Adult Palliative and Supportive Care: Policy for Anticipatory Prescribing in the Community

December 2017

DOCUMENT PROFILE

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Short Title	Policy for Anticipatory Prescribing in the Community
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Linked Policies	Ambulatory Syringe Pump Policy Consent Policy Guidelines Disposal of Sharps Policy Health and Safety Policy Incident Accident and Near Miss Reporting and Management Policy Incident Accident and Near Miss Reporting and Management Procedure Infection Prevention and Control Policies Medicines Policy Mental Capacity Policy Non-Medical Prescribing Policy Policy for Management of Serious or Untoward Incidents Prescription Writing Standards Safe Handling Policy
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1. INTRODUCTION

1.1 Rationale

Many patients approaching the end of their lives express a desire to die at home, this has been recognised in the National End of Life Care (EOLC) Strategy published in July 2008 (UK Department of Health) and the National Institute for Health and Care Excellence (NICE) Clinical Guideline for Care of dying adults in the last days of life (2015). Providing a good death at home is vital, but presents unique problems for the practitioners especially during the out-of-hours period when access to the patient's own general practice and regular community pharmacy may not be possible.

Anticipatory prescribing is designed to provide access to essential medicines for symptom control at the end of life in the patient's usual place of residence. It prevents delays in treating the most common symptoms at the end of life when they may be unable to swallow oral medication; improves symptom control for patients and can prevent unwanted admissions to the Hospital or Hospice in-patient unit (IPU).

Anticipatory prescribing is based on the premise that although each patient is an individual with individual needs, many acute events during the palliative period can be predicted and management measures put in place in advance. However as per the NICE guidance the treatment plan should be tailored to the individual patient and circumstances, taking into account the risks and benefits of prescribing in advance.

Although the benefits of anticipatory prescribing are well recognised, some practitioners have concerns about prescribing and administering medications in this way. This policy is designed to help practitioners in this important field to individualise patient care.

Palliative care is traditionally thought of as being a part of cancer care, but many life-limiting illnesses such as cardiac, neurological and respiratory diseases can benefit from this approach.

'Just in Case' (JIC) boxes are only a small part of anticipatory prescribing, and refers to a system used to improve the security and audit trail of the medications prescribed. JIC boxes are only to be used in patients own homes and not other care settings (e.g. residential/nursing homes, or the Hospice IPU) where alternative systems are in place for medication storage and stock management.

1.2 Scope

This policy is intended to be used by registered clinical professionals who manage adult palliative and supportive care patients within Jersey Health and Social Services Department (HSSD), Family Nursing & Home Care (FNHC), Primary Care Body (PCB), Residential/Nursing Homes and Jersey Hospice Care (JHC). This will include medical, nursing and pharmacy staff.

It covers anticipatory prescribing for symptoms in the last days of life for patients to be cared for in the community setting, but does not include guidance on recognition of dying or other aspects of end of life care.

1.3 Principles

This policy was produced to assist healthcare professionals prescribing, dispensing and administering anticipatory medications for patients in their preferred place of care and/or death. It will also promote a procedural uniformity amongst those professionals working in the hospital, hospice or community setting.

2. POLICY PURPOSE

The policy aim is to promote consistency and sustain improved clinical practice and care standards to adult palliative care patients across Jersey.

The intention is to:

- Support patient choice if they wish to remain in their usual place of residence, and help to prevent unplanned hospital or hospice admissions.
- Improve access to palliative care medicines in the community.
- Encourage prescribers to anticipate common symptoms in the dying phase, and to promote anticipatory prescribing.
- Promote procedural uniformity and support safe and accountable practice across healthcare providers.
- Ensure that patient's, family and carers understand the purpose of anticipatory medications and the JIC box.
- Assist practitioners who are involved in setting up and/or administering anticipatory medications from a JIC box.

3. PROCEDURE

3.1 Roles and responsibilities

Divisional/Departmental Managers, Ward Managers, Team Leaders, Clinical Consultants and any others identified within each organisation as involved with staff management are responsible for the implementation and compliance with this policy within their clinical teams. Individual healthcare professionals are also accountable for their own practice.

3.2 Training

During the launch of the anticipatory prescribing policy, training related to the new documentation (e.g. JIC box documentation) and clinical guidelines (e.g. medication algorithms for symptom management in end of life care) will be provided locally in line with the implementation plan.

All healthcare professionals registered in Jersey (medical, nursing and pharmacy) involved with anticipatory prescribing and JIC boxes in the community should be trained, competent and personally accountable for such tasks.

Managers should ensure that relevant training takes place (e.g. at induction, and updates as per organisation policy), and maintain a record of those who have read this policy.

3.3 Assessing a patients suitability for anticipatory prescribing

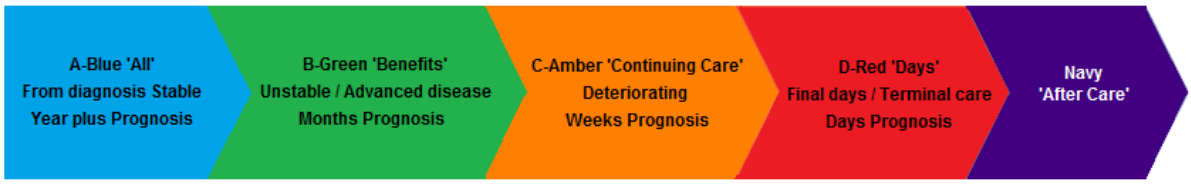
3.3.1 Patient selection

The scheme is open to all adult patients with a life limiting illness in Jersey.

3.3.2 Inclusion Criteria

Any adult patient with a terminal illness who has a poor prognosis, where the condition is unpredictable or is likely to deteriorate rapidly should be considered for anticipatory prescribing.

These patients should be identified using the Gold Standard Framework (GSF) Prognostic Indicator Guideline shown below. Patients classified as either **Amber (Deteriorating, weeks prognosis)** or **Red (Terminal Care, days prognosis)** should be considered as candidates for anticipatory prescribing.



Practitioners should aim to have anticipatory medications placed within a patient's preferred place of care a few weeks prior to their anticipated death, or where appropriate for symptom control (e.g. the use of Buccal Midazolam for patients at risk of acute seizures).

3.3.3 Potential Risks

- Patient, family or carers unwilling to participate. For example due to fears that anticipatory medications are a provision for euthanasia, or may cause anxiety to them that death is approaching. Good communication, reassurance and provision of a patient information leaflet (Appendix 1) should help allay fears.
- Related to the security of medicines. For example where there is a documented history or suspicion of drug misuse by the patient, family, carers or visitors to the home.
- If there are any concerns about the mental health/well-being of the patient, family members, carers or visitors to the home (e.g. suicidal ideation).

Based on all of the above, if a registered practitioner feels that a patient would benefit from anticipatory medications being available in their preferred place of care this should be discussed with the multi-disciplinary team (MDT).

The MDT may consist of any of the following: GP, HSSD medical/nursing/ pharmacy team, FNHC nursing team, Care Home staff, Specialist Palliative Care Doctor, Specialist Palliative Care Team (SPCT) Nurse, SPCT Pharmacist, Hospice IPU nursing team, and the Day Hospice nursing team.

An anticipatory prescribing assessment form should be completed for all patients in their own home (Appendix 2 or via EMIS) or in a care home (Appendix 3 or via EMIS). Where EMIS is not available a copy of this form should be faxed (or e-mailed) to the JHC MDT co-ordinator.

Any discussions within the MDT about the appropriateness of anticipatory medications should be documented on the assessment form.

A patients anticipatory care needs may change during the course of their illness. An identified practitioner (Palliative Care Key Worker or designated practitioner) must be responsible for ensuring a patient's suitability for anticipatory medications is reviewed routinely, or with any known change in their circumstances.

If it is not appropriate for a patient to have anticipatory medications or a JIC box in their preferred place of care alternative arrangements should be discussed, agreed and implemented by the MDT (in conjunction with the patient, family and carers).

3.4 Patient and carer education

Good communication with patients, family and carers is an essential aspect of end of life care. Provision of anticipatory medications will usually take place as part of a care plan after a discussion with the patient, family and carers about their current situation and what to expect in the future.

If possible discuss with the patient about their Preferred Priorities of Care for end of life, and where their preferred place of care and death would be. Inform them that the usual procedures for symptom assessment and management will apply regardless of care setting.

The registered practitioner assessing the patient must explain the purpose and benefits of the anticipatory medications and JIC box to the patient, family and carers.

A copy of the patient information leaflet should be given to the patient, family and carers.

The patient, family and carers should be reassured that they may opt out of the scheme at any time.

Reinforce that if the patient's clinical condition improves or stabilises, the ongoing requirement for anticipatory medications may be reviewed. The anticipatory medications will not be removed without the patients consent, but they should be reassured that if taken out their condition will be regularly reviewed and anticipatory medications can be reintroduced at a later stage when felt necessary.

Explain that for patients at home all anticipatory medications contained within the JIC box are for use by healthcare professionals only. There is a unique combination lock on the JIC box which will be known to the healthcare teams, but not given to the patient, family or carers.

Storage precautions for the JIC box should be discussed with the patient, family and carer to ensure that it will be stored securely and cannot be accessed by a child, animal or vulnerable member of the household.

Inform patients who reside in a residential/nursing home, anticipatory medications will be stored securely by the care home staff in a designated locked treatment room in line with their organisational policies.

3.5. Prescribing anticipatory medications

Anticipatory medications can be prescribed by a registered medical practitioner (preferably the patient's usual GP), or an appropriate non-medical prescriber (following discussion with the patient's GP).

The prescriber should have access to the patient's current notes, and document any decisions made. A retrospective entry on EMIS may be needed if visiting the patient at home or in a care home.

For patients in the community setting the prescription should be written on a Health Insurance Prescription Form to be dispensed by a community pharmacy.

If the requirement for anticipatory medications is identified while the patient is an in-patient at an HSSD site, they should be prescribed on a hospital discharge prescription to be dispensed by the hospital pharmacy.

The following documentation should also be completed by the prescriber to authorise the medications to be administered by a registered nurse:

Patient home	Anticipatory prescribing medication administration record (Appendix 4)
Care homes	Anticipatory prescribing medication administration record *
* This is additional to the Medication Administration Record (MAR) issued by the dispensing community pharmacy. An annotation should be made by care home staff on the patient's MAR next to anticipatory medications to: '*Use anticipatory prescribing medication administration record*'.	

Where possible the anticipatory prescribing medication administration record should be printed in colour, double sided on card. However single side, black and white photocopies of the chart may be used.

Medications authorised for administration by the prescriber on the anticipatory prescribing medication administration record are valid for **3 months**. After this period they should review the anticipatory medications to ensure they are still required and the doses are appropriate. If so, the prescriber should reauthorise the chart by signing and dating the relevant boxes.

An individualised approach to prescribing anticipatory medications for patients who are likely to need symptom control in the last days of life should be adopted.

Ensure appropriate medications and routes (e.g. subcutaneous) are prescribed as early as possible. State indications for use and medication dosage.

When considering medicines for symptom control, take into account:

- The likely cause of the symptom (is it reversible, e.g. an infection).
- The patient's agreed ceilings of treatment.
- The dying person's preferences, alongside benefits/harms of the medicine.
- Any individual or cultural views that might affect their choice.
- Any other medicines being taken to manage symptoms.
- Any co-morbidities that could affect prescribing decisions.
- The patient's ability to swallow safely and their preferred administration route.

The prescription should include the following medicines (or an appropriate alternative) for the specified indications:

- Diamorphine for **pain control** and **breathlessness**.
- Levomepromazine for the relief of **nausea** and **vomiting**.
- Glycopyrronium for the relief of **respiratory tract secretions**.
- Midazolam for the relief of **anxiety** in a lucid patient.
- Haloperidol for the relief of **agitation** and **restlessness** in confused or hallucinating patients.
- Water for Injections to be used as a **diluent** (for Diamorphine) and **flush**.

3.5.1 Syringe Pumps

Where the clinical decision is taken by a prescriber that the patient requires a syringe pump, this should be prescribed on the Ambulatory subcutaneous syringe pump prescription chart (see policy).

For further information, including alternative medication options refer to the anticipatory prescribing guidance (Appendix 5) and the medication algorithms for end of life care (Appendix 6). Alternatively prescribing information is available in the Ambulatory Syringe Pump Policy, or from the SPCT.

3.6 Dispensing of anticipatory medications

Once the Health Insurance Prescription Form has been completed by the prescriber it should be taken to a community pharmacy by the patient, a family member, or carer to be dispensed.

A network of palliative care link pharmacies (Appendix 7), has been established to improve accessibility to anticipatory medications. They have agreed to stock a core list of medications used in palliative care (Appendix 8). The list of pharmacies should be given to the patient, family or carer.

If the requirement for anticipatory medications is identified while the patient is an in-patient at an HSSD site, they should be prescribed on a discharge prescription to be dispensed by the hospital pharmacy.

Medication prescribed for an individual patient should **never** be given or administered to any other patient.

In the event of a supply problem with one or more of the prescribed medicines, the palliative care key worker or a designated practitioner should contact the community or hospital pharmacy directly for additional information. Advice should then be sought from the patient's GP or the SPCT for alternative treatment options.

For access to anticipatory medications in the community out of hours contact Jersey Doctors On-Call (JDOC, tel. 445445).

3.7 Transport of anticipatory medications

In **exceptional circumstances** (i.e. where nobody else can) the medicines may be collected and transported by the registered practitioner in accordance with their organisations Medicines Policy or Standard Operating Procedures (SOP). Care agency staff collecting medications should follow their organisation SOPs.

Whoever collects the medications from the community pharmacy should take their photographic identification (e.g. passport or driving license), and be able to confirm the patients details (i.e. name, date of birth, address and social security number).

3.8 Administration of anticipatory medications

3.8.1 Administration

Practitioners administering a medication via the subcutaneous route should be aware that:

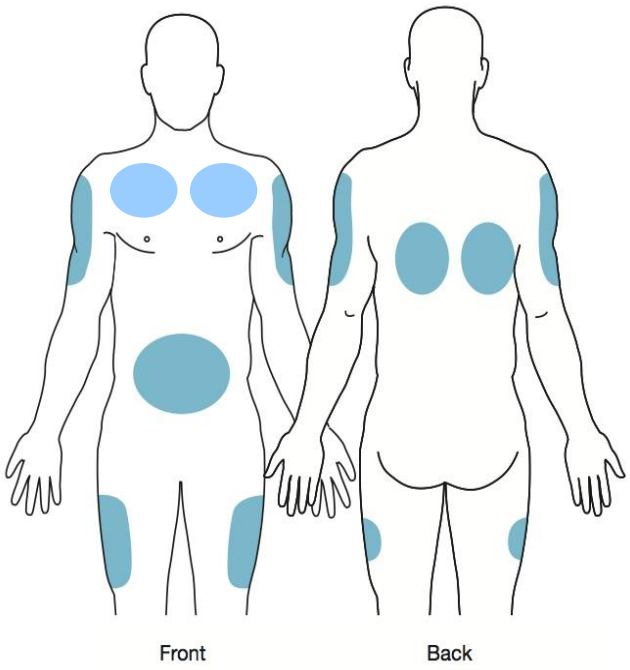
- Absorption may be slower than the intramuscular route.
- Absorption will be severely limited in patients who are hypovolaemic or oedematous.
- For breakthrough dose bolus injections the recommended max volume is 2ml.

Where possible, involve the patient in the choice of administration site. Both the outer arm and upper thigh are commonly used. In other patients, the chest or abdomen may be more suitable. Avoid the chest wall in cachectic patients (danger of causing pneumothorax).

The following sites should be **avoided**:

- Oedematous areas including lymphoedema affected arms (poor drug absorption and increased risk of infection/exacerbation of oedema).
- Bony prominences (poor absorption and discomfort).
- Irradiated sites (may have poor perfusion and hence poor drug absorption).
- Skin folds, sites near a joint and waistband area (movement may displace infusion device and cause discomfort).
- Broken skin.

Acceptable subcutaneous administration sites are shown below:



Wherever possible Controlled Drugs (CD) and injectable medications should be checked and administered by two registered healthcare professionals (e.g. GP, Registered Nurses). However it is acknowledged that in some community settings (e.g. patient homes) often only one registered professional may be available.

Where a second healthcare worker is present (e.g. Healthcare Assistant) it is permissible for them to act as a witness for the medication administration.

Once a patient's condition deteriorates and there is a requirement to administer anticipatory medications for symptom control the patient's GP and any other nursing teams involved with their care (i.e. FNHC and JHC) should be informed. A review of whether a syringe pump is indicated may be needed, refer to the medication algorithms for end of life care for advice.

A medical review by a GP (or advice from the SPCT) may also be required if:

- There is an unexplained or a sudden change in the patient's condition.
- There is a potentially reversible condition requiring further assessment.
- The symptoms are not controlled by prescribed anticipatory medications.
- The patient, family or carer requests medical assessment.

3.8.2 Documenting administration

3.8.2.1 Patient homes and Residential Homes

GPs, and nursing staff from FNHC and/or JHC are to record administration of medications to the patient on the anticipatory prescribing medication administration record.

3.8.2.2 Nursing Homes

Registered Nurses in nursing homes are to record administration of anticipatory medications to the patient on the anticipatory prescribing medication administration record.

It is the responsibility of nursing home management to ensure all their registered nurses are competent and confident to give subcutaneous medications and set-up syringe pumps. In **exceptional circumstances** JHC nursing staff can provide advice and support (at times this may be on-site) to nursing home staff.

3.8.3 Consumables for administration of anticipatory medications

A full list of consumables needed by healthcare professionals to administer anticipatory medications subcutaneously is provided (Appendix 9).

Based on advice from the States of Jersey Police Crime Prevention Team the decision has been taken that consumables should not be left inside JIC boxes in patient's homes.

Therefore it is important that all professionals caring for palliative care patients who have anticipatory medications in place should have access to these consumables when they are planning to visit the patient's place of residence.

It is advised that GPs and nursing staff (from FNHC and JHC) who are undertaking home visits carry the required stock of consumables stored in an appropriate opaque container available at their base of work. When travelling by car these kits should be kept out of sight, and locked in their car boot.

Nursing homes should also hold a stock of these consumables for use by their own staff or visiting professionals.

3.8.4 Recording of batch numbers and expiry dates

When administering medications from the JIC box in the patient's home, expiry dates and batch numbers should be documented on the medication record sheets (Appendix 10). In other care settings (i.e. care homes) the requirement to do this should be based on organisational policy.

3.9 Storage and stock control of anticipatory medications

The storage and stock control of anticipatory medications varies depending on the care setting. In residential and nursing homes this is to be undertaken by care home staff, in patient own homes it will be the role of nursing staff (FNHC/JHC) and GPs.

Any discrepancies in stock should be immediately reported to your team leader or line manager, as well as other healthcare organisations involved. An incident form should be completed per organisational policy, the police need to be contacted if the medications whereabouts cannot be accounted for and further investigation is required.

The medications remain the property of the patient, however the system of JIC boxes and stock control is to ensure that these injectable medications (which are often CDs) can be safely left unattended in a patient's home where healthcare professionals will be visiting at intervals. It is a widely established system in the UK as a means of risk management.

3.9.1 Patient's own home

Anticipatory medications must be stored in the JIC box within the patient's own home, this will be supplied by either FNHC or JHC.

Ideally two registered practitioners should be involved when installing the JIC box and placing the medications inside, however if staffing does not permit this it can be completed by one nurse alone or with a healthcare assistant as a witness.

The number of dose units (i.e. ampoules) of each medication (including Water for Injections) should be documented on the medication record sheets. The box should be closed and locked by scrambling the numbers on the combination keypad, then sealed with a numbered security tag. The JIC box tag sheet should also be completed (Appendix 11).

The stock level of **all** medications in the JIC box should be checked every time it is opened. However it is only necessary to complete the medication record sheet(s) for medications administered from, or received into the JIC box. On each occasion the JIC box tag sheet should be completed to confirm the stock levels for all medications are correct.

At all times patient care should be prioritised over completing the documentation.

The box should be stored out of sight (ideally a lockable drawer or cupboard), and out of reach of children, animals or vulnerable members of the household. The location of the box should be documented in the patient's notes.

3.9.2 Residential and Nursing homes

Anticipatory medications are to be stored in the care homes usual secure medication storage locations (e.g. the CD cupboard). They are to be stock controlled by the care home staff as per their organisations Medicines Policy or SOPs.

In residential homes there is no requirement for GPs, or nursing staff from FNHC or JHC to keep records of medications received or administered on stock sheets as they would in a patient's home. However where CDs are administered the GP or FNHC/JHC nursing staff should make an appropriate entry in the care home CD register, countersigned by an authorised member of the care home staff. Nursing staff from FHNC or JHC should liaise with the residential home staff (and each other where appropriate) to ensure medications are requested when needed.

Anticipatory medications can be kept by care homes up until their expiry date, then they should be sent back to a pharmacy for destruction. Prior to this their ongoing requirement should be reviewed, and represcribed if necessary.

3.9.3 Syringe Pumps

If a patient is to be started on a syringe pump the anticipatory medications already available can be used to make up the syringe, this must be documented on the appropriate medication record sheet. Depending on the anticipated usage of medications, additional supplies may need to be prescribed.

3.10 JIC box storage security

To minimise the risks associated with placing injectable medications (including CDs) in a patient's home the system of JIC boxes has been utilised. The purpose of this is to ensure that only healthcare professionals can access the medications, and thus that an audit trail of the medications can be maintained in line with NMC standards.

Attempts to mitigate the risks further include:

- Risk assessment of putting a JIC box into a patient's home.
- Patient, family and carer education about the JIC boxes.
- Storing the JIC boxes out of sight, and ideally in a lockable drawer/cupboard.
- Using hard case metal boxes with a number combination lock.
- Using uniquely numbered security tags to determine if someone has tried to gain access to the JIC box.
- A system for checking stock levels and the security tag.

When not in use the empty JIC boxes will be stored at either a FNHC or JHC base. The number combination lock on each of the JIC boxes will be set centrally by JHC, and will be updated every **12 months**. GPs and nursing staff from FNHC and JHC will be informed of the number combination for the JIC boxes.

Under no circumstances should the box number combination be documented in the patient's paper notes, or given to the patient, family or carers.

The box number combination can be recorded in the patient's EMIS record.

3.11 Documentation

All the below documents are available via the JHC external website, or where appropriate on EMIS.

3.11.1 Anticipatory Prescribing Assessment form

The completed assessment form for patients at home, or in a care home should be faxed (**fax no. 720292**) or e-mailed to the JHC MDT co-ordinator. The original copy of the form should be filed in the patients' notes.

3.11.2 Anticipatory Prescribing Medication Administration Record

When anticipatory medications are no longer required in a residential home, a photocopy of the medication administration record should be left with the care home staff.

The original should be taken by a member of the FNHC/JHC nursing staff and filed in the relevant organisations notes, a photocopy may be needed for the other organisation when under joint care.

3.11.3 JIC Box Medication Record Sheets

When no longer required the original copy of the JIC box medication record sheets should be filed in the patients' notes.

3.11.4 JIC Box Tag Sheet

When no longer required the original copy of the JIC box tag sheet should be filed in the patients' notes.

3.11.5 Outcome Form

The anticipatory prescribing outcome form (Appendix 12) should only be completed when the medications are to be removed from the patient's usual place of residence. This form should be completed for **all** patients who have been prescribed anticipatory medications in the community.

The completed forms are evaluated 6 monthly by the SPCT and used to determine the schemes success, any problems encountered and future changes to practice which may be needed. Completed forms should be faxed (**fax no. 720292**) or e-mailed to the SPCT for review, the original version should be filed in the patient notes.

3.11.6 Documentation to be kept with the JIC box

The following paperwork should be kept in the plastic sleeve attached to the JIC box in the patient's home (this may be in a booklet format):

- Anticipatory prescribing medication administration record.
- JIC box medication record sheet (for each medication including WFI).
- JIC box tag sheet.
- Anticipatory Prescribing Guidance (including opioid conversion guide).

Give the patient information leaflet directly to the patient, family or carer.

3.12 Healthcare professionals documenting their patient visit

In all care settings the manner of documentation in the patient's notes should be in line with the policies of the healthcare professional's respective organisation, and the professional body they are registered with.

3.12.1 Patient own home

GPs, or nursing staff from FNHC or JHC should document the outcome of their visit to a patient in the relevant section of their notes. This can either be in the paper copy of the patients notes held by that organisation, or preferably electronically in their EMIS record.

3.12.2 Residential and Nursing Homes

GPs, or nursing staff from FNHC or JHC visiting patients at Residential and Nursing homes should document the outcome of their visit in the 'visiting professionals' section of the patients' notes.

A photocopy of this entry should be taken, or a separate entry documenting the visit should be made in the paper copy of the patients notes held by that organisation, or preferably electronically in their EMIS record.

3.13 Regular assessment of patients with anticipatory medicines

A patient's anticipatory care needs may change during the course of their illness. For example the breakthrough doses of medications for pain control may require review if their background opioid analgesia is increased, or if their condition stabilises it may be felt that anticipatory medications are no longer required.

It is therefore important that regular assessment of the patient's anticipatory medications is undertaken by the palliative care key worker or a designated practitioner. For nursing homes this should be completed by a member of the care home nursing staff, advice can be sought from the GP or SPCT where needed.

If any changes are felt to be required the GP or another appropriate prescriber should be contacted and asked to review the patient.

If a patient's condition has stabilised or improved it may be appropriate to remove anticipatory medications from the patients usual place of residence as they are no longer needed. This should be discussed by the MDT, then explained to the patient and their agreement sought. The medications can be put in again at a later stage if required, but it is not appropriate to leave injectable medications in patient's homes (or in a care home) for long periods when they are not clinically indicated.

A review should be completed at least **monthly**, or with any change in the patient's clinical condition. The outcome must be documented in the patient notes.

If the patient is at home the JIC box and its contents should be checked at least **monthly**. The JIC box and each box of medication should be opened and stock levels checked to ensure they match the medication record sheet. Ideally this should be undertaken by two registered practitioners, however if staffing does not permit this it can be completed by one nurse alone or with a healthcare assistant as a witness.

Once the prescriber has authorised administration of the medication on the anticipatory prescribing medication administration record it is valid for **3 months**. After this period the prescriber should review and re-authorise the chart by signing and dating the relevant boxes, or make amendments as appropriate.

The JHC MDT co-ordinator should be contacted (**tel no. 786105**) when either of the above steps are undertaken for patients with a JIC box in place or anticipatory medications (Residential Homes) so that the electronic tracking system can be updated.

3.14 Disposal of anticipatory medications (and removal of JIC box)

Anticipatory medications may need to be removed in the following circumstances:

- Patient has died.
- Patient condition has stabilised or improved.
- Patient has been transferred to a different care setting, and anticipatory medications are no longer needed.
- Medications or doses have been altered.
- Any of the anticipatory medications have expired and need to be replaced.

In the above situations the following process should be followed:

i. Discuss with the patient, family and/or carer to gain consent.

ii. In patient own homes the medication should be returned to the dispensing pharmacy by the patient, family or carer for destruction.

iii. In **exceptional circumstances** (i.e. where nobody else can, or there are safety concerns about leaving the medication in the home) the registered practitioner may return the medications to the dispensing pharmacy. This must be completed in line with each organisations policies.

iv. Care agency staff returning medications for destruction should follow their organisation SOPs.

v. The return of this medication for disposal should be documented on the JIC box medication record sheet.

vi. The JIC box itself should be removed from the patient's home by FNHC/JHC nursing staff. The box should be cleaned, decontaminated and any paperwork removed on return to the FNHC or JHC base as per organisation policy.

vii. In care homes the medication should be returned to the dispensing pharmacy for destruction and records kept as per the organisations policy.

viii. All anticipatory medication and JIC box paperwork should be completed and filed.

ix. The JHC MDT co-ordinator must be contacted so that the electronic tracking system can be updated accordingly for JIC boxes and anticipatory medications (Residential Homes).

3.15 Tracking JIC boxes and anticipatory medications

To ensure a robust audit trail for all JIC boxes and anticipatory medications in the community setting (patient's own and residential homes), an electronic tracking system will be maintained by the JHC MDT co-ordinator.

The tracking system will be updated based on receipt of faxed or e-mailed assessment forms, updates to patient EMIS records or following direct contact from a member of the FNHC or JHC nursing staff.

The tracking system will include information on the:

- JIC box number (each box has a unique identity number).
- Patient demographics (name, date of birth and URN).
- Date anticipatory medications/JIC box put in place.
- Location of JIC box in the patient's home.
- Date of last assessment of anticipatory medications/JIC box.
- Date anticipatory prescribing medication administration record last reauthorised.
- Date anticipatory medications/JIC box removed.

The JHC MDT co-ordinator is reliant on staff from FNHC/JHC to ensure that the information in the electronic tracking database is up to date and accurate.

The JHC MDT co-ordinator should be informed in the following circumstances:

- Anticipatory medications/JIC box put in place.
- Reassessment of the patient's anticipatory medications/JIC box (monthly).
- The patients anticipatory prescribing medication administration record has been reauthorised (3 monthly).
- Removal of anticipatory medications/JIC box from a patient's home.

The JHC MDT co-ordinator should be provided with the date and name of the healthcare professional who undertook each of the above steps, in addition to any other information which needs to be updated.

The electronic tracking system has been set-up with a traffic light system to flag when reassessment of the patient's anticipatory medications, and rewrite of their medication administration is required.

Checks needed	Frequency of check	Electronic tracking flag system	
		Yellow	Red
Assessment of anticipatory medication	**Every MONTH**	**After 21 days**	**After 28 days**
Anticipatory prescribing medication administration record reauthorised	**Every 3 MONTHS**	**After 2.5 months (75 days)**	**After 3 months (90 days)**

The JHC MDT co-ordinator will regularly liaise with the FNHC clinical services administrator and relevant JHC staff to ensure they are aware when the above checks are required for patients under their care.

In the absence of the JHC MDT co-ordinator (due to leave or sickness), the SPCT pharmacist (**tel no. 786148**) or another designated person will be responsible for ensuring the electronic tracking record is kept up to date and liaising with relevant teams.

3.16 Anticipatory prescribing in different care settings

A flow chart (Appendix 13) is available to summarise the process to follow when managing anticipatory medications and JIC boxes in the community. A full summary (Appendix 14) is available of the practice requirements concerning anticipatory medications and JIC boxes in the patient home and care homes.

3.16.1 Patient's own home

When patients are temporarily admitted to a HSSD site or care home (e.g. for respite), their JIC box and its contents including anticipatory medications must be left in their home.

If there are any concerns about the security of the JIC box or if the admission is likely to be prolonged (e.g. more than 4 weeks), the requirement of the box to remain in place at the home should be discussed with the patient, family and carers as appropriate.

If the decision is taken for the JIC box and anticipatory medications to be removed from the patient's own home, the medication disposal process should be followed.

3.16.2 HSSD sites

The decision to send the patients anticipatory medications in to a HSSD site from the care home or the Hospice IPU should be based on their individual Medicines Policy and SOPs.

Anticipatory medications can be sent in with patients being admitted to an HSSD site from home where appropriate. However they should be removed from the JIC box, and the stock sheets updated accordingly. **Under no circumstances** should the JIC box itself be sent in with them. If for any reason the JIC box is brought in with the patient, arrange for it to be taken home by a family member or carer.

The receipt and storage of medications must follow the HSSD Medicines Policy.

The need for a patient to be discharged with anticipatory medications should be discussed by the wards medical, nursing and pharmacy teams, and the SPCT based in the hospital. If agreed as appropriate (following risk assessment) they should be prescribed on the patients discharge summary, and dispensed by hospital pharmacy.

Wherever possible when the patient is to be transferred to their own home or a residential home, the anticipatory prescribing medication administration record should be completed prior to discharge.

The chart should ideally be filled out by a SPCT prescriber based in the hospital. If not available this task can be undertaken by a ward doctor (Registrar level or above), or in exceptional circumstances FY2 / Clinical Fellow however prescribing support must be provided by the SPCT. The completed chart should accompany the patient home on discharge along with the prescribed medications.

It is acknowledged that not all patients who are to have anticipatory medications put in place are discharged from hospital with a completed chart. In this situation the primary care team should be contacted to ensure that an appropriate prescriber completes the chart on or prior to the day of discharge.

For patients going home with anticipatory medications, nursing staff from FNHC and/or JHC should be contacted (in addition to the GP) so that they can visit the patient as soon as possible after discharge to set up the JIC box and complete the relevant paperwork. Ensure adequate notice is given.

In certain situations (i.e. rapid discharges) two members of the SPCT may set up the JIC box and complete the paperwork prior to discharge, which can then be sent home with the patient.

3.16.3 Care Home (Residential/Nursing)

Under no circumstances should the JIC box or its contents be sent in with the patient if they are admitted to a care home (from home or the Hospice IPU).

If the patient is being transferred to the care home for a respite admission from home the JIC box and its contents should remain in the patient's own home.

If there are any concerns about the security of the JIC box or if the admission is likely to be prolonged (e.g. more than 4 weeks), the requirement of the box to remain in place at the home should be discussed with the patient, family and carers as appropriate.

If it is felt that anticipatory medications may be required during the respite admission, a prescription should be generated by the prescriber and appropriate prescribing documentation completed.

A MAR sheet should be generated by the dispensing pharmacy. The receipt and storage of the medications must follow the care homes medicines management policy. Anticipatory medications should be stored in a secure drugs cupboard, a JIC box must **never** be used.

The CD record book is held as a stock and administration record in the care home setting. Any controlled drugs **must** be signed in and out of the CD record book by a registered nurse and another responsible member of staff who acts as a witness.

All medication remains the property of the resident when they enter a care home. However the responsibility passes to the care home or carer on the death of the resident, who should ensure the safe storage of the medication until destruction at a community pharmacy can be organised. Care homes are required to retain patients' own medication (including CDs) for 7 days following their death.

3.16.4 Day Hospice

The Day Hospice nursing staff should discuss with the patient the requirement to bring in their JIC box from home, based on their clinical condition and likely requirement for subcutaneous medications when they attend.

This should be done on an individualised basis, and the requirement to bring in the box may change over time depending on the patient's clinical condition. All decisions should be documented in the patient's notes.

If the JIC box is brought in by the patient when attending Day Hospice, it should be handed over by the patient to a member of the nursing staff or other authorised person on arrival so that it can be stored in a designated locked cupboard in the Day Hospice treatment room.

If the Day Hospice nursing staff are acting as the Palliative Care Key Worker for the patient, they should undertake the regular assessment of their anticipatory medicines.

3.17 Safety and risk management

3.17.1 Unlicensed use of medications in Palliative Care

The use of medicines without a UK market authorisation ('unlicensed') or outside the terms of their product license ('off-label') is common practice in palliative care (e.g. administration of medications via the subcutaneous route), but carries the additional responsibilities for prescribers, nurses and pharmacists.

Refer to the use of unlicensed medication in each organisations Medicine Policy, or guidance from the healthcare professional's regulatory body (if not stated in organisational policy) for information. Alternatively contact the SPCT for advice.

3.17.2 Incident Reporting

An incident is any unexpected or untoward event that has a short or long-term detrimental effect on patients, clients, visitors, staff and the organisation.

Medication incidents usually fall into one of the following categories; prescribing, preparation of medicines/dispensing in pharmacy, administration/supply of medicine from a clinical area, monitoring or follow up of medicine use, or advice.

Examples of incidents include:

- Administration of incorrect medication, dose and/or route.
- A stock discrepancy with anticipatory medications in the JIC box.
- Any other incident or near miss which may compromise patient safety.

Any member of staff who is involved in, or witnesses an incident, accident or near miss should report it in line with their respective organisational policies.

In residential or nursing homes if a near miss or incident is identified by a GP or nursing staff (from FNHC/JHC), the care home manager or another designated person in their absence should be informed as soon as possible.

All relevant parties involved in an anticipatory prescribing incident should be informed, and where appropriate a joint investigation should take place. Learning from such incidents should be used to inform future practice and guidelines, and shared with staff and relevant partner organisations to reduce the likelihood of the incident re-occurring.

3.17.3 Concordance

HSSD, PCB, FNHC, CF and JHC should monitor concordance with this policy document as per local audit plans.

Some of the information from the anticipatory prescribing outcome forms can be used to monitor concordance with the policy. This will be fed back to organisations as appropriate by the SPCT.

3.17.4 Review Period

This policy will be reviewed by the multi-agency working party at a frequency of not less than a one year interval, but no more than every three years after its implementation.

4. DEVELOPMENT AND CONSULTATION PROCESS

Name of Committee / Group	Date of Committee / Group meeting / Consultation
Representatives from HSSD, FNHC, PCB, GP Champions, CF and JHC	October 2016 – October 2017 (ongoing consultation)
Chief Pharmacist, Care Home Regulators, Quality Assurance Officer and HSSD Commissioners	
Palliative Care Link Pharmacies	
End of Life Care Implementation Steering Group	October 2017 (Ratification)
HSSD Policy & Procedures Ratifying Group	December 2017 (Ratification)

5. REFERENCE DOCUMENTS

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7. GLOSSARY OF TERMS

Anticipatory Prescribing	Advance provision of medications in anticipation of symptoms occurring at the end of life.
CD	Controlled Drug
CF	Care Federation
EMIS	Egton Medical Information Systems
EOLC	End of Life Care
FNHC	Family Nursing and Home Care
GP	General Practitioner
GSF	Gold Standard Framework
HSSD	Health and Social Services Department
IPU	In-patient unit (Hospice)
JDOC	Jersey Doctors On Call
JHC	Jersey Hospice Care
JIC	Just in Case
MAR	Medication Administration Record
MDT	Multi-disciplinary team
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
PCB	Primary Care Body
PO	Per os (by mouth)
PRN	Pro re nata (when required)
RGN	Registered General Nurse
S/C	Subcutaneous
SOP	Standard Operating Procedure
SPCT	Specialist Palliative Care Team
WFI	Water for Injections

8. IMPLEMENTATION PLAN

A variety of dissemination methods will be put into place to ensure that all staff within the different healthcare organisations involved are made aware of the policy.

The policy will be deemed as ready for launch once ratified by the End of Life Care Steering Implementation Group. However the launch date may be delayed to allow training to take place for all relevant staff.

Action	Responsible Person(s)	Planned Timeline
E-mail to all clinical staff	Specialist Palliative Care Team Communications Officer (HSSD) PCB Lead (PCB)/GP Champions Information Governance (FNHC) CF Secretary and Care Home Managers (CF)	1 week prior to launch
Policy and patient information leaflet to be placed on each organisations intranet/ internet under the relevant section	Information Governance (HSSD) PCB Lead (PCB) Information Governance (FNHC) Governance Facilitator (JHC) CF Secretary (CF)	1 week prior to launch
Staff training days/sessions regarding the policy	Specialist Palliative Care Team Practice Development Team and Education Department (HSSD) GP Champions (PCB) Education and Development Co-ordinator (FNHC) Care Home Managers (CF)	Ongoing prior to and after launch
Complete audit to ensure concordance with revised policy	Specialist Palliative Care Team FNHC Nursing Team Care Home Nursing Teams	Ongoing after launch

9. APPENDICES

Appendix 1: Anticipatory prescribing patient information leaflet

Any questions

If you have any concerns before you are given anticipatory medicines, please speak to a member of your medical, nursing or pharmacy team.

Specialist Palliative Care Team
(Jersey Hospice Care)

Tel: +44 (0)1534 876555

24 hours a day

.....

Family Nursing & Home Care

Tel: +44 (0)1534 443600

Monday to Thursday 8.30am to 5pm
Friday 8.30am to 4.30pm

.....

You can also speak to your own General Practitioner.

HSS-LFT-0415-01 **April 2018**

Patient Information

Anticipatory Prescribing

This leaflet gives you an overview of the reasons you may be prescribed anticipatory medicines in palliative care

Specialist Palliative Care Team

What Anticipatory Prescribing is

Anticipatory prescribing is used to ensure that a small supply of injectable medication is available in your home or care home, in order to relieve symptoms which may occur unexpectedly at night or over a weekend.

These medicines may never be required, but anticipatory prescribing ensures that they are always available in case you need them in a hurry.

What the different medicines are for

They are usually prescribed for some or all of the below symptoms:

- pain
- sickness
- shortness of breath
- lung secretions
- restlessness and anxiety
- water for injections is used to dilute other medicines

The medicines used will depend on your individual symptoms, medical conditions, and other medicines you take.

Where you get the medicines from

A doctor or non-medical prescriber, for example a specialist nurse, will prescribe them for you. The prescription will be dispensed by:

- a community pharmacy, if you are at home or in a care home
- the hospital pharmacy, if you are an in-patient

The medicines can be collected by a family member, carer or yourself. A list of community pharmacies which usually stock these medicines is given at the end of this leaflet. Note there can sometimes be supply problems with the medicines. Check if the pharmacy have them all when you take in the prescription.

Payment for these medicines

You don't have to pay for the medicines, but you will be charged for the visit in the usual way when your GP reviews you and prescribes the anticipatory medications.

Who administers the medicines

A doctor or nurse gives the medicines to you when needed to control your symptoms.

They are usually given using a small needle which is inserted under your skin, either on your tummy, chest or on the top of your arm or leg.

You may need injections to control your symptoms if you have trouble swallowing, or absorbing your medicines when taken by mouth.

How to look after the medicines

If you are at home the medicines will be placed in a 'Just in case box' (see overleaf) by the doctor or nurses. If you are in a care home, the staff will store the medicines in their treatment room.

You must not give the medicines prescribed for you to anyone else. Keep them in a safe and cool place, out of reach of children and animals.

How long you will have the medicines for

Anticipatory medicines are only kept in place as long as you need them. The doctor or nurse will review the ongoing need for the medicines and the doses each month, or with any change in your condition.

If your condition improves and is stable, the doctor or nurse may talk to you about removing the medicines, although this will not be done without your agreement.

If we remove the medicines, we will continue to review you regularly and they can be put back in at a later stage if needed.

How the medicines are destroyed

If the medicines are no longer required, you must return them to the pharmacy that dispensed them. They must **not** be disposed of in the household waste or given to anyone else to use.

If you are being cared for at home, the district nurse or hospice nurse will take the medicines out of the 'Just in Case' box. A family member, carer or yourself should then return them to the pharmacy.

If you are in a care home, the nursing staff will return the medicines to the pharmacy to be destroyed for you.

What the 'Just in Case' box is

This is a metal box which we use to safely store the anticipatory medicines prescribed for you in your own home. If you are in a care home the box is not required.

A doctor or nurse will put your anticipatory medicines in this box, and seal it with a plastic security tag. The box has a combination lock and only members of the healthcare team have the code. The box should only be opened by a doctor, nurse or pharmacist.

The medicines remain your property. The box and paperwork just make it easier for the doctors and nurses to stock control the medicines while they are in your home. It is nothing to worry about. There will also be a medication chart authorising the nurse to give the medicines.

Taking the box into hospital or a care home

If you are admitted to the hospital or a care home, please leave your 'Just in Case' box at home. The hospital medical team or GP will review your condition. They will prescribe any anticipatory medications you may need during your stay.

If your stay is prolonged, longer than 4 weeks, or there are concerns about the boxes security in your home, the hospice or district nurse team will contact you for permission to remove the box and to destroy the medications. The need for anticipatory medications will be reviewed again when preparing your discharge.

Taking the box into the Hospice inpatient unit

If you are admitted into the Hospice in-patient unit, please take your 'Just in Case' box in with you. When you arrive on the unit, make sure you hand it over to one of the staff nurses. They will ensure that the box and medicines are stored safely during your stay.

The need for anticipatory medications will be reviewed again when preparing for your discharge. They may not be needed at home, for example if your condition has stabilised or improved.

Taking the box to the Day Hospice

Discuss this with the nursing staff at Day Hospice, the decision will be based on your individual needs.

If your condition is stable, they may not feel you need to bring the box in each time you visit. However, they may ask that you bring the box in once a month to be checked.

What happens if my box goes missing?

Call your district nurse or hospice nurse straight away for advice if:

- your box or medicines go missing from your home, or
- it looks like they have been tampered with

You do not have to worry, but we need to make sure that your medicines are safe and available at all times.

List of palliative care link pharmacies

Whoever is collecting the medicines should take their photo id, for example a driving license or passport, to the pharmacy.

Pharmacy	Tel no.	Opening Hours
Boots Pharmacy La Grande Route de St Pierre, **St. Peter** JE3 7AY	482164	**Mon to Sat:** 8.30am to 6.30pm **Sun:** 10am to 5pm
Boots Pharmacy 23-29 Queen St **St. Helier** JE2 4WD	730432	**Mon to Sat:** 8.30am to 6pm **Sun:** Closed
(Co-op) Pharmacy Locale New Era Medical Centre Georgetown, **St. Clement** JE2 6QG	720642	**Mon to Fri:** 8.30am to 6.30pm **Sat:** 8.30am to 5pm **Sun:** 10am to 2pm
Island Pharmacy 14 Gloucester St **St. Helier** JE2 3QR	516171	**Mon to Fri:** 8am to 6.30pm **Sat:** 8.30am to 1pm **Sun:** Closed
Le Quesne's 25 Don St. **St. Helier** JE2 4TR	722571	**Mon to Fri:** 8.30am to 5.45pm **Sat:** 9am to 5pm **Sun:** Closed
Lloyds Pharmacy 1 Centrepoint **St. Brelades** JE3 8LB	741313	**Mon to Fri:** 8.30am to 6pm **Sat:** 9am to 5pm **Sun:** Closed
LV Pharmacy 24 Beresford St **St Helier** JE2 4WN	870771	**Mon to Fri:** 8am to 5.30pm **Sat:** 9am to 12.30pm **Sun:** Closed
Queens Road Pharmacy Queens Rd **St. Helier** JE2 4HY	762983	**Mon to Fri:** 8.30am to 6pm **Sat:** 9am to 1pm **Sun:** Closed
Roseville Pharmacy 7 Roseville St. **St. Helier** JE2 4PJ	734698	**Mon to Sat:** 9am to 9.30pm **Sun:** 9.30am to 9.30pm (closed 1pm to 2pm)

Appendix 2: Anticipatory medication assessment form (Patient home)

Family Nursing & Home Care | Jersey Hospice Care

Anticipatory Medications Assessment Form (Patient Home)

Jersey Care Federation | Primary Care Body | States of Jersey

SURNAME: _____ FORENAMES: _____ ADDRESS: _____ _____ URN: _____ DOB: _____		GP Name	
		GP Telephone no.	
		Palliative Care Key Worker	Tel no.

ADDRESSOGRAPH

GSF Code (tick)	Blue (A) ☐ Year plus prognosis	Green (B) ☐ Months prognosis	Amber (C) ☐ Weeks prognosis	Red (D) ☐ Days prognosis

Section 1: Inclusion Criteria (tick)	Yes	No	Comments
Patient has a poor prognosis, and their condition is unpredictable or is likely to deteriorate rapidly? GSF Prognostic Indicator Guidance of 'Deteriorating' (Amber) or 'Terminal Care' (Red)			
Based on your clinical judgement are anticipatory medications indicated for this patient?			
If YES to both questions proceed to section 2 **If NO to any question discuss with multi-disciplinary team (MDT) if anticipatory medications are appropriate***			
Section 2: Potential risks (tick)	**Yes**	**No**	**Comments**
Patient/carers unwilling to participate, e.g. due to fears anticipatory medications are a provision for euthanasia? (concerns can be allayed by good communication and reassurance)			
Is there documented history or suspicion of drug misuse by the patient, family, carers or visitors to the home?			
Are there any documented concerns about the mental health/well-being of the patient, family, carers or visitors to the home (e.g. suicidal ideation)?			
If YES to any question discuss with MDT if anticipatory medications are appropriate* **If NO to all questions confirm with patients GP anticipatory medications are appropriate, then proceed to section 3**			
Section 3: Patient/carer education (tick)	**Yes**	**No**	**Comments**
Has the purpose and benefits of anticipatory medications been discussed with the patient and/or carers?			
Has a patient information leaflet been given to the patient/carers?			
Have precautions been discussed to ensure the JIC box will be stored securely and cannot be accessed by a child, animal or vulnerable member of the household?			
Discussion with patient/carers to confirm that the items in JIC box are for use by healthcare professionals only?			

Completed by:

Date	Name (print)	Signature	Role

Turn over page

PATIENT'S NAME ..... **DOB** ..... **URN** .....

Section 4: Just in Case (JIC) box details (tick)			
Organised by:	**Jersey Hospice Care (JHC)** ☐ **Family Nursing & Homecare (FNHC)** ☐	**Team location:**	**Town** ☐ **East** ☐ **West** ☐
Location of JIC box in patient's home		**JIC Box number:**	

Section 5: Checklist for putting anticipatory medications in place	**Initial**	**Comments**
Anticipatory prescribing medication administration record completed in full by registered prescriber		
Medications prescribed on a appropriate prescription form (community or hospital) by registered prescriber		
Patient/carer given contact details of nearby Palliative Care Link Pharmacies where medications are available to be dispensed		
Medication record sheets completed (once medications are available)		
Medications placed in JIC box and sealed using security tag, and tag sheet completed		
Fax or e-mail assessment form to JHC MDT co-ordinator to update database for tracking anticipatory medications/JIC boxes		
Contact FNHC (tel. 446300) and Specialist Palliative Care Team (tel. 876555) to inform them anticipatory medications are in place		

Completed by:

Date	**Name (print)**	**Signature**	**Role**

File the original assessment form in the patient care records.
A copy should be faxed (fax. 720292) or e-mailed (CommunityTeam@jerseyhospicecare.com)
to the Jersey Hospice Care MDT co-ordinator.

Additional comments (e.g. outcome of any MDT discussion*)			
Date	**Name (print)**	**Signature**	**Role**

Appendix 3: Anticipatory medication assessment form (Care homes)

Anticipatory Medications Assessment Form (Care Homes)

SURNAME: _____ FORENAMES: _____ ADDRESS: _____ _____ URN: _____ DOB: _____		GP Name	
		GP Telephone no.	
		Palliative Care Key Worker	Tel no.

GSF Code (tick)	Blue (A) ☐ Year plus prognosis	Green (B) ☐ Months prognosis	Amber (C) ☐ Weeks prognosis	Red (D) ☐ Days prognosis

Section 1: Inclusion Criteria (tick)	Yes	No	Comments
Patient has a poor prognosis, and their condition is unpredictable or is likely to deteriorate rapidly? GSF Prognostic Indicator Guidance of 'Deteriorating' (Amber) or 'Terminal Care' (Red)			
Based on your clinical judgement are anticipatory medications indicated for this patient?			

If YES to both questions proceed to section 2

If NO to any question discuss with multi-disciplinary team (MDT) if anticipatory medications are appropriate

Section 2: Potential risks (tick)	Yes	No	Comments
Patient/carers unwilling to participate, e.g. due to fears anticipatory medications are a provision for euthanasia? (concerns can be allayed by good communication and reassurance)			

If YES to above question discuss with MDT if anticipatory medications are appropriate

If NO to above question confirm with patient GP anticipatory medications are appropriate, then proceed to section 3

Section 3: Patient/carer education (tick)	Yes	No	Comments
Has the purpose and benefits of anticipatory medications been discussed with the patient and/or family?			
Has a patient information leaflet been given to the patient/family?			

Section 4: Checklist for putting anticipatory medications in place	Initial	Comments
Anticipatory prescribing medication administration record completed in full by registered prescriber		
Medications prescribed on a health insurance prescription form by registered prescriber		
Prescription sent to a community pharmacy for medications to be dispensed		
Medication recorded and stock controlled as per Care Home Medicines Policy		
Fax or e-mail assessment form to JHC MDT co-ordinator to update database for tracking anticipatory medications		
Contact FNHC (tel. 443600) and Specialist Palliative Care Team (tel. 876555) to inform them anticipatory medications are in place (residential home)		

Date Completed	Name (print)	Signature	Role

File the original assessment form in the patient care records. A copy should be faxed (fax. 720292) or e-mailed (CommunityTeam@jerseyhospicecare.com) to the Jersey Hospice Care MDT co-ordinator.

Appendix 4: Anticipatory Prescribing Medication Administration Record

Family Nursing & Home Care | Jersey Hospice Care

ANTICIPATORY PRESCRIBING MEDICATION ADMINISTRATION RECORD

Jersey Care Federation | Primary Care Body | States of Jersey

SURNAME: _____

FORENAMES: _____

ADDRESS: _____

_____

URN: _____ DOB: _____

ADDRESSOGRAPH

GP NAME	
GP SURGERY	
GP TELEPHONE NO.	
PALLIATIVE CARE KEY WORKER	Tel no.

DRUG ALLERGIES & SENSITIVITIES

PLEASE CIRCLE AS APPROPRIATE

NONE KNOWN YES

SIGNED: .....

NAME: .....

DATE: ..... ROLE: .....

THIS SECTION SHOULD BE COMPLETED PRIOR TO ADMINISTRATION OF ANY MEDICINE

DRUG / ALLERGEN (describe reaction)

PRESCRIPTIONS FOR ONCE ONLY MEDICATIONS

DATE	MEDICINE (Approved Name)	DOSE	ROUTE	TIME TO GIVE	PRESCRIBER SIGNATURE	DATE	TIME GIVEN	GIVEN BY	CHECK BY

JUST IN CASE BOX INFORMATION (PLEASE TICK)

JUST IN CASE BOX IN PLACE:

YES ☐ NO ☐

BOX NO. .....

DETAILS OF SUPPLEMENTARY CHARTS (PLEASE TICK)

- ☐ SYRINGE PUMP
- ☐ SUPPLEMENTARY INFUSION CHART
- ☐ OTHER (specify) .....

CHART RE-AUTHORISED (every 3 months)

PRESCRIBER SIGNATURE	DATE

AS REQUIRED MEDICINES

DATE	MEDICINE (Approved Name)										
	WATER FOR INJECTIONS	DATE										
		TIME										
PRESCRIBER SIGNATURE	INDICATION	DOSE										
	DILUENT / FLUSH	GIVEN BY										
DATE	MEDICINE (Approved Name)	DATE										
		TIME										
DOSE / ROUTE / FREQUENCY / MAX DOSE IN 24 HOURS		DOSE										
		ROUTE										
PRESCRIBER SIGNATURE	INDICATION	GIVEN BY										

PATIENT'S NAME .... DOB .... URN ....

AS REQUIRED MEDICINES

DATE	MEDICINE (Approved Name)			DATE										
				TIME										
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE										
				ROUTE										
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY										
DATE	MEDICINE (Approved Name)			DATE										
				TIME										
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE										
				ROUTE										
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY										
DATE	MEDICINE (Approved Name)			DATE										
				TIME										
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE										
				ROUTE										
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY										
DATE	MEDICINE (Approved Name)			DATE										
				TIME										
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE										
				ROUTE										
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY										
DATE	MEDICINE (Approved Name)			DATE										
				TIME										
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE										
				ROUTE										
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY										
DATE	MEDICINE (Approved Name)			DATE										
				TIME										
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE										
				ROUTE										
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY										

Appendix 5: Anticipatory prescribing guidance

Anticipatory Prescribing Guidance

Anticipatory prescribing avoids delays in treating the most common symptoms at the end of life, improves symptom control and may prevent unwanted admissions to Hospital or Hospice. Plan ahead and consider it early on.

'Just in Case' (JIC) boxes are a small part of anticipatory prescribing, and is a system to improve the security and audit trail of medications prescribed. JIC boxes are only to be used in patients own homes, and not other care settings.

The below medications are suggested for anticipatory prescribing assuming that there are no known allergies or contra-indications (e.g. renal failure, hepatic failure). **Refer to the medication algorithms for symptom control in the last days of life, or the Ambulatory Syringe Pump Policy for additional prescribing recommendations.**

SYMPTOM	MEDICATION	ADVISED STARTING DOSE	SUGGESTED QUANTITY*
PAIN	DIAMORPHINE	Opioid naive patients: **2.5-5mg s/c 1 hourly prn** If the patient is already taking opioids refer to the conversion table overleaf and consult the syringe pump policy	5 (FIVE) AMPOULES OF 5mg
NAUSEA & VOMITING	LEVOMEPROMAZINE	**6.25mg s/c 6 hourly prn (max 25mg/24 hours)** NB: Higher doses are used for agitation Alternative anti-emetics may be more appropriate depending on the cause of symptoms and patient medical history	5 AMPOULES OF 25mg/ml
AGITATION & ANXIETY	MIDAZOLAM (if patient is ANXIOUS, FRIGHTENED, BUT LUCID)	**2.5-5mg s/c 1 hourly prn**	5 (FIVE) AMPOULES OF 10mg/2ml
	HALOPERIDOL (if patient is CONFUSED, AGITATED and/or HALLUCINATING)	**1-2.5mg s/c 4 hourly prn (max 10mg/24 hours)** NB: Lower doses are used for nausea	5 AMPOULES OF 5mg/ml
RESPIRATORY SECRETIONS	GLYCOPYRRONIUM BROMIDE	**200 micrograms s/c 4 hourly prn**	10 AMPOULES OF 200 micrograms/ml
BREATHLESSNESS	DIAMORPHINE	Opioid naive patients: **1.25-2.5mg s/c 1 hourly prn** If the patient is already taking opioids refer to the conversion table overleaf and consult the syringe pump policy	USE SUPPLY PRESCRIBED FOR PAIN
Remember to prescribe WATER FOR INJECTIONS (diluent for Diamorphine ampoules and flush)			10 AMPOULES OF 10ml
CRISIS DOSE (i.e. seizure or haemorrhage)	MIDAZOLAM Only prescribe if patient at risk of a seizure and/or bleed	**10mg s/c stat** **AND / OR** **10mg by buccal route stat**	USE SUPPLY PRESCRIBED FOR ANXIETY 2 (TWO) PRE-FILLED ORAMUCOSAL SYRINGES OF 10mg/2ml

***Suggested quantities are a guide, if expected usage is likely to be higher adjust the quantity prescribed accordingly.**

The prescriber must complete the Anticipatory prescribing medication administration record AND Health Insurance prescription form (community patients) OR HSSD discharge prescription (hospital in-patients)

Anticipatory Prescribing Guidance

The below tables only give approximate dosages for opioid conversion, due to the risk of toxicity it may be necessary to use lower doses especially in patients who are:

- Elderly and frail.
- Opioid naive.
- In renal impairment.
- In hepatic impairment.
- Already on high doses of opioids (there may be incomplete cross tolerance, it is normal practice to reduce the dose by 30-50%).

Review patients' regularly after opioid switching, check for signs of toxicity and their level of pain control.

OPIOID DOSE CONVERSION GUIDE Note that dose conversions are approximate only							
PO Morphine	24hr total dose (mg)	30	60	120	180	240	360
	breakthrough dose (mg)	5	10	20	30	40	60
S/C Diamorphine	24hr total dose (mg)	10	20	40	60	80	120
	breakthrough dose (mg)	2.5	2.5-5	7.5	10	12.5-15	20
PO Oxycodone	24hr total dose (mg)	15	30	60	90	120	180
	breakthrough dose (mg)	2.5	5	10	15	20	30
S/C Oxycodone	24hr total dose (mg)	7.5-10	15-20	30-40	45-60	60-80	90-120
	breakthrough dose (mg)	1.25-2.5	2.5-5	5-7.5	7.5-10	10-15	15-20
Fentanyl Patch	72 hour patch (micrograms/hr)	12	25	50	75	100	150

Buprenorphine patches:

Buprenorphine patch strength (micrograms/hr)	PO Morphine		PO Oxycodone	
	24 hour total dose (mg)	breakthrough dose (mg)	24 hour total Dose (mg)	breakthrough dose (mg)
5	12	2	6	1
10	24	4	12	2
15	36	6	18	3
20	48	8	24	4

Fentanyl or Buprenorphine patches should <u>not</u> be started as a form of pain control at the end of life.

If a patient is already on an opioid patch **DO NOT REMOVE IT** (unless there are concerns related to efficacy or toxicity), if you need to increase the level of pain control add a syringe pump (see Ambulatory Syringe Pump Policy for further information).

References:
Twycross R., Wilcock A., & Howard P. (2017) *PCF6: Palliative Care Formulary (6th Ed.)*. Oxford: Radcliffe Medical Press.
Palliative Adult Network Guidelines. Accessed via http://book.pallcare.info/index.php

Appendix 6: Medication algorithms for end of life care

Family Nursing & Home Care

Jersey Hospice Care

States of Jersey

Health & Social Services

PRIMARY CARE BODY

JERSEY CARE FEDERATION

Supporting Last Days of Life
Symptom Control Medication Guidance: Algorithm

Agitation & Anxiety

Present

(Exclude or treat **REVERSIBLE causes***)

Patient is **anxious / frightened**, but **lucid**

Prescribe MIDAZOLAM 2.5-5mg s/c 1 hourly prn (Max total 24 hour dose of 60mg)

If patient requires 3 doses at hourly intervals seek prompt medical review

Review after 24 hours. If 3 or more doses are required then consider use of a CSCI (Continuous Subcutaneous Infusion)

Continue to give prn doses as needed (Max total 24 hour dose of 60mg)

Patient is **confused, agitated** and / or **hallucinating**

Prescribe **HALOPERIDOL 1-2.5mg s/c 4 hourly prn** (Max total 24 hour dose of 10mg)

Review after 24 hours

If 3 or more doses are required then consider value of giving 2.5-10mg over 24 hours via a CSCI

The dose can be titrated to max of 10mg over 24 hours

If patient is still agitated and distressed, consider adding in Midazolam to the CSCI

Absent

Prescribe **MIDAZOLAM 2.5-5mg s/c 1 hourly prn** (Max total 24 hour dose of 60mg)

If patient requires 3 doses at hourly intervals seek prompt medical review

Review after 24 hours. If 3 or more doses are required then consider use of a CSCI

SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

Exclude or treat **REVERSIBLE causes***, e.g. alcohol withdrawal, hypercalcaemia, infection, opioid toxicity, urinary retention or constipation.

If a dose range is prescribed always commence at the lower dose.

The treatment of agitation and anxiety does not usually require the use of opioids unless it is thought to be caused by pain.

LEVOMEPROMAZINE 12.5-25mg s/c 6 hourly prn (Max total 24 hour dose of 100mg) can be used as an alternative to Haloperidol.

If using either Levomepromazine or Haloperidol for the management of nausea and vomiting this should be taken into account when titrating doses for agitation and restlessness.

Consider dose reduction for the elderly, frail or patients with dementia.

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

Twycross R., Wilcock A., & Howard P. (2017) *PCF6: Palliative Care Formulary (6th Ed.)*. Oxford: Radcliffe Medical Press.
Palliative Adult Network Guidelines. Accessed via http://book.pallcare.info/index.php

Family Nursing & Home Care

Jersey Hospice Care

States of Jersey
The States of Jersey Department for Health & Social Services

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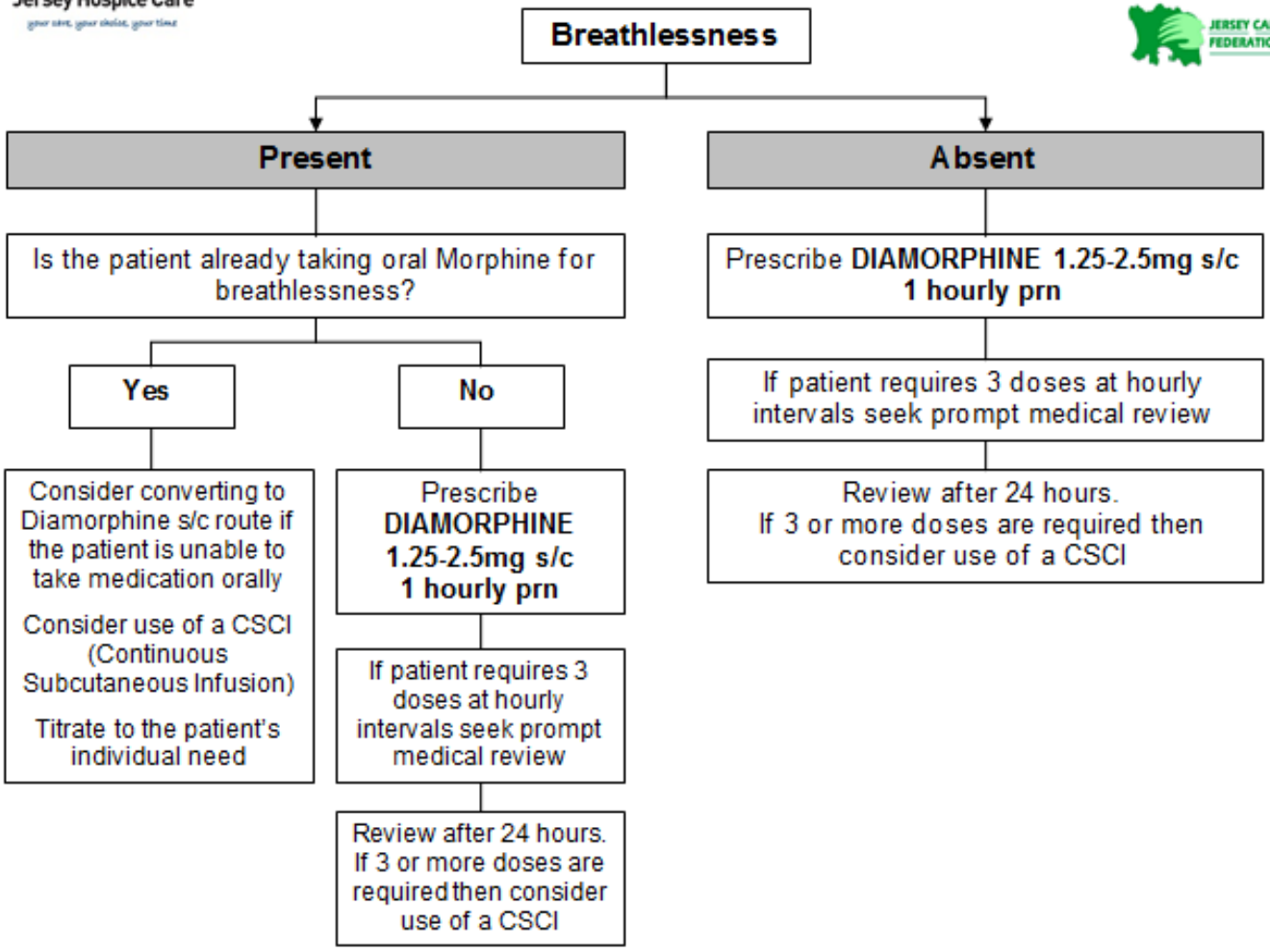
JERSEY CARE FEDERATION

Supporting Last Days of Life
Symptom Control Medication Guidance: Algorithm



SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team (SPCT) for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

If the patient is breathless and anxious, consider MIDAZOLAM 2.5mg s/c 1 hourly prn.

If a dose range is prescribed always commence at the lower dose.

To convert oral Morphine to a 24 hour CSCI of Diamorphine divide the total (24 hour) dose of Morphine by 3 (e.g. 30mg bd orally = 60mg morphine in 24hrs ÷ 3 = Diamorphine 20mg via a CSCI).

For breakthrough breathlessness prescribe a prn dose of Diamorphine which is 1/6th of total 24 hour dose (i.e. the equivalent of Diamorphine 30mg subcutaneously over 24 hours = 5mg s/c 1 hourly prn).

If using opiates for the management of pain this should be taken into account when titrating opiates for breathlessness.

Consider dose reduction for the elderly, frail or patients with dementia and mild / moderate renal impairment (avoid Diamorphine and Morphine in renal failure – seek advice from SPCT).

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

Twycross R., Wilcock A., & Howard P. (2017) *PCF6: Palliative Care Formulary (6th Ed.)*. Oxford: Radcliffe Medical Press.
Palliative Adult Network Guidelines. Accessed via http://book.pallcare.info/index.php

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Supporting Last Days of Life
Symptom Control Medication Guidance: Algorithm

Nausea & Vomiting

Present

If the patient is already being given anti-emetics, review the benefit of continued use

Prescribe **LEVOMEPROMAZINE 6.25mg s/c 6 hourly prn**
(Max total 24 hour dose of 25mg)

Use alternative* if Levomepromazine has already been given and is ineffective

Review after 24 hours (earlier review may be required if patient does not respond to Levomepromazine after 2 doses)

If 2 or more doses are required over a 24 hour period then consider use of giving 12.5mg over 24 hours via a CSCI (Continuous Subcutaneous Infusion)

The dose can be titrated to a max of 25mg over 24 hours

Absent

Is the patient already being given anti-emetics?

Yes

Continue treating with current anti-emetics

Review if nausea and vomiting develop

No

Prescribe **LEVOMEPROMAZINE 6.25mg s/c 6 hourly prn**

(Max total 24 hour dose of 25mg)

SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

***Alternative anti-emetics may be prescribed:**

- **CYCLIZINE 50mg s/c TDS prn (max 150mg via a CSCI over 24 hours) – NOT recommended in patients with heart failure**
- **HALOPERIDOL 0.5-1.5mg s/c 6 hourly prn (1.5-5mg via a CSCI over 24 hours)**

If using either Levomepromazine or Haloperidol for the management of agitation and restlessness this should be taken into account when titrating doses for nausea and vomiting.

Consider dose reduction for the elderly, frail or patients with dementia.

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

Twycross R., Wilcock A., & Howard P. (2017) *PCF6: Palliative Care Formulary (6th Ed.)*. Oxford: Radcliffe Medical Press.
Palliative Adult Network Guidelines. Accessed via http://book.pallcare.info/index.php

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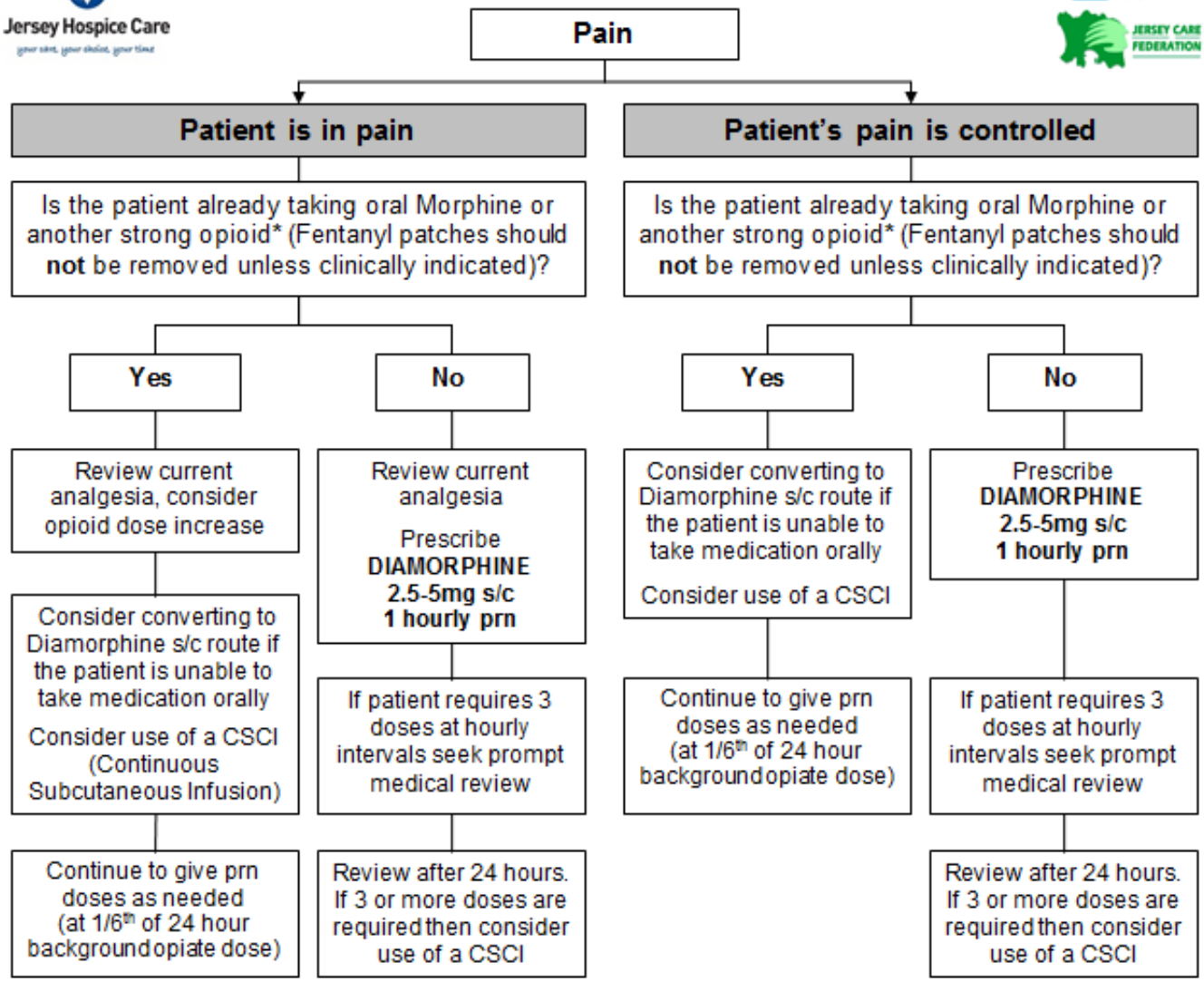
Symptom Control Medication Guidance: Algorithm



SUPPORTING INFORMATION:

***For conversion of all other strong opioids (e.g. Oxycodone, Fentanyl) into a CSCI / prn doses, or if symptoms persist please contact the Specialist Palliative Care Team (SPCT) for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.**

If a dose range is prescribed always commence at the lower dose.

To convert oral Morphine to a 24 hour CSCI of Diamorphine divide the total (24 hour) dose of Morphine by 3 (e.g. 30mg bd orally = 60mg morphine in 24hrs ÷ 3 = Diamorphine 20mg via a CSCI).

For breakthrough pain prescribe a prn dose of Diamorphine which is 1/6th of total 24 hour dose (i.e. the equivalent of Diamorphine 30mg subcutaneously over 24 hours = 5mg s/c 1 hourly prn).

If using opiates for the management of breathlessness this should be taken into account when titrating opiates for pain.

Consider dose reduction for the elderly, frail or patients with dementia and mild / moderate renal impairment (avoid Diamorphine and Morphine in renal failure – seek advice from SPCT).

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

Twycross R., Wilcock A., & Howard P. (2017) *PCF6: Palliative Care Formulary (6th Ed.)*. Oxford: Radcliffe Medical Press.
Palliative Adult Network Guidelines. Accessed via http://book.pallcare.info/index.php

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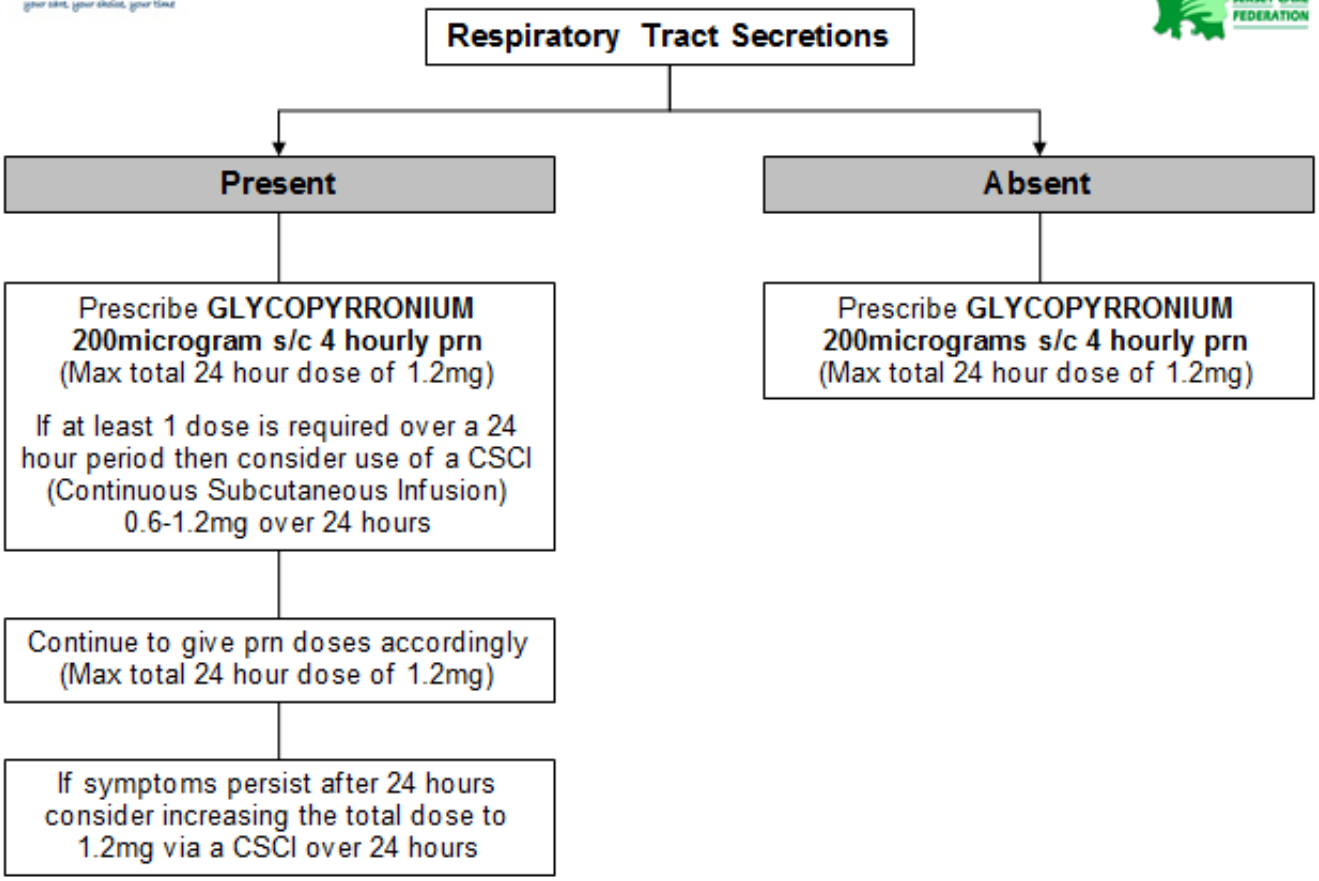
Symptom Control Medication Guidance: Algorithm



SUPPORTING INFORMATION:

If symptoms persist please contact the Specialist Palliative Care Team (SPCT) for advice on 01534 876555 (24 hour service). Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside work hours (Mon-Fri 09.00-17.00) via switchboard.

HYOSCINE HYDROBROMIDE 400micrograms s/c 4 hourly prn (Max total 24 hour dose of 2.4mg) can be used as an alternative.

If Glycopyrronium OR Hyoscine Hydrobromide have been used and found to be ineffective, do NOT switch to the alternative option - instead please contact the SPCT for advice.

Early treatment of respiratory tract secretions is essential. If treatment with the above medications is withheld until the patient already has excessive secretions they are unlikely to be effective.

Please note that treatment will only reduce secretions for about 50-66% of patients[1].

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay responding to a symptom if it occurs.

[1] Twycross R., Wilcock A., & Howard P. (2017) *PCF6: Palliative Care Formulary (6th Ed.)*. Oxford: Radcliffe Medical Press. Palliative Adult Network Guidelines. Accessed via http://book.pallcare.info/index.php

Appendix 7: Palliative care link pharmacy contact details

Pharmacy	Tel No	Opening Hours
Boots Pharmacy La Grande Route de St Pierre **St. Peter** JE3 7AY	482164	**Mon to Sat: 8.30am to 6.30pm** **Sun: 10am to 5pm**
Boots Pharmacy 23 to 29 Queen St **St. Helier** JE2 4WD	730432	**Mon to Sat: 8.30am to 6pm** **Sun: Closed**
(Co-op) Pharmacy Locale New Era Medical Centre Georgetown **St. Clement** JE2 6QG	720642	**Mon to Fri: 8.30am to 6.30pm** **Sat: 8.30am to 5pm** **Sun: 10am to 2pm**
Island Pharmacy 14 Gloucester St **St. Helier** JE2 3QR	516171	**Mon to Fri: 8am to 6.30pm** **Sat: 8.30am to 1pm** **Sun: Closed**
Le Quesne's 25 Don St. **St. Helier** JE2 4TR	722571	**Mon to Fri: 8.30am to 5.45pm** **Sat: 9am to 5pm** **Sun: Closed**
Lloyds Pharmacy 1 Centrepoint **St. Brelades** JE3 8LB	741313	**Mon to Fri: 8.30am to 6pm** **Sat: 9am to 5pm** **Sun: Closed**
LV Pharmacy 24 Beresford St **St Helier** JE2 4WN	870771	**Mon to Fri: 8am to 5.30pm** **Sat: 9am to 12.30pm** **Sun: Closed**
Queens Road Pharmacy Queens Rd **St. Helier** JE2 4HY	762983	**Mon to Fri: 8.30am to 6pm** **Sat: 9am to 1pm** **Sun: Closed**
Roseville Pharmacy 7 Roseville St. **St. Helier** JE2 4PJ	734698	**Mon to Sat: 9am to 9.30pm** **Sun: 9.30am to 9.30pm (closed 1pm to 2pm)**

Note that opening hours for public holidays will differ, contact the individual pharmacy for further information if required.

Appendix 8: Palliative care link pharmacy medication stock list

Drug Name	Strength	Form	Pack size	Min Stock Level
Buprenorphine	5 micrograms/hour	Patch (CD)	4 patches	4 patches
Cyclizine	50mg/ml	Injection	5 ampoules	10 ampoules
Dexamethasone	500 micrograms	Tablet	28 tablets	28 tablets
Dexamethasone	2mg	Tablet	50 tablets	28 tablets
Dexamethasone	3.3mg/ml	Injection	5 vials	10 vials
Diamorphine	5mg	Injection (CD)	5 ampoules	10 ampoules
Diamorphine	10mg	Injection (CD)	5 ampoules	10 ampoules
Diazepam	10mg	Enema	5 rectal tubes	5 tubes
Fentanyl	12 micrograms/hour	Patch (CD)	5 patches	5 patches
Fentanyl	25 micrograms/hour	Patch (CD)	5 patches	5 patches
Fentanyl	50 micrograms/hour	Patch(CD)	5 patches	5 patches
Glycopyrronium	200 micrograms/ml	Injection	10 ampoules	10 ampoules
Glycopyrronium	600 micrograms/3ml	Injection	10 ampoules	10 ampoules
Haloperidol	5mg/ml	Injection	10 ampoules	10 ampoules
Hyoscine Butylbromide	20mg/ml	Injection	10 ampoules	10 ampoules
Hyoscine Hydrobromide	400 micrograms/ml	Injection	10 ampoules	10 ampoules
Hyoscine Hydrobromide	1mg/72 hours	Patch	2 patches	2 patches
Levomepromazine	25mg/ml	Injection	10 ampoules	10 ampoules
Lorazepam	1mg	Tablet	28 tablets	28 tablets
Metoclopramide	10mg/2ml	Injection	10 ampoules	10 ampoules
Midazolam	10mg/2ml	Injection	10 ampoules	10 ampoules
Midazolam	10mg/2ml	Buccal Solution	4 pre-filled syringes	2 pre-filled syringes
Morphine	5mg	Modified Release Tablet (CD)	60 tablets	28 tablets
Morphine	10mg	Modified Release Tablet (CD)	60 tablets	28 tablets
Morphine	30mg	Modified Release Tablet (CD)	60 tablets	28 tablets
Morphine	10mg/5ml	Oral Solution (CD)	100ml	200ml
Morphine	10mg	Immediate Release Tablet (CD)	56 tablets	56 tablets
Oxycodone	5mg	Modified Release Tablet (CD)	28 tablets	28 tablets
Oxycodone	10mg	Modified Release Tablet (CD)	56 tablets	28 tablets
Oxycodone	5mg/5ml	Liquid (CD)	250ml	100ml
Oxycodone	5mg	Immediate Release Capsule (CD)	56 capsules	28 capsules
Oxycodone	10mg/1ml	Injection (CD)	5 ampoules	10 ampoules
Sodium Chloride	0.9% (10ml)	Injection	10 ampoules	20 ampoules
Water For Injections	(10ml)	Injection	10 ampoules	20 ampoules

It should be noted that the Palliative Care Link Pharmacies will aim to hold the above stock list at all times, however this may not always be possible for instance if there is a supply issue from the manufacturers or wholesalers.

Appendix 9: List of consumables needed for patients with anticipatory medicines

The below list includes items needed for a syringe pump, in addition to those used to administer the anticipatory medications subcutaneously.

Consumables (Anticipatory prescribing)	Minimum quantity
Adhesive plasters	-
Adhesive tape roll	1
Mediswabs	-
Filter needles	10
Needles (23 gauge - blue)	10
Needles (25 gauge - orange)	10
Sharps bin	1
Syringes - 1ml, 5ml and 10ml	5 of each size
Transparent surgical dressings	5
Consumables (Syringe Pump)	**Minimum quantity**
Battery - 9V alkaline (e.g. Duracell MN1604 or equivalent)	1
Cannula and subcutaneous infusion set for syringe pump (per practice of each organisation)	3 of each
Luer lock syringes - 20ml and 30ml (BD Plastipak)	3 of each size
Medication additive label (for syringe pump)	3

It is important that all professionals caring for palliative care patients who have anticipatory medications in place should have access to these consumables when they are planning to visit the patient's place of residence.

It is advised that GPs and nursing staff (from FNHC and JHC) who are undertaking home visits keep the required stock of consumables stored in an appropriate opaque container available at their base of work. When travelling by car these kits should be kept out of sight, and locked in their car boot.

Nursing homes should also hold a stock of these consumables for use by their own staff or visiting professionals. Quantities held should be relative to the number of palliative care patients being looked after, so may need to exceed the minimum quantities stated above.

Appendix 10: Just in case (JIC) box medication record sheet

Just in Case (JIC) Box Medication Record Sheet

Family Nursing & Home Care · Jersey Hospice Care · Jersey Care Federation · Primary Care Body · States of Jersey

SURNAME: _____

FORENAMES: _____

ADDRESS: _____

_____

URN: _____ DOB: _____

ADDRESSOGRAPH

MEDICATION	
NAME	
STRENGTH	
DOSAGE FORMULATION	

DATE	TIME	NO. OF DOSE UNITS RECEIVED	NO. OF DOSE UNITS USED	BATCH NUMBER	EXPIRY DATE	STOCK BALANCE	SIGNATURE(s)

Hospice IPU Admission: Make an entry below to record the stock balance in JIC box on admission.

DATE	TIME	NO. OF DOSE UNITS	SIGNATURE	SIGNATURE

Disposal: Record below when the medication is removed from JIC box to be sent to a pharmacy for destruction.

DATE	TIME	NO. OF DOSE UNITS TO BE DESTROYED	BATCH NUMBER	EXPIRY DATE	SIGNATURE	SIGNATURE

Appendix 11: Just in case (JIC) box security tag sheet

Family Nursing & Home Care | Jersey Hospice Care

Just in Case (JIC) Box Security Tag Sheet

Jersey Care Federation | Primary Care Body | States of Jersey

SURNAME: _____

FORENAMES: _____

ADDRESS: _____

_____

ADDRESSOGRAPH

URN: _____ DOB: _____

The tag should be broken and replaced:

- **Once a month when the JIC box contents are routinely checked.**
- **When medications are received into or given from the JIC box.**

DATE	TIME	SECURITY TAG IN PLACE AND INTACT? (Yes/No)*	IF BOX IS OPENED, STOCK OF ALL MEDICATIONS CORRECT? (Yes/No/Not applicable)*	TAG NUMBER	SIGNATURE(s)

* If it is suspected the tag has been tampered with or there is a stock discrepancy, contact your team leader immediately and investigate accordingly.

Appendix 12: Anticipatory prescribing outcome form

Anticipatory Prescribing Outcome Form

SURNAME: _____

FORENAMES: _____

ADDRESS: _____

_____

URN: _____ DOB: _____

ADDRESSOGRAPH

Fax (no. 720292) or e-mail communityteam@jerseyhospicecare.com completed forms to the specialist palliative care team

ANTICPATORY MEDICATIONS	DATE REQUESTED	DATE PUT IN	DATE REMOVED	JUST IN CASE (JIC) BOX (tick)	☐ Yes ☐ No
				JIC BOX PUT IN PLACE BY (tick)	☐ Jersey Hospice ☐ Family Nursing
ANTICIPATORY MEDICATION ASSESSMENT FORM COMPLETED (tick)	☐ Yes ☐ No	If 'No' contact the team who requested the anticipatory medications to notify them of this omission			
ANY PROBLEMS GETTING MEDICINES INTO PATIENT CARE SETTING? (tick)	☐ None ☐ Medication unavailable at pharmacy ☐ Other (please state)	☐ Delay in prescribing ☐ Medication chart not completed			
REASON MEDICINES REMOVED (tick)	☐ Patient condition stabilised ☐ Change of care setting ☐ Other (please state)	☐ Patient died ☐ Admitted to Hospice IPU			

DID ANTICIPATORY MEDICATIONS PREVENT? (tick)	Yes	No	OTHER COMMENTS
JDOC OUT OF HOURS CALL			
ADMISSION TO HOSPITAL			
ADMISSION TO HOSPICE IPU			

MEDICATION NAME	STRENGTH	QUANTITY DISPENSED	QUANTITY USED	QUANTITY RETURNED FOR DESTRUCTION
DIAMORPHINE	5mg			
	10mg			
OXYCODONE	10mg/ml			
	20mg/2ml			
LEVOMEPROMAZINE	25mg/ml			
HALOPERIDOL	5mg/ml			
MIDAZOLAM	10mg/2ml			
GLYCOPYRRONIUM	200microgram/ml			
	600microgram/3ml			
OTHER (please state)				

Date	Name (print)	Signature	Role

Appendix 13: Flow chart for anticipatory prescribing

Flow Chart for Anticipatory Prescribing

This flow chart provides an overview of the process related to anticipatory prescribing and Just in Case (JIC) boxes. Refer to the Anticipatory Prescribing policy for detailed information, particularly related to specific care settings.

At ALL stages any actions taken by a healthcare professional should be documented in the patients notes.

Identification of patients for Anticipatory Medications:
Patient assessed as needing anticipatory medications using clinical judgement and the GSF Prognostic Indicator Guideline.
Discuss with multi-disciplinary team (MDT) to get agreement this is appropriate.
Complete assessment form and send to Jersey Hospice Care (JHC) MDT co-ordinator by fax, or electronically (EMIS/e-mail).

↓

Patient, family and carer education:
Discuss process with patient, family and carer. Gain consent, undertake education and provide patient information leaflet.

↓

Prescribing Anticipatory Medications:
Prescriber writes health insurance prescription form (or hospital discharge summary),
and completes anticipatory prescribing medication administration record.

↓

Dispensing of Anticipatory Medications:
Patient, family or carer takes health insurance prescription form to a palliative care link community pharmacy, medication dispensed and collected (person collecting medication needs their own photographic ID).
Care home residents: A Medication Administration Record (MAR) sheet will be generated by community pharmacy.
Hospital discharges: The discharge summary prescription will be dispensed by the hospital and collected by the ward staff.

↓

Anticipatory Medication Stock Control:
Patient own home: Registered practitioners place dispensed medications in a JIC box, tag the box and store in a safe place.
Care Homes: Medications to be stored in designated medicine cupboard(s) in line with Medicines Policy.

↓

Appropriate documentation should be completed:
Patient own home: Complete medication record and tag sheets.
Care Homes: Follow Medicines Policy.

↓

Regular assessment of Anticipatory Medications:
To be completed at least **monthly**, or with any change in the patient's clinical condition.
Anticipatory prescribing medication administration record needs to be reauthorised every **3 months**.
Patient own/Residential home: Inform the JHC MDT co-ordinator when the above steps are taken.

↓

Administration of Anticipatory Medications:
Record doses given on anticipatory prescribing medication administration record.
Complete medication record sheets for JIC boxes (**patient own home** only).

↓

Disposal of Anticipatory Medications (when no longer needed):
Patient own home: (Patient), family or carer to return medication to dispensing pharmacy for destruction.
JIC box to be removed and returned to FNHC/JHC base by registered practitioner for cleaning and storage.
Care Homes: Return medication to dispensing pharmacy for destruction, follow Medicines Policy.

Documentation and Communication:
Inform JHC MDT co-ordinator anticipatory medications/JIC box are no longer in place. File documents in patient notes.
Outcome form to be completed and faxed or e-mailed to Specialist Palliative Care Team.

Appendix 14: Summary of anticipatory prescribing for community care settings

Summary of anticipatory prescribing for community care settings

Anticipatory prescribing avoids delays in treating the most common symptoms at the end of life, improves symptom control and may prevent unwanted admissions to Hospital or Hospice.

'Just in Case' (JIC) boxes are a small part of anticipatory prescribing, and is a system to improve the security and audit trail of medications prescribed.

JIC boxes are only to be used in patients own homes, and not other care settings.

Criteria	Care Setting		
	Patient own Home	Residential Home	Nursing Home
Medication storage			
Just in Case Box required to store medications	Yes	No	No
Medications to be stored in treatment room at care home	-	Yes	Yes
Prescribing			
S/C medications to be prescribed on the 'Anticipatory prescribing medication administration record'	Yes	Yes	Yes
'MAR sheet' generated by community pharmacy when dispensing S/C medications for anticipatory prescribing	-	Yes*	Yes*
*For Care Homes annotate the 'MAR sheet' to indicate that doses of S/C medications administered should be recorded on 'Anticipatory prescribing medication administration record'			
Administration of S/C medications			
FNHC/JHC nursing staff to administer	Yes	Yes	No*
RGNs on site to administer	-	-	Yes
*JHC nursing staff are available to support and advise RGNs at nursing homes (at times this may be on-site), but it is the responsibility of the home to ensure their staff are competent and confident to administer S/C medications			
Documentation			
Doses of S/C medication given to be recorded on 'Anticipatory prescribing medication administration record'	Yes	Yes	Yes
Doses of S/C medication administered to be recorded on 'MAR sheet'	-	No	No
Controlled Drug (CD) transactions (i.e. receipt and administration) to be recorded in care home CD register	-	Yes	Yes
When 'Anticipatory prescribing medication administration record' is no longer needed (e.g. patient passes away) photocopy of chart to be left with care home staff	-	Yes	Keep original
JHC nursing staff to record details of patient visit in notes	Yes	Yes*	Yes*
FNHC staff to record details of patient visit in notes	Yes	Yes*	-
*For care homes this should be recorded in the visiting professionals section of the patient notes			

Glossary:

CD	Controlled Drug
FNHC	Family Nursing & Home Care
JHC	Jersey Hospice Care
MAR	Medication Administration Record
RGN	Registered General Nurse
S/C	Sub-cutaneous

Appendix 15: Contact Details

In the first instance contact the prescriber.

If you need any further information contact one of the following (as appropriate based on the care setting):

Role / Team	Contact Details
Specialist Palliative Care Team (24/7 service)	Tel: 01534 876555 Fax: 01534 720292
JHC MDT Co-ordinator	Tel: 01534 786105 Fax: 01534 720292 e-mail: CommunityTeam@jerseyhospicecare.com
SPCT Pharmacist	Tel: 01534 786148
On-call Palliative Care Consultant (Southampton)	**HSSD*** Tel: 01534 442000
	Community (via SPCT) Tel: 01534 876555
Jersey Doctors On-Call (JDOC)	Tel: 01534 445445 Fax: 01534 444342
HSSD Medicines Information	Tel: 01534 442628

* Hospital Drs (Clinical Fellow or above) can contact an on-call Palliative Care Consultant off island, outside standard work hours (Mon – Fri, 9am - 5pm) via switchboard.