prescribing palliative medications;

Rationale for this guideline

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.

In 2011, The Gippsland Region Palliative Care Consortium (GRPCC) Emergency Medication Audit and Report \(^5\) showed there was varied consensus among GPs and nursing staff, from the different health services, regarding approaches and protocols.
to anticipatory prescribing and obtaining supplies of emergency medications. Recent research by Monash University in Gippsland in 2018 has confirmed that issues continue to be experienced in rural and remote regions regarding access to anticipatory medications. Challenges experienced include doctors not willing to order anticipatory medication pharmacy shortages, inability to access medications, and lack of formal education of health care providers and specific organisational guidelines in use of anticipatory medications.

**Anticipatory prescribing**

Anticipatory prescribing is defined as ‘the proactive prescribing of medicines that are commonly required to control new or worsening symptoms in the last days of life’.

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

There are two circumstances where prescribing of parental medications in the community may be necessary:

1. **Emergency symptom support** based on client’s condition, deterioration and symptom profile - medications to be administered whilst awaiting reassessment and decisions regarding goal of care, site of care and ongoing management plan over the next weeks

2. **Terminal care medications** where the patient is in the terminal phase of life (ie anticipated last hours to days) See Care Plan for the Dying Person (CPDP) medication algorithm (appendix 5).

The CPDP medication algorithm is predominantly for the latter (terminal care) setting, however distinction between the two circumstances (emergency and terminal symptom support) will be determined by the conversation between the nurse and the prescribing doctor and which medications may be requested.

This guideline contains:

Anticipatory prescribing flow chart (appendix 1)  
Palliative Care Outcome Collaborative PCOC Phase of Care tools (appendix 2)  
Letter proforma for GP informing assessment regarding anticipatory prescribing (appendix 3)  
Recommended Anticipatory Medications (appendix 4)  
CPDP medication algorithm (appendix 5)

**Companion Documents to Anticipatory Prescribing Guidelines:**

GRPCCS Symptom Management Guidelines (under review)
Flow Chart Anticipatory Medications

Palliative Care patients commonly require anticipatory medication orders at end of life, however it is not routine practice to initiate support medications for all clients on admission to the palliative care service.

**Question:**
Does the client require anticipatory medication for end of life care in the home?

Assess using clinical judgement plus:
- ESAS
- Karnosky Performance Scale
- Palliative Care Phase of Care

*See reverse side of this page for further details.

**Yes**

Check:
- Allergies
- Current medications/requirements

Request anticipatory medications
- Contact GP
- Fax letter

When returned from GP check
- Signed and dated
  - Appropriate medication
  - Appropriate dose

Document in Medical Record

Provide carer with symptom management sheets as needed

**Discuss with GP / Palliative care team leader / Nurse Practitioner / Gippsland Region Palliative Care Consultancy Service (GRPCCS) regarding plan**

**No**

Client:
- Stable
- Has no symptom issues
- Opioid naive
- Refused / declined
- Lives alone with no available carer
- Drug dependent family or carer

Review at each phase of care

Document in Medical Record
Phase Definitions

The Palliative care phase is the stage of the patient’s illness. Palliative care phases are not sequential and a patient may move back and forth between phases. Palliative care phases provide a clinical indication of the level of care required and have shown to correlate strongly with survival within longitudinal prospective studies.

PALLIATIVE CARE PHASE OF ILLNESS

**Clinician rated**

1. **STABLE** Symptoms are adequately controlled by established management
2. **UNSTABLE** Development of a new problem or a rapid increase in the severity of existing problems
3. **DETERIORATING** Gradual worsening of existing symptoms or the development of new but expected problems
4. **TERMINAL** Death likely in a matter of days
5. **BEREAVED** Death of a patient has occurred and the carers are grieving

Refer to complete Phase Definitions

KARNOFSKY SCALE

AKPS (Australian modified Karnofsky Performance Scale)

**Clinician rated**

100 Normal, no complaints or evidence of disease
90 Able to carry on normal activity, minor signs or activity
80 Normal activity with effort, some signs or symptoms of disease
70 Care for self, unable to carry on normal activity or to do active work
60 Occasional assistance but is able to care for most needs
50 Requires considerable assistance and frequent medical care
40 In bed more than 50% of the time
30 Almost completely bedfast
20 Totally bedfast & requiring nursing care by professionals and/or family
10 Comatose, barely arousable

PROBLEM SEVERITY SCORE

**Clinician rated**

0 = Absent
1 = Mild
2 = Moderate
3 = Severe
Appendix 3- Proforma letter to GP requesting anticipatory medications

Dear «FirstName»,

This is to inform you that your client (name __________), admitted to (service name_________), community palliative care service on (date__________) is experiencing symptom changes.

Current assessment has identified that your client requires timely access to appropriate medications (anticipatory prescribing), including injectable medications, that are crucial to relief of symptoms and supporting the client to be at home.

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

- Managing the acute onset and/or exacerbation of distressing symptoms for clients in their homes- please refer to the ‘Recommended anticipatory medications’ (appendix 3).
- Caring for clients when they are no longer swallowing, close to death and wanting to die at home- please refer to the ‘Algorithm for CPDP’ (appendix 4).

Access to a Palliative Medicine Physician or Palliative Care Nurse Practitioner is available to discuss concerns or advice on complex symptom management in both business and after hours. Gippsland Regional Palliative Care Consultancy Service is based at Latrobe Regional Hospital- contact details:
  Monday to Friday- 51738713 (0800-1700h) - direct to Palliative Care Coordinator
  After hours - 51738000 (LRH switchboard will connect to on call physician).

The community palliative care nurses will liaise with you on an ongoing basis, highlighting concerns regarding changing conditions and unstable symptom control.

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.

«Referral/triage Coordinator/and/or NP or NPC»
<<NameofOrganisation/Company>>
### Appendix 4 - Recommended Anticipatory Medication

<table>
<thead>
<tr>
<th>Drug</th>
<th>Use</th>
<th>Recommended Dose*</th>
<th>Route</th>
<th>Frequency</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
| **Morphine mixture**  
Strengths on PBS  
2mg/mL  
5mg/mL  
10mg/mL  
Script 200/mL bottle | Oral breakthrough Medication for pain and/or breathlessness | Oral | prn | |
| **Morphine sulfate**  
Strengths on PBS  
10mg/mL  
Script for 5 (five) ampoules/box or authority script required for one month’s supply | Subcutaneous (SC) breakthrough Medication for pain and/or breathlessness | SC | prn or 6 (six) doses 24 hourly | |
| 30mg oral morphine= 10mg SC morphine | | | | |
| **Methoclopramide**  
10mg/2mL  
Script 10 ampoules/box | Nausea and vomiting | 10 mg | SC | **6-8 hourly prn** |
| **Haloperidol**  
5mg/mL  
Script 10 ampoules/box | Nausea and vomiting and/or delirium | 0.5mg-2.5mg | SC | 6 hourly prn |
| **Midazolam**  
(not on PBS)  
Script 5mg/5mL | Agitation, restlessness and/or fitting | 2.5mg-5mg | SC | 2-3 hourly prn |
| **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 sublingual (SL) | 1-2 hourly prn |
| **Hyoscine butylbromide**  
20mg/1mL  
Script 5 ampoules/box | Excessive chest secretions | 20mg | SC | 2-4 hourly prn |
Appendix 5 – CPDP medication algorithm for terminal phase of care

CARE PLAN FOR THE DYING PERSON SYMPTOM CONTROL ALGORITHMS

PAIN

Patient not previously taking any opioid

- Morphine 2.5mg - 5mg s/c hourly prn
- Review morphine requirement hourly
- Review required dosage after 24 hours
- If 3 or more doses required consider use of CSCI @ 10mg - 20mg / 24 hours
- Plus continue breakthrough Morphine pm s/c 2.5mg - 5mg
- Reassess daily

Patient previously taking oral Morphine or Oxycodone

- Review current analgesia
- Convert to CSCI by dividing total equivalent oral Morphine dose / 24 hours by 3
  - Example:
    a) MS Contin 0.30mg twice daily
    = 60mg 5 daily ÷ 3
    = CSCI Morphine 20mg / 24 hours
    b) Oxycontin 0.20mg twice daily
    (x 1.5 potency conversion to oral Morphine)
    = 60mg oral Morphine / 24 hours ÷ 3
    = CSCI Morphine 20mg / 24 hours

- Plus s/c Morphine pm breakthrough 1/2 to 1/3 of 24 hour dose
- Reassess daily

Patient currently on other opioids

- To convert from other strong opioids consult with:
  - Palliative care team (CNC, NP)
  - Palliative Care Physician
    (Phone: 51738713)
  - Gippsland Region Palliative Care Consultancy Service
    (Phone: 51738713)
  - Clinical Pharmacist
  - Palliative Care Therapeutic Guidelines

- Reassess daily

If 3 or more breakthrough medication doses required and effective in 24 hours, then add together all breakthrough doses and increase CSCI by that value, but do not exceed 50% of CSCI dose at any one time. Continue breakthrough medication at 1/2 to 1/3 of the new 24 hour CSCI dose if required

NOTES

* Must always be seen by the senior unit clinician within 24 hours of using the algorithm
1. Not all patients who are dying require a CSCI. Consider anticipatory prescribing of these medications to ensure no delay in responding to symptoms in the last hours of life
2. Use a validated pain assessment tool to ensure consistent assessment of patient’s pain
3. Review drug / dose / frequency in patients who are elderly, frail, have dementia or renal impairment
4. In severe renal impairment morphine metabolites may accumulate and are associated with increased risk of side effects and narcosis. Consider using other opioids eg. Fentanyl or Hydromorphone
5. If patient has morphine allergy consider Hydromorphone 0.5mg - 1mg s/c hourly pm
6. If using opiates for management of dyspnoea this should be taken into account when titrating opiates for pain
7. All drugs listed on the algorithms for all symptoms should be compatible in the same syringe driver, however if signs of incompatibility become evident, eg. cloudiness or precipitate, do not proceed and seek further advice from consultant pharmacist
8. If any concerns contact your local palliative care team or the Gippsland Regional Palliative Care Consultancy Service on 51738713 or afterhours via LRH switchboard 5173 8000

Care Plan for the dying person symptom control algorithm—Final July 2018, Review date July 2020
Appendix 5 – CPDP medication algorithm for terminal phase of care

CARE PLAN FOR THE DYING PERSON SYMPTOM CONTROL ALGORITHMS

Nausea and Vomiting

METOCLOPRAMIDE
10mg s/c
4hrly prn
(Not usually suitable for patients with Parkinson’s disease or total bowel obstruction with colic)

Review antiemetic requirement hourly
Review required dose after 24 hours.
If 3 or more doses are required consider use of CSCl

Alternate antiemetics may be prescribed eg:
- Haloperidol
  1.5mg - 3mg s/c 2 hourly prn
  1.5 - 3mg via CSCl / 24 hours
- Cyclizine*
  25 - 60mg s/c 4 hourly prn
  150mg - 300mg via CSCl / 24 hours
- Levomepromazine*
  6.25mg s/c 4 hourly prn
  6.25 - 12.5mg via CSCl / 24 hours
- Dexamethasone
  2 - 4mg s/c daily

(* Please consult with the palliative care team if prescribing Cyclizine or Levomepromazine. These are SAS drugs—additional forms from pharmacy

Terminal Restlessness / Agitation

MIDAZOLAM
2.5mg - 5mg s/c
15 minute prn

Review Midazolam requirement hourly
Review required doses in 24 hours
If 3 or more doses are required consider use of CSCl

Continue prn dosage as symptoms occur

If patient requires more than 3 doses of prn in a 24 hour period, contact the palliative care team

Dyspnoea

MORPHINE
2.5mg - 5mg s/c **
hourly prn

Review Morphine requirement hourly
Review required dose after 24 hours
If 3 or more doses are required consider use of CSCl Morphine at 10 - 20mg / 24 hours

If patient is breathless and anxious consider Midazolam 1 - 2.5mg s/c hourly

(** If GFR < 30ml/min consider alternative opioids (Hydromorphone / Fentanyl)

Respiratory Tract Secretions

Position of patient and explanation of cause of secretion and treatment are important to both patient and carer

HYOSCINE BUTYLBROMIDE
20mg s/c 4 hourly prn
or
GLYCOPYRRONIUM (Glycopyrrole)
200mcg s/c 2 hourly prn
or
ATROPINE
600mcg s/c
2 hourly prn
in unconscious patient only

If symptoms persist after 24 hours consider Hyoscine Butylbromide CSCl
60mg - 120mg over 24 hours

NOTES

- Must always be seen by the senior unit clinician within 24 hours of using the algorithm
- CSCl = Continuous subcutaneous infusion

1. Not all patients who are dying require a CSCl.
2. Consider anticipatory prescribing of these medications to ensure no delay in responding to symptoms in the last hours of life
3. Review drug / dose / frequency in patients who are elderly, frail, have dementia or renal impairment
4. All drugs listed on the algorithms for all symptoms should be compatible in the same syringe driver, however if signs of incompatibility become evident, eg, cloudiness or precipitate, do not proceed and seek further advice from consultant or pharmacist.
5. If any concerns contact your local palliative care team or the Gippsland Regional Palliative Care Consultancy Service on 5173 8713 or afterhours via LHI switchboard 5173 3000

Care Plan for the dying person symptom control algorithm—Final July 2018. Review date July 2020
References


2. Victorian Government’s ‘end of life and palliative care framework, 2016’ p.25


4. ibid

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