Policy for anticipatory prescribing of ‘Just in Case’ medication for symptom control in the last days of life in adult community palliative and end of life care patients.

Version:	2.0
Name of originator/author:	Originated from the BNSSG document authored by Dr Cornish, transferred to Sirona policy by Karla Smith-Bishton
Name of executive lead:	Dr Ben Burrows
Date ratified:	November 2025
Review date:	*October 2028*

N.B. Please check you are referring to the latest version, however the policy remains valid even if the review date has passed, until a new version is approved.

Applicable to

All registered clinicians who may be involved in the completion and/or use of Community Palliative Drug Charts within the Bristol, North Somerset, and South Gloucestershire (BNSSG) region. This is a system wide shared policy overseen by Sirona care and health for governance.

This policy applies to colleagues across the BNSSG region and therefore any amendments must be made in agreement with representatives from the BNSSG End of Life (EOL) Care Collaborative and disseminated to all relevant parties.

Including but not exclusively:

- St Peter’s Hospice, Charlton Road, Brentry, Bristol BS10 6NL. Please email CQITeam@StPetersHospice.onmicrosoft .
- Weston Hospicecare, Jackson-Barstow House, 28 Thornbury Road, Uphill, Weston-super-Mare, BS23 4YQ. Please email Community- team@westonhospicecare.org.uk .

- For dissemination to GPs, care homes, SWAST, BrisDoc, secondary care and others, Remedy will be updated (email BNSSG.referral.service@nhs.net) with any amendments being approved by the End of Life Programme Board whose responsibility will be to ensure effective communication and dissemination of any changes to relevant parties.

Executive Summary

Healthcare professionals provide care and support to adults dying with a life limiting illness in their own homes, in hospices, hospitals and care homes. Healthcare professionals (HCP) all aim for the optimum management of end of life (EOL) symptoms, with the comfort of the patient dying being of paramount importance for all. As they approach the last days of life and may be unable to swallow oral medication, this guideline seeks to avoid distress caused by delayed access to medicines by anticipating need and providing appropriate medication in the home (NICE 2017, Wilcock et al 2022). For palliative care patients who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication.

Implementation

This policy must be cascaded by clinical managers to all clinicians who will be involved in end of life care. All staff involved in caring for people at the end of their lives should be aware of this policy and associated documents. All staff involved in caring for people at the end of their lives should attend training appropriate to their role. All staff involved in end of life care should be aware of the correct documents and record keeping requirements within EMIS and shared care records.

Equality Commitment

This policy is written with the aim of providing equity of treatment for all patients. It takes into account current UK legislative requirements, including the Equality Act 2010, Human Rights Act 1998 and promotes equality of opportunity for all. No particular group or individual will be disadvantaged over others on the grounds of; race, ethnic origin or nationality, disability, gender, gender reassignment, marital status, age, sexual orientation, religion or belief, pregnancy or maternity status; during the application of this policy. Appropriate consideration has also been given to the impact of the policy on gender identity, socio-economic status and immigration status. We have considered the principles of the NHS Constitution when looking at this policy.

Sirona commits to informed due regard to the Public Sector Equality Duty (PSED) in the development, review and implementation of the policy.

This document can only be considered valid when viewed via Sirona's intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one on-line. The document applies equally to full and part time employees, bank workers, contract and casual workers, volunteers, students, learners on placement and apprentices for Sirona.

Consultation Process

Key individuals involved in developing the document

Name	Designation
Dr Dida Cornish	Consultant in Palliative Medicine, St Peter's Hospice & UHBW
Karla Smith-Bishton	Clinical and Operational Lead, Sirona End of Life Specialist Service
Dr Andrew Appleton	GP and Clinical Digital Lead and CCIO BNSSG ICB
Dr Lucy Pocock	GP and NIHR Doctoral Research Fellow, Specialist Interest Palliative and End of Life Care
Michelle Jones	Principal Medicines Optimisation Pharmacist
Kate Ryan	Medicines Optimisation Pharmacist

Circulated to the following individuals/groups for consultation

Name of Individual & designation	Date approved
BNSSG ICS wide Anticipatory Medicine Task & Finish Group	10 February 2023
Sirona End of Life Steering Group	10 February 2023
Sirona Medicines Management Group	10 February 2023
BNSSG ICB EOL Programme Board	10 February 2023
Fiona Chiplen Consultant Palliative Medicine Weston Hospice Care	10 February 2023
Sirona EOL Steering	26 September 2025
BNSSG EOL Care Collaborative Working Group for the Community Palliative Care Drug Chart	10 October 2025
Sirona Medicines Management	18 September 2025

Details of approval by Lead Director

Director	Designation	Date approved
Dr Ben Burrows	Interim Chief Medical Officer	

Circulated to the following Committee for Ratification

Name of Committee(s)	Date ratified
Sirona Professional Council	13 February 2023
Policy and Competency Group	October 2025
Clinical Governance Forum	November 2025

Version Control

Version	Updated By	Updated On	Summary of changes from previous version
1	Karla Smith-Bishton	Feb 2023	Originated from the BNSSG document authored by Dr Cornish, transferred to Sirona policy by Karla Smith-Bishton and updated by key individuals referenced on page 3.
1.1	Karla Smith-Bishton	January 2025	Extended to July 2025
2.0	Karla Smith-Bishton	July 2025	Planned review

Contents

1. Introduction/Policy Summary

Patients with a terminal illness who are deteriorating often experience new or worsening symptoms as they approach the last days of life and may be unable to swallow oral medication. This guideline seeks to avoid distress caused by delayed access to medicines by anticipating need and providing appropriate medication in the home to administer if the patient is unable to take oral medication (NICE 2017, Wilcock et al 2022). This guideline also seeks to deliver the NHS 10 year plan's goal to ensure people nearing the end of their lives are enabled to have a good death in the place of their choosing, which for most people is their home (DHSC 2025). To ensure every individual has the opportunity for a peaceful, dignified and person-centred death in the place of their choosing. For palliative care patients who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home for the management of symptoms which commonly occur in the last days of life (NICE 2015). A range of subcutaneous (SC) medication should be prescribed and authorised on the Community Palliative Care Drug Chart to allow clinicians working in the community, to administer if the patient is unable to take oral medication. Individuals who deteriorate or develop uncontrolled symptoms will always require full clinical assessment to ensure there is appropriate treatment of any reversible factors and a clear management plan. Anticipatory prescribing should be tailored to the individual person and circumstances, taking into account risks and benefits of prescribing in advance. Patients and carers must consent to JiC medication in the home.

The Dying without dignity report (Parliamentary and Health Service Ombudsman 2015) identified key themes in their casework;

- Not recognising that people are dying and not responding to their needs – if the needs of those who are close to death are not recognised, their care cannot be planned or co-ordinated, which means more crises and distress for the person and their family and carers.
- Poor symptom control – people have watched their loved ones dying in pain or in an agitated state because their symptoms have been ineffectively or poorly managed
- Poor communication – poor communication is an important element in our complaints on end of life care. It is clear that healthcare professionals do not always have the open and honest conversations with family members and carers that are necessary for them to understand the severity of the situation, and the subsequent choices they will have to make.
- Inadequate out-of-hours services – people who are dying and their

carers suffer because of the difficulties in getting palliative care outside normal working hours.

- Poor care planning – a failure to plan adequately often leads to the lack of co- ordinated care, for example, GPs and hospitals can fail to liaise.
- Delays in diagnosis and referrals for treatment – this can mean that people are denied the chance to plan for the end of their life and for their final wishes to be met.

Providing pharmacological management of common symptoms at the end of life and appropriate non-pharmacological methods of symptom management are an important part of high-quality care at the end of life. Using an individualised approach to prescribing anticipatory medicines for people who are likely to need symptom control in the last days of life (Leadership Alliance for the Care of Dying People One Chance to Get it Right (2014), NICE Guidance NG 31 Care of dying adults in the last days of life (2015)).

2. Definitions

Provision of medication in advance, in anticipation of symptoms occurring at the end of life has been termed anticipatory prescribing or pre-emptive prescribing. The terms 'Just in Case' (JiC) medication, anticipatory medication and 'Just in Case' box / bag (where available) are also used. For the purpose of this guideline the terms 'Just in Case' (JiC) medication and anticipatory prescribing (AP) will be used.

3. Purpose

To help ensure that:

- Common symptoms in the last days of life (e.g. pain, secretions, nausea and vomiting, agitation and shortness of breath) are anticipated and treated promptly.
- Appropriate 'Just in Case' medicines are prescribed in advance for the patient and stored in the patient's home.
- The JiC medicines can be easily identified in the home by healthcare professionals by ensuring they are appropriately labelled and stored, this may be in a 'Just in Case' box or 'Just in Case' bag if available.
- Carers and patients understand the purpose of the JiC medication.
- There is consistent clinical guidance and a safe framework for the use of JiC medication for patients in the community at the end of life, across the Bristol,

North Somerset and South Gloucestershire area.

- there are adequate local governance structures and excellent recording to facilitate evaluation and audit of the policy of anticipatory prescribing.

4. Scope

This guideline covers anticipatory prescribing for symptoms in the last days of life and does not include guidance on the diagnosis of dying or guidance on other aspects of care at the end of life.

It is relevant to:

- Patients in the community with a terminal illness who have been assessed by a qualified healthcare professional as actively deteriorating and are in the last few weeks or days of life.
- Healthcare professionals in the community and in inpatient settings caring for these patients (this list is not exhaustive):
    - General Practitioners and Prescribers within the GP Surgery with the appropriate competencies such as Advanced Nurse Practitioners
    - Specialist Palliative Care Professionals such as Hospices and Secondary Care Palliative Care
    - Registered Nurses working in the community e.g., Community Matrons, Advanced Clinical Practitioners, District Nurses, Community Nurses, Community Specialist Practitioners
    - Allied Health Professionals with appropriate competencies
    - Community pharmacists and dispensing staff
    - Out of hours services including GPs.
    - Hospice clinicians discharging patients' home for end of life care.
    - Ambulance staff
    - Sirona Our of Hours clinicians
    - Secondary care clinicians and pharmacists involved in discharge planning in palliative and end of life care
- Healthcare professionals working in the community (with appropriate competencies) who may take the lead, or be involved in provision or administration of JiC medication (e.g., Hospice at Home Nurses, Community Nurses or other registered professionals with appropriate competencies).
- Ambulance clinicians with the necessary competencies (defined by their own policy)

may administer PRN medication recorded on an authorisation chart but are not trained in the use of syringe pumps.

- Secondary care colleagues who will be supporting discharges of patients into the community and prescribing anticipatory medications
- Hospice colleagues who will be prescribing or administering anticipatory medications in the community setting or as part of discharging a patient home from the Hospice in-patient setting.

The principles of anticipatory prescribing apply to patients in Care Homes. Individual Nursing Homes may choose to use their own paperwork for prescribing. However, it is recommended they use the Community Palliative Care Drug Chart and add a note on the regular Medicines Administration Record (MAR) chart that this is in use. See cautions below with regard to authorising syringe pumps in advance or with dose ranges in a Nursing Home setting.

5. Patient suitability for anticipatory prescribing

The patient will have been assessed by a qualified healthcare professional as actively deteriorating and in the last few weeks or days of life this will have been communicated to the patient (unless they decline to engage or lack capacity) and, wherever possible, to their relative/carers. The patient may be dying of malignant or non-malignant disease.

The patient and, wherever possible, the relative/carer must understand the purpose of the JiC medication and agree to the principle of anticipatory prescribing for end of life symptoms. For patients who lack capacity the principles of the Mental Capacity Act (2005) regarding treatment decisions must be followed.

Exclusions/Cautions:

The patient, their carers or visitors to the house have a history of drug misuse or there is a strong suspicion to indicate this (individual risk assessment will be needed).

Patients who are themselves unwilling to participate, or carers who are unwilling to participate.

Patients with a life limiting illness, may require urgent medical assessment and hospital admission for treatment of a reversible condition. These patients are generally not appropriate for the full set of anticipatory medications typically prescribed in the final days/weeks; however, there may be circumstances where specific symptoms such as pain, nausea, or agitation necessitate the use of injectable medications or the temporary use of a syringe pump. For these patients,

a tailored plan should be developed that allows for symptom control without implying that they are imminently dying, respecting both their treatment goals and clinical needs.

For these patients it is **imperative** that the box on the front of the chart is completed to indicate that the chart is being used for symptom control in a patient with a life limiting illness who is not end of life (**see image 1 below** and section 7 for more information).

See also 9.1 for specific cautions related to syringe pumps in advance and/or with ranges.

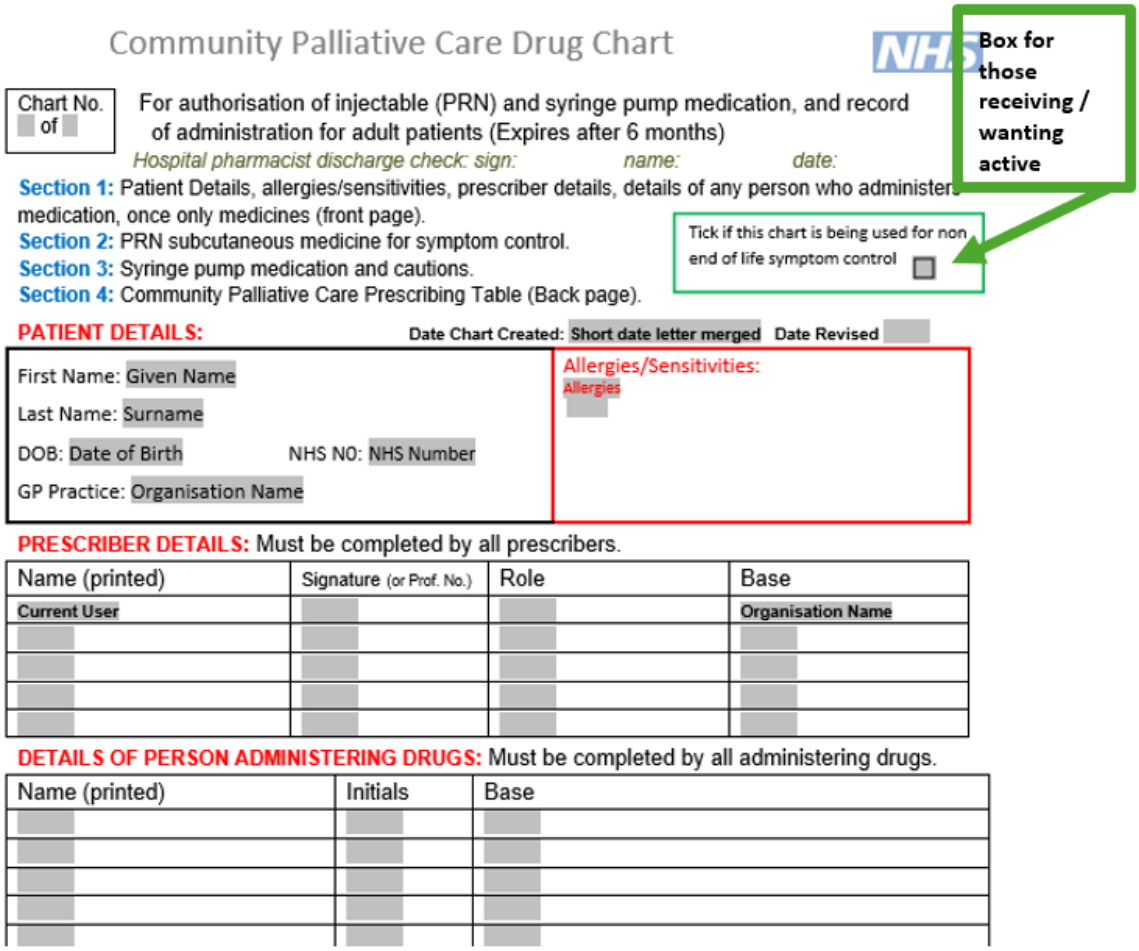


Image 1

6. Procedure for the provision of 'Just in Case' medication in the community

- Registered community clinicians, Specialist Palliative Care Nurses, GP's or other relevant health care professional should identify the appropriate patient ahead of need. The need for JiC medication should be part of the regular review of patients on the palliative/supportive care register during the practice palliative care (or Gold Standards Framework) meeting. Healthcare professionals should assess and plan the implementation of anticipatory medications to avoid unnecessary suffering and to appropriately manage symptoms.

- Discussions by involved healthcare professionals with the patient and wherever possible the relatives/carers should include:
    - current medical situation and the plan of care
    - the concept of JiC medication
    - consent for medications to be left in the home

- A GP, doctor or independent prescriber with relevant experience, who is actively involved with the patient should provide an individualised prescription for JiC medications, taking into account the patients' current medication, current and past medical history and known intolerances or allergies to medication. The prescriber should refer to relevant guidelines (See section 8).
- The prescriber should authorise the same drugs on the Community Palliative Care Drug Chart to allow registered clinicians to administer medications if needed for symptom control in the future.
- The prescriber or community clinician will ensure the patient or carer is able to get the medicines dispensed from the pharmacy.
- If the medications are needed urgently the prescriber or community clinician should contact the pharmacy to ensure they have the items needed in stock to dispense the prescription. Alternatively, refer to the list of pharmacies which stock Palliative Care Medication under the NHS Specialist Medicine Service and send the prescription to the most convenient one. These pharmacies may have extended opening hours.
- The prescriber or community clinician should check the understanding of the patient and carers about the plan of care and the JiC medication and provide information in an accessible format about 'Just in Case' medication (appendix 10), available on the following websites: Sirona, St Peter's Hospice or Remedy.

- Depending on the current clinical situation, prognosis and setting (see below) it may be appropriate to prescribe and authorise only as required (PRN) subcutaneous medication (last weeks of life) or both syringe pump medication **plus** PRN medication (approaching last days).
- The prescriber must consider the risks and benefits of prescribing in advance, particularly in a rapidly changing patient. The drugs and doses prescribed will need regular review. In particular, it will not always be appropriate to prescribe syringe pump medication in advance due to the difficulty of predicting what drugs and doses a patient may need (see cautions below).

7. Community Palliative Care Drug Chart

All 'Just in Case' medication will need to be prescribed, dispensed and written (authorised) on the Community Palliative Care Drug Chart (CPCDC). This chart has been approved across Bristol, North Somerset and South Gloucestershire to authorise Registered Clinicians working in the community to administer subcutaneous/injectable PRN or syringe pump medication for symptom control in palliative care patients who are in one of the following groups:

- Those who cannot take oral medication, because they are in the last few days of life.
- Those who cannot take oral medication for another reason e.g. nausea and vomiting or bowel obstruction. In those who have a longer prognosis than weeks it is important to tick the box **'non end of life'** on the front of the chart. In this situation clinicians should ensure appropriate advance care planning discussions have taken place and decisions related to future hospital admission for reversible factors should be clearly recorded on a ReSPECT form or a ReSPECT plus electronic record.

The CPCDC can be completed by a GP, another doctor or independent prescriber (with the necessary skills, as specified by their respective organisation, in palliative care). Patients may be discharged from a hospital or a hospice with the necessary JiC medications and the CPCDC already completed (see section 8).

The chart includes the Community Palliative Care Prescribing Table: symptom control in last days of life for adults (appendix 7). This table represents local consensus based on local guidelines and the Palliative Care Formulary (Wilcock et al 2022).

The prescribing advice within the chart is general guidance only and as such a health care professional is at liberty to use their clinical judgement and take an individualised approach to prescribing. However, it is suggested that clinicians should seek specialist advice when deviating from this guidance and document the

rationale for doing so. More guidance is available within this SOP and additional resources are available on the St Peters Hospice website.
http://www.stpetershospice.org.uk/Clinical-Guidelines

In the unusual circumstance that a patient has a CPCDC for 6 months, the chart should be reviewed and rewritten to reflect the current clinical indications or discontinued if no longer appropriate (see section 14.1 on superseded charts, 14.2 on discontinued charts).

The prescriber should also enter the following additional information on the chart (see image 2 and 3 below)

- Details of any opioid patches recorded at the top of page 2 (see image 2 below)
- Tick box if additional drugs are authorised on page 6, recorded at the top of page 2 and page 4 (see image 2 and 3 below)
- Additional instructions can be added to free text box on page 6 to include for example, advice about concentration of ampoules to be used, advice to call hospice before changing doses of certain medications, additional information about order of trying certain PRN medications etc. Tick boxes are present on Page 2 if this applies to PRN medications and Page 4 if applies to syringe pump medications (see image 4 below).

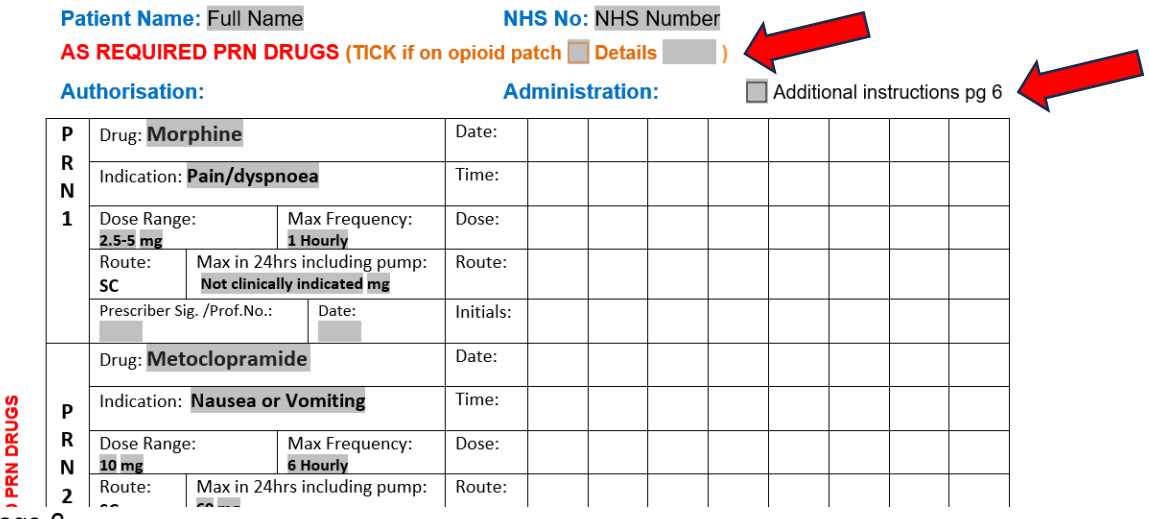
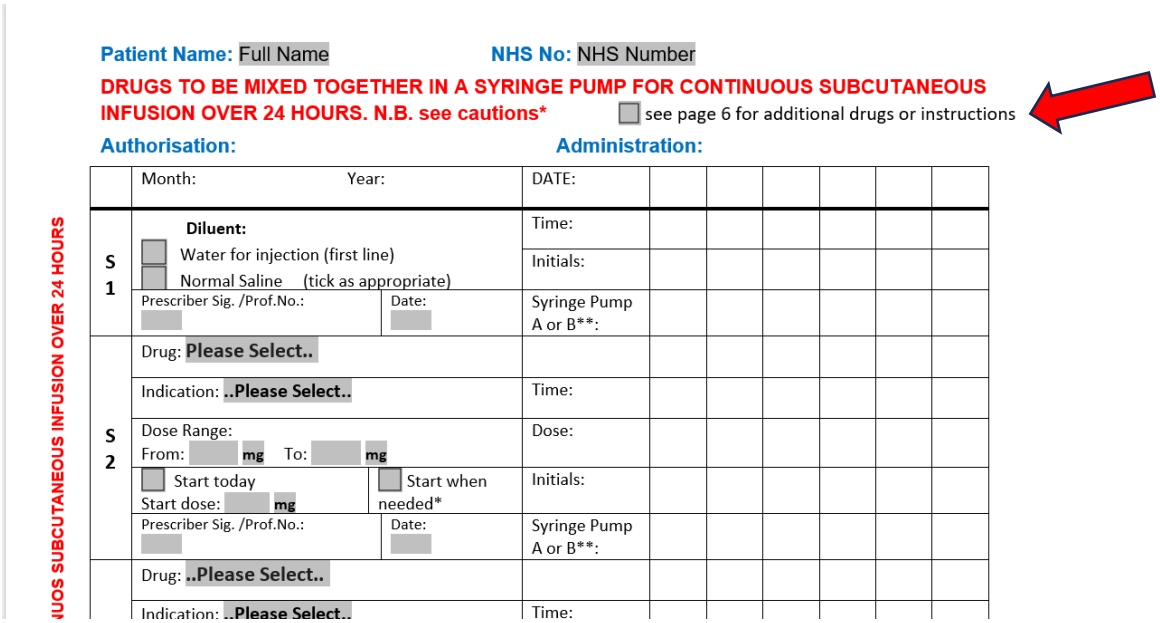


Image 2



Patient Name: Full Name **NHS No:** NHS Number

DRUGS TO BE MIXED TOGETHER IN A SYRINGE PUMP FOR CONTINUOUS SUBCUTANEOUS INFUSION OVER 24 HOURS. N.B. see cautions*

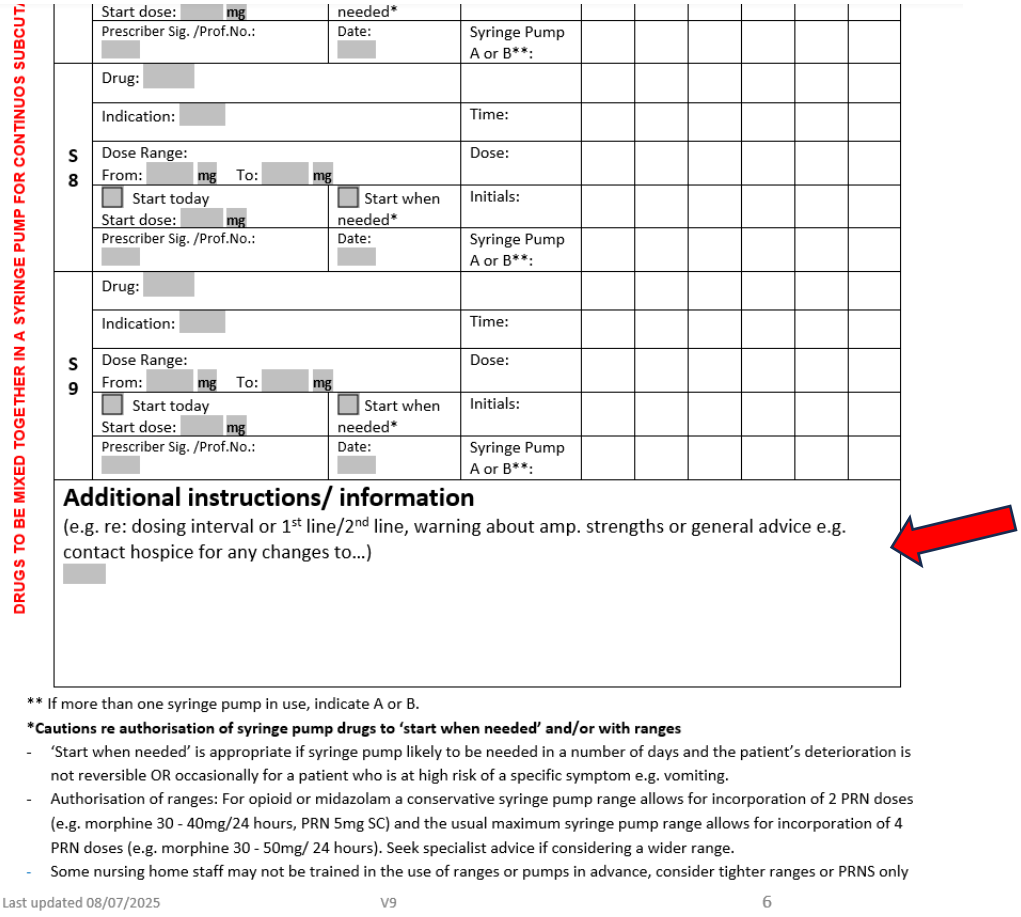
☐ see page 6 for additional drugs or instructions

Authorisation: **Administration:**

NUOS SUBCUTANEOUS INFUSION OVER 24 HOURS

	Month: Year:	DATE:						
S 1	**Diluent:** ☐ Water for injection (first line) ☐ Normal Saline (tick as appropriate)	Time:						
		Initials:						
	Prescriber Sig. /Prof.No.: / Date:	Syringe Pump A or B**:						
S 2	Drug: **Please Select..**							
	Indication: **..Please Select..**	Time:						
	Dose Range: From: mg To: mg	Dose:						
	☐ Start today Start dose: mg / ☐ Start when needed*	Initials:						
	Prescriber Sig. /Prof.No.: / Date:	Syringe Pump A or B**:						
	Drug: **..Please Select..**							
	Indication: **..Please Select..**	Time:						

Image 3



DRUGS TO BE MIXED TOGETHER IN A SYRINGE PUMP FOR CONTINUOS SUBCUT.

	Start dose: mg	needed*								
	Prescriber Sig. /Prof.No.:	Date:	Syringe Pump A or B**:							
S 8	Drug:									
	Indication:		Time:							
	Dose Range: From: mg To: mg		Dose:							
	☐ Start today Start dose: mg	☐ Start when needed*	Initials:							
	Prescriber Sig. /Prof.No.:	Date:	Syringe Pump A or B**:							
S 9	Drug:									
	Indication:		Time:							
	Dose Range: From: mg To: mg		Dose:							
	☐ Start today Start dose: mg	☐ Start when needed*	Initials:							
	Prescriber Sig. /Prof.No.:	Date:	Syringe Pump A or B**:							

Additional instructions/ information

(e.g. re: dosing interval or 1st line/2nd line, warning about amp. strengths or general advice e.g. contact hospice for any changes to…)

** If more than one syringe pump in use, indicate A or B.

***Cautions re authorisation of syringe pump drugs to 'start when needed' and/or with ranges**

- 'Start when needed' is appropriate if syringe pump likely to be needed in a number of days and the patient's deterioration is not reversible OR occasionally for a patient who is at high risk of a specific symptom e.g. vomiting.
- Authorisation of ranges: For opioid or midazolam a conservative syringe pump range allows for incorporation of 2 PRN doses (e.g. morphine 30 - 40mg/24 hours, PRN 5mg SC) and the usual maximum syringe pump range allows for incorporation of 4 PRN doses (e.g. morphine 30 - 50mg/ 24 hours). Seek specialist advice if considering a wider range.
- Some nursing home staff may not be trained in the use of ranges or pumps in advance, consider tighter ranges or PRNS only

Last updated 08/07/2025 V9 6

Image 4

7.1. Use of EMIS protocol, the electronic and paper charts

There are three ways of completing the chart.

i. Electronic rich text versions of the chart are available in EMIS documents for community organisations including hospices. This is launched using the Anticipatory Prescribing Protocol in most primary care organisations or added as a document to EMIS in other organisations. These charts will often be printed out in black and white with typed drug names are signed electronically with a professional number not a 'wet' signature next to each drug.

ii. In Brisdoc out of hours service and in some other settings such as hospitals a rich text version is available in word. These charts will often be printed out in black and white with typed drug names and may be signed electronically

with a professional number not a ‘wet’ signature next to each drug.

iii. There are also printed colour booklet-style charts which can be handwritten by prescribers. These require wet signatures.

Both written and typed charts are acceptable but must include appropriate signature (typed prof number or wet signature) at the following points

Front page: Full name, prof reg number, role, organisation, signature (or prof number if electronic)

Each drug authorised PRN and each drug authorised for addition to a syringe pump must include signature (or prof number if electronic) and date.

Electronic charts must be printed (ideally double sided) and stapled together securely to create a booklet. The administration pages must align to the prescription for each drug. This may be undertaken by the prescriber and made ready for collection by the community team/relative or Community Nurses can print directly from EMIS or from email and take it into the house. It is essential that the prescriber has agreed this with the relevant team via Sirona SPA to check this can be achieved in time.

Out-of-hours prescribers completing an electronic chart must make a telephone referral to Sirona Single Point of Access (SPA) giving an indication of how urgently the chart will be needed in the home. SPA will give instructions on emailing the chart. If calling after 22:00 this will divert direct to the Out of Hours Clinicians.

For patients being discharged from a Secondary Care inpatient setting with a chart, wherever possible the chart should be emailed to Sirona via Sirona SPA sirona.psd.nhs.net, after making a telephone referral to the SPA. However this is not essential if the chart is not in electronic format. The original MUST go with the patient.

Anyone being discharged from a Sirona Rehab Unit should have the chart scanned on to their EMIS record, if in use, and the original should go home with the patient.

Anticipatory Drugs Protocol (EMIS)

A locally developed Anticipatory Drugs Protocol is available in EMIS to issue electronic prescriptions and an appropriate EMIS document version of the Community Palliative Care Drug Chart. The protocol is designed with specific prompts so that the most appropriate chart and prescription is produced. Resource

publisher is available to nearly all local practices, so it is vital that practices use the most recent version of the protocol, which is available in the One Care Shared folders, and delete all old versions from their own folders.

It is best practice to individualise anticipatory prescribing.

Pre-populated chart with default medication: The protocol is designed so that the pre-populated chart within the EMIS protocol is only used for the following patients:

- opioid naïve
- have an eGFR more than 30 ml/min/ 1.73m^2
- where metoclopramide is an appropriate anti-emetic

Chart with drop downs and individualised prescriptions: For all other patients it is important to select **'no'** when asked if you want to issue the default set of anticipatory medications. If followed correctly, for all other patients the chart produced will have drop downs for each drug option which can be selected. There are also boxes with no drop downs where alternative drugs and indications can be authorised by free typing. Always follow the prompts and take note of the automated alerts (e.g., for Parkinson's Disease or renal function).

Management of electronic charts in EMIS documents

Clinicians must be aware that a CPCDC may be produced by any organisation with EMIS in BNSSG so it is essential that they view documents with 'all organisations' selected so they are referring to the most up to date version.

To make a change to medication (new drug, dose or dose range) to an existing electronic CPCDC in EMIS, the prescriber can edit the previous chart in EMIS but then '**save as'** in EMIS documents to create a new version renamed with appropriate date in the title. The clinician should then save and close. This will ensure it appears in documents with the correct date without over writing the previous version. Please see Appendix 11.

Note this only applies to editing a CPCDC in EMIS documents of the prescriber's organisation. Prescribers must view EMIS documents with 'all organisations' open so they update the most recent CPCDC. It is possible to make changes to a CPCDC on the EMIS documents of another organisation by downloading it ('export'), editing then uploading to the prescriber's EMIS documents ('attach document') with appropriate date in the title.

When updating a chart the prescriber must ensure they add the new date on the front of the chart and sign (with professional number) and date any medication changes. It is important to retain the title 'BNSSG Anticipatory Prescribing Form V.9' so that the chart can be easily located by other organisations looking at EMIS documents.

If creating a 2nd chart to be used in addition to existing chart this must be clear on the front e.g. 1/2, 2/2. See section regarding superseded charts (section 14).

With all changes it is essential to inform Sirona and give an idea of urgency so they know when to take the new chart into the house.

For additional prescribing advice see section 9.

8. 'Just in Case' medication for inpatients being discharged into the community

The principles of anticipatory prescribing for end-of-life symptoms apply to patients being discharged from a hospital, hospice or rehab unit who meet the criteria set out in section 5. A discussion should take place to ensure the patient understands and consents to JiC medications being sent home with them (see section 6) and if the patient agrees, informal carers/relatives should be informed if possible.

Individual hospital trusts will have their own governance arrangements in place for providing JiC medication and completing Community Palliative Care Drug charts for appropriate patients on discharge. However, the principles here will be followed by all inpatient organisations.

For inpatients being discharged into the community from hospital or hospice who meet the criteria for anticipatory prescribing, the appropriate injectable JiC medication should be supplied on discharge. The Community Palliative Care Drug Chart should be completed with 'as required' JiC medication by doctors or independent prescribers based in the Hospital Palliative Care Team (HPCT), on the hospital wards or based at the local hospice. Individual trusts will put in place processes to ensure there is prescribing advice or checking of the anticipatory prescribing on the charts if not completed by a member of the HPCT.

For inpatients being discharged from hospices who are approaching last days or on syringe pumps, the hospice prescribers will follow the guidance in this policy and where appropriate authorise syringe pumps in advance, 'to start when needed' and appropriate syringe pump ranges.

If the inpatient is being discharged from an acute trust on a syringe pump the current medication will be authorised on the Community Palliative Care Drug Chart by a hospital prescriber. Due to the high turnover of staff, it may not be possible to train/supervise junior doctors in the acute trusts to authorise syringe pumps in advance or ranges for pumps on the Community Palliative Care Drug Chart. If the Hospital Specialist Palliative Care Team are involved the team may be able to facilitate the authorisation of syringe pumps to start when needed or appropriate syringe pump ranges, prioritising those being discharged from hospital and who are approaching last days, particularly those who already have 1 or 2 drugs in a syringe pump. If this has not been possible, they should inform Sirona SPA that the patient is approaching last days when they make the referral.

When sending patients home with JiC medication, staff must inform the GP via the discharge letter and Sirona via the Single Point of Access (SPA) by making a referral on 0300 125 6789. A patient should not be discharged without prior arrangements being made and confirmed by phoning Sirona's SPA. If completed, the Community Palliative Care Drug Chart should accompany the patient home with the prescribed medication on discharge. If the CPCDC is available in electronic format this should be emailed to SPA sirona.psd@nhs.net. The original MUST be sent home with the patient.

Once the patient is in the community it is the responsibility of primary care prescribers to complete / update the chart.

8.1. Process for inpatients discharged into the community on a syringe pump

Any patients who are discharged to the community and require a syringe pump should be discussed in advance with the relevant community nursing team. Community teams should not be using hospital's syringe pumps whilst a patient is in the community. If a patient is discharged to the community with a hospital or hospice syringe pump in situ, the relevant community team should endeavour to swap the syringe pump for a Sirona community syringe pump and send the original pump back to the hospital or hospice at the earliest practicable opportunity.

The protocol for when patients are discharged from University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), who have been on a syringe pump, is that they are administered appropriate STAT doses by the hospital staff prior to being discharged. This is because the syringe pump will have been removed by the ward prior to discharge. Patients should not be discharged until ward staff have received confirmation from Sirona care & health's Single Point of Access (SPA) that the community teams are able to accept the referral. Once the referral has been accepted, UHBW ward staff are to contact the relevant community team,

on the number that SPA will provide, when the person has left hospital so that their visit can be scheduled. Sirona care and health community staff will then meet the individual at their home or new setting to set up a Sirona syringe pump as required. The syringe pump must be signed out of the Integrated Neighbourhood Team (INT) hub completing the relevant information.

9. Prescribing guidance for Just in Case medication

See also appendix 6: Anticipatory prescribing (AP) of Just in Case (JiC) medication for symptom control in adult palliative care patients in last days of life: BNSSG quick reference guide and appendix 7: Community Palliative Care Prescribing Table.

In general, individualised prescribing is recommended. For example, if a patient is already on a specific opioid or antiemetic that suits them, then this should be converted to the equivalent subcutaneous dose if available. For those on patches the opioid which they use as required should be converted to the equivalent subcutaneous dose. Advice about prescribing is contained within the Community palliative care prescribing table: symptom control in last days of life for adults.

Please note: The prescribing advice here and within the table is general guidance only and as such a health care professional is at liberty to use their professional judgement (following recognised formularies/guidance) to take an individualised approach to choice of drug, dose range, frequency and number of ampoules provided. However, it is suggested that clinicians should seek specialist advice when deviating from this guidance and document their reason for doing so.

9.1. Provision of as required (PRN) subcutaneous medications only

For patients who have been assessed by an experienced clinician(s) as deteriorating and thought to be in the last few weeks of life (i.e., those who are likely to have difficulty with oral medication in the next few weeks) the prescriber should consider prescribing and authorising PRN JiC medication. When authorising PRN medication, the prescriber may indicate a maximum dose which includes PRN and syringe pump doses. It is common practice not to indicate a maximum for the opioid unless there is a specific concern, such as opioid toxicity or history of abuse.

PRN subcutaneous medications should be provided for each of the 5 symptoms commonly experienced at the end of life: i.e.: pain (opioid), dyspnoea (also use opioid), nausea/vomiting, agitation and respiratory tract secretions.

The following medications are usually provided (refer to the table in Appendix 6 for more detail)

- Opioid: The appropriate drug and dose should be chosen for the individual. If the patient is on oral morphine; SC Morphine is first line due to cost. NB the highest concentration of injectable morphine is 30mg/ml; therefore, the maximum PRN injection dose is 60mg (2mls). The equivalent SC diamorphine dose should be prescribed instead of morphine if the individual requires higher doses than this.
- Anti-emetic: The appropriate drug should be chosen for the individual depending on likely cause of nausea and any contra-indications. If the patient is already on an antiemetic convert this to SC dose if available. NB cyclizine should **not** be used first line as it is a painful injection and is incompatible in a syringe pump with hyoscine butylbromide and with higher doses of oxycodone.
- Sedative: Midazolam is the usual first line drug for agitation at the end of life. Haloperidol (less sedating) may be used for hallucinations/delirium and levomepromazine may be used second line for agitation if midazolam is not effective.
- Anticholinergic for secretions: Hyoscine *butyl*bromide is first line in BNSSG due to the small risk of delirium with hyoscine hydrobromide. Hyoscine *butyl*bromide is not compatible with cyclizine so if this antiemetic is prescribed glycopyrronium should be prescribed as the antisecretory.
- A diluent should be prescribed and authorised with the prescriber's signature for the syringe pump (water for injection is first line).

For all patients the amount prescribed should be tailored to the individual person. For most patients at least 10 doses of each medication are recommended. For less complex patients, for example those who are currently not symptomatic e.g., those with frailty of old age 5 ampoules may be sufficient. For more complex patients e.g., those requiring frequent PRN medications it is important to consider their 24-hour requirements and estimated PRN use. **Water for injection should also be prescribed at this time, so it is available if a syringe pump is needed**.

Standard example if prescribing PRN drugs only:

- Midazolam 10mg/2ml (10 ampoules)
- Hyoscine Butylbromide (10 ampoules)
- Opioid (10 doses)
- Antiemetic (10 doses)
- Water for injection 10ml (20 ampoules)

PRN lorazepam tablets may be prescribed sublingually for anxiety (0.5-1mg 8 hourly).

The need for other oral PRN medication should also be considered but is beyond the scope of this guidance.

9.2. Provision of syringe pump medication for subcutaneous administration over 24 hours

For patients who have been assessed by an experienced clinician as approaching the last days of life, with no reversible factors, consider prescribing and authorising syringe pump drugs (Collis 2013) in the circumstances described in this section.

For patients who are unable to swallow, the prescriber will usually provide an FP10 and authorise on the Community Palliative Care Drug Chart the following:

- Current regular medication for symptom control, such as analgesics and anti- emetics, converted to equivalent doses for subcutaneous use in a syringe pump. Tick box 'start today' and indicate starting dose.
- Any other medications that are now required for symptom control in the syringe pump. Tick box 'start today' and indicate starting dose.
- PRN subcutaneous medication for the 5 common symptoms.
- If appropriate syringe pump medication may be authorised in advance and tick box to 'start when needed' for any of the 5 common symptoms 'Just in Case' they are needed in the in the future (see cautions below).
- Authorisation of an appropriate range may be considered for syringe pump drugs, see cautions below.
- A diluent should be prescribed and authorised for the syringe pump (water for injection is first line).

For patients who can still swallow but are likely to have difficulty with oral medication in a number of days, as they approach the last days of life, the prescriber should complete a prescription and authorise the following:

- PRN subcutaneous medication for each of the 5 common symptoms.
- If authorising syringe pump drugs where it is anticipated they are needed imminently, this should include appropriate conversion of current regular oral drugs for symptom control. In this instance the prescriber may choose to tick the box 'start when needed'.
- Authorisation of an appropriate range may be considered for syringe pump drugs, see cautions below
- A diluent should be prescribed and authorised for the syringe pump (water for injection is first line).

If appropriate, the prescriber may authorise a modest dose range for the syringe pump medications to allow for 1 or 2 dose increases by community clinicians (see cautions below).

Dose ranges for syringe pump should be tailored to the individual person and circumstances. A conservative range would allow for incorporation of two PRN doses of opioid or midazolam. The usual maximum range would allow for incorporation of up to four PRN doses.

Example: Morphine 30mg SC over 24 hours via syringe pump (PRN dose is 5mg)

- Conservative range: 30-40mg/24 hours. (A range of 10mg allows for 2 x 5mg PRN doses)
- Usual maximum range: 30- 50mg/24 hours. (A range of 20mg allows for 4 x 5mg PRN doses).

Seek specialist advice e.g. from a hospice healthcare professional if considering authorisation of a wider range for syringe pump drugs.

For those requiring a syringe pump the prescriber should ensure there is enough medication for 7 days including PRN medication.

For those where JiC syringe pump medication is being provided in advance, to start when needed, the prescriber should ensure there is at least a 4 day supply of medication (e.g. to cover a long weekend).

For all opioids, except alfentanil, the subcutaneous PRN dose should be equivalent to 1/6th of the total 24-hour background SC opioid. For alfentanil, the PRN dose should be equivalent to 1/10th of SC alfentanil total over 24 hours. Therefore, when increasing a syringe pump dose, the PRN should be increased in line with these calculations. Prescribers should seek specialist advice for complex calculations e.g., involving more than one opioid.

9.3. Cautions re authorisation of syringe pump drugs to start when needed and/or with range

There are some risks associated with prescribing syringe pumps in advance and/or with dose ranges as identified in the Gosport Independent Panel (2018). However, it is accepted practice in many regions and an audit, in this region, following the launch of stricter guidelines incorporating the cautions below showed good adherence to safe practice (Cornish 2017).

The guidance in Palliative Care Formulary states the following:

Recently, the risks inherent in anticipatory prescribing of drugs by Continuous Subcutaneous Infusion (CSCI) have been highlighted, e.g. of unintentional under- or

overdosing of a strong opioid. However, some centres use anticipatory CSCI prescriptions for selected situations, when the following criteria are met:

- the drug choice and dose is unlikely to change before next review
- all health professionals (including OOH) can:
  - recognise the situation for which the CSCI is intended *and*
  - have the expertise required to safely initiate the CSCI
- the initiation of the CSCI triggers a timely review by an appropriate clinician (Palliative care Formulary 2025).

Following the guidance below ensures we take these risks into account.

Syringe pump drugs should usually only be authorised ***in advance to start when needed*** for patients who are thought to be approaching the last days of life, with no reversible factors who are likely to lose their oral route in a number of days. Occasionally syringe pump drugs may be authorised to start when needed for symptom control in a palliative care patient who is at high risk of a specific symptom e.g. vomiting from bowel obstruction where decisions about future admission to hospital for reversible causes are clearly documented. If authorised in advance for a specific symptom in someone who is not in last weeks or days of life the box on the front 'non end of life care' should be ticked and it would not be appropriate to prescribe in advance for other end of life symptoms such as midazolam for agitation.

In some settings (e.g. some nursing homes) the nurses may not have received adequate training to administer syringe pump drugs based on an authorisation written in advance 'to start when needed' and/or with a range of drug doses. In these situations, the prescriber should assess whether it is more appropriate to prescribe PRN drugs only. Syringe pump drugs would then be authorised with a specified start dose at the time they are required. Alternatively, for those approaching last days a clinician may choose to authorise a tighter range or no range on the syringe pump drugs in these settings.

9.4. Prescribing for patients in the last days of life: guidance for specific circumstances*

Patients established on fentanyl or buprenorphine patches

The dose of opioid patch is not usually titrated in last days of life, as slow absorption of the drug would result in delays achieving required increases. The patch should be continued and replaced at normal intervals. Tick the box if on an opioid patch on the PRN page of the chart and complete details.

If required, patches can be supplemented with oral, or subcutaneous opioids if the patient is unable to swallow. The dose should be calculated by first converting the patch strength to equivalent oral morphine and then subcutaneous morphine if required. Further dose conversion may be required if the patient isn't able to have morphine.

If a person is approaching last days of life, consider authorising a syringe pump 'to start when needed' for the 5 common symptoms. The dose range for the opioid can be the calculated equivalent to two-four SC PRN doses of opioid. If several PRN doses are needed, a syringe pump can be set up containing appropriate opioid in addition to the fentanyl or buprenorphine patch.

Medication	Patch strength (micrograms per hour)	Equivalent 24-hour dose **oral morphine**	Equivalent 24-hour dose **subcutaneous morphine**	PRN dose of **subcutaneous morphine**	Syringe pump dose 'to start when needed'
Fentanyl	25 micrograms per hour (25mcg/hr.)	60-90mg/24hrs	30-45mg/24hrs	5 - 7.5mg Max 1 hourly	Morphine 15-30mg/24hrs
Buprenorphine	20 micrograms per hour (20mcg/hr.)	36-65mg/24hrs	~15-30mg/24hrs	2.5 - 5mg Max 1 hourly	Morphine 10-20mg/24hrs

Steroids

Continue steroids if considered essential for symptom control for example if symptomatic of raised intracranial pressure or bowel obstruction. In those where they were prescribed for general wellbeing or not thought to be helpful for symptoms consider discontinuation or gradual reduction. See St Peter's Hospice clinical guidelines on their website for more detail on steroids in palliative care.

Dexamethasone 4mg orally is considered equivalent to dexamethasone 3.3mg injection prescribed as dexamethasone base. Dexamethasone may be given as a single daily SC injection, preferably in the morning, if dose is 6.6mg or less (ampoules are 3.3mg/ml or 6.6mg/2ml). Dexamethasone to be given once daily, should be authorised on the Sirona Patient Specific Direction form which is available in EMIS documents not on a CPCDC. Dexamethasone doses of more than 6.6mg can be administered via a syringe pump, in which case it would be authorised on a CPCDC, but dexamethasone is incompatible when mixed with most other drugs so a second syringe pump is usually required.

Patients requiring seizure management / established on anticonvulsants

For individuals approaching last days of life, on anticonvulsant drugs for the control of seizures who are unable to take oral medication (or those likely to become unable to take oral medication in the next few days): prescribe and authorise midazolam 20-30mg/24 hours SC via syringe pump for control of seizures (seek advice about using lower doses e.g. 10-15mg/24 hours in frail/very low weight patients with good seizure control on monotherapy). Prescribe Midazolam 10mg SC/IM or Buccal PRN for treatment of a prolonged seizure more than 5 minutes, which can be repeated once after 10 minutes in status epilepticus (seek advice about using lower doses in frailer/very low weight patients). This is usually authorised on the front of the CPCDC but for those with frequent seizures it can be authorised PRN provided the indication of seizure is clear.

Some antiemetics lower the seizure threshold. If the patient has a primary brain tumour or a history of seizures consider cyclizine as 1st line antiemetic and glycopyrronium as the anti-secretory for anticipatory prescribing (hyoscine butylbromide is not compatible with cyclizine in a syringe pump). Seek specialist advice from epilepsy/neurology experts for those **not** in last days of life. Levetiracetam can be administered via syringe pump but only with involvement/guidance from hospice or palliative care teams.

Patients at risk of major haemorrhage

Consider authorising crisis medication e.g., Midazolam IM OR Buccal on the front of the chart as a once only medication but seek advice from the local hospice team.

Please note: Midazolam 10mg/2ml injection would be used to give IM and Midazolam buccal 10mg for buccal administration.

Patients with Parkinson's Disease

Avoid haloperidol and metoclopramide for patients with Parkinson's Disease. Ondansetron should be used 1st line as it is least likely to worsen Parkinson's symptoms. For difficult to control nausea or vomiting cyclizine is 2nd line and levomepromazine is 3rd line, although both carry some risk of exacerbating Parkinson's symptoms. Seek advice on managing rigidity from a Parkinson's Specialist, if available. Oral Parkinson's medications can be converted to a patch using appropriate calculator tools. Additional guidance is available on St Peter's Hospice Guidelines page.

Patients with inoperable complete gastro-intestinal (GI) obstruction

Seek specialist advice from the local hospice team. Metoclopramide may be used in a syringe pump if there is incomplete obstruction and absence of colic. Avoid metoclopramide in complete obstruction or in the presence of colic. Hyoscine butylbromide can be used via a syringe pump for colic and to reduce volume of GI secretions alongside haloperidol or levomepromazine as an antiemetic.

Patients with Renal impairment

It is not usually necessary to adjust doses of JiC medications if eGFR more than 30 ml/min.1.73m^2. If eGFR is less than 30 ml/min/1.73m^2 the clinician should consider reducing doses if there is a clinically relevant risk of side effects. This will include weighing up prognosis, severity of symptoms and risk of side effects. Appropriate dose reductions are available on the community prescribing table (appendix 6).

For more information about the use of opioids if eGFR less than 30 ml/min/1.73m^2 refer to the St Peters Hospice guidelines 'Subcutaneous Fentanyl and Alfentanil in Palliative Care: Information for primary care' available on their website Clinical Guidelines - St Peter's Hospice , and seek specialist advice from the local hospice team. It is important to consider the risk of potential side effects for the patient alongside the risk of administration error by community staff when using drugs they are less familiar with.

Patients with liver impairment

It is not usually necessary to change opioid for Anticipatory Prescribing in mild to moderate liver impairment but seek specialist advice if needed. Those with severe impairment, classified as Charles-Pugh score of C, may be at increased risk of side effects from JiC medication. This is more likely in those with cirrhosis than liver metastases. The clinician should make a judgement about reducing doses if there is a clinically relevant risk of side effects. This will include weighing up prognosis, severity of symptoms and risk of side effects. Consider seeking specialist advice from local hospice team. Appropriate dose reductions are available on the prescribing table (appendix 6).

Patients with severe frailty and/or low body mass index

The clinician should make a judgement about reducing doses if there is a clinically relevant risk of side effects. This will include weighing up prognosis, severity of symptoms and risk of side effects. Appropriate dose reductions are available on

the prescribing table (appendix 6). Consider seeking specialist advice from local hospice team.

Informal Carer Administration of Subcutaneous Injections in the Community for End of Life Care

Informal carers such as family members or close friends can be trained to give SC as required injections for symptom control at the end of life. There is a Sirona policy relating to the approval, training and documentation of this process which must be followed.

10. Communication and documentation

Good communication with patients, their relatives and carers is an essential aspect of end of life care. “End of life care is care that affects us all, at all ages, the living, the dying and the bereaved.” (Ambitions for Palliative and End of Life Care 2021). The ambition is for everyone approaching the end of life to receive high quality care that reflects individual needs, choices and preferences (DoH 2016). Supported by NICE Quality Standard for End-of-Life Care (2017), One Chance to get it right (Leadership Alliance 2014), Ambitions for Palliative and end of life care (2021) and the NHS 10-year health Plan for England (2025). Anticipatory prescribing is designed to provide prompt symptom relief at whatever time the patient develops distressing symptoms. It involves the prescribing by a GP, other doctor, or Independent Prescriber of a range of medications that are dispensed and kept in the persons house until they are needed. They may be kept in a specially marked container called a ‘Just in Case Box or Bag’ if available and should be individualised to the person’s needs.

Research (Bowers et al 2022) has shown that informal care givers and patients are generally reassured by anticipatory prescribing (Bowers et al 2019). However, there can be confusion and concern for carers relating to AP and therefore it is essential that the patient and, with their consent, relevant carers receive an adequate explanation. Concerns include that they are an unwelcome reminder of impending death but also there may be incorrect assumptions that drugs will be used to hasten death. Therefore, they should always be offered a copy of the local leaflet or accessible alternative, which is available on Sirona website, Remedy and found in appendix 10.

Advance care planning is a process whereby an individual makes clear their wishes relating to their care in the future should they not have capacity to make decisions related to their care and/or have lost the ability to communicate their wishes to others in the future. Everyone approaching the end of their life should be offered the chance to create a personalised care plan. Any information about the

person's wishes and relevant advance statements that they made prior to their loss of capacity should be taken into account when making best interest decisions. This should be recorded in the patient's medical record and if they consent in the ReSPECT plus electronic record, which contains a specific section for anticipatory prescribing. Provision of 'Just in Case' medication will usually take place as part of this care plan after a discussion with the patient (and relatives/carers if possible/relevant) about their current situation and what to expect in the future. Detailed guidance on care and communication in the dying person is beyond the scope of this guidance.

The detail of communication and prescriptions should be documented in the relevant clinical notes and the community nursing record in the home. ,

Out of hours teams and all relevant professionals e.g. Hospice Teams/ambulance should be informed of the present clinical situation, plan of care and medications prescribed. This is best achieved through completion of the ReSPECT plus record which is available electronically to all clinicians in BNSSG through integration with other systems and write back into EMIS records.

11. Managing 'Just in Case' medication in the home

The patient or carer will obtain the dispensed medicines from the pharmacy.

If only PRN drugs have been prescribed, to aid with the easy identification of the JiC medication the Registered Clinician working in the community will do one of the following:

- Where available provide a 'Just in Case' box or bag to the patients home and ensure medications are placed inside with syringes, needles and diluent.
- If syringe pump drugs are prescribed Sirona clinicians will bring the syringe pump box to the house when the equipment is required and ensure medications are placed in the box with syringes, needles, giving sets and diluent. If JiC medication is already authorised and in the home these drugs can be added to the syringe pump box and the JiC box or bag (if available) should then be removed by the clinician.
- Sirona clinicians will complete the Controlled Drug Running Balance Record found on Sirona's intranet for any subcutaneous controlled medication in the home. (e.g., opioid or midazolam).
- Clinicians should offer the patient a leaflet "Guide to your 'Just in Case' Medication" *(see appendix 10)* and leave the Community Palliative Care Drug Chart (completed by prescriber) in the home *(see appendix 5)*.
- The clinician should ensure the patient's carer is aware of the safe storage requirements for the JiC medication.

- The JiC medicines are prescribed for the named patient only and should never be used for any other patient.

Patient's anticipatory needs may change over time, therefore community clinicians should check JiC medications regularly and liaise with the GP to ensure they are appropriate in terms of quantity, dose and type.

Every time any palliative care injectable drug is administered, all injectable JiC medication should be checked to work out how many doses remain and when it is appropriate to order a new supply.

In patients who are not requiring frequent visits, all JiC medication should be checked at least **every 4 weeks**, after any change in clinical condition and if a new medication is prescribed for JiC. It is important to ensure expired medicines are not overlooked and they are replaced before doses are needed. This is unlikely as they will usually only be in the home for a number of weeks, but it can sometimes happen for people that have had JiC medication in place for several months. All checks should be documented in the patient's clinical record and individual controlled drug balance checks should be recorded on the corresponding CD balance record.

If the community clinician discovers during these checks that controlled drugs are missing and cannot be accounted for they should report this via Ulysses (for Sirona clinicians) or their organisations appropriate reporting procedure. Losses, however, minor should be reported and investigated. Sirona clinicians should refer to the Controlled Drug Discrepancy Checklist found on Sirona's intranet.

If the patient's condition unexpectedly improves it may no longer be appropriate to have JiC medication in the house. The appropriate clinician working in the community should ask the GP to review the situation and follow guidance in section 15 if JiC medication is no longer required.

The Community Palliative Drug Chart should be reviewed within 6 months and rewritten to reflect the current clinical indications or withdrawn.

12. Administration of 'just in Case' medication

Any patient who develops uncontrolled symptoms will require a clinical assessment by a competent healthcare professional.

Administration of prescribed medication should only take place following full clinical assessment.

All those administering drugs must complete their details including their initials on the front page. Initials can then be used to confirm administration of each dose of PRN or syringe pump medication in addition the date of administration.

Assessment should include the cause of the symptom, whether there are any reversible or treatable factors and whether further investigation or assessment by a medical practitioner is required. The patient must consent to treatment (or for those who lack capacity the principles set out in the Mental Capacity Act must be followed) and wherever possible (with consent from the patient) the carer/relative should be informed. If the healthcare professional assessing the patient is unsure about the appropriate management, they should seek further advice from a GP or a palliative care/hospice healthcare professional.

A medical review by GP or suitably experienced community clinician may be required:

- If there are unexplained symptoms or an unexpected sudden change in the patient's condition.
- If there is a potentially reversible condition which requires further assessment.
- If symptoms are not controlled with prescribed JiC medication.
- If the patient or carer requests medical assessment.

The healthcare professional working in the community will document the rationale for the administration of the medication within the patient's clinical records.

If the clinician initiates or increases syringe pump medication in line with an authorised range they should take into account the patient's symptoms and their requirements over the previous 24 hours, including PRN and regular doses. **Note, it is not usually appropriate to incorporate all PRN doses into the syringe pump, particularly if this would result in more than a 50% increase in total dose of opioid or midazolam. Particular caution is required if a patient has mainly movement related pain or complex psychosocial issues affecting their request for opioid or midazolam. In these circumstances consider advice from local hospice teams. The clinician must document rationale to explain the choice of dose and it is good practice to record relevant calculations.**

If the clinician starts a syringe pump based on an authorisation written in advance, they should usually start on the lowest dose in range but if assessment of PRN requirements indicates the need for a higher dose (within the range) the clinician must document rationale to explain the choice of dose and it is good practice to record relevant calculations.

Clinicians will record the dose and sign for the medication administered on the Community Palliative Care Drug Chart. They will also clearly record their assessment, reason for administering the medication and clinical response in the patients record. If controlled drugs (e.g. opioid or midazolam) are administered the Controlled Drug Running Balance Record must be completed. Any discrepancies should be reported via Ulysses and if controlled drugs have gone missing and cannot be accounted for clinicians should also report this via Ulysses.

Individual care homes may choose to use their own drug chart, although it is recommended the care homes use the Community Palliative Care Drug Chart. The record of administration must be written on the care homes equivalent chart in addition to their organisations nursing care plan. Where Sirona clinicians are required to support with syringe pumps in Care Homes, a Community Palliative Care Drug Chart must be used.

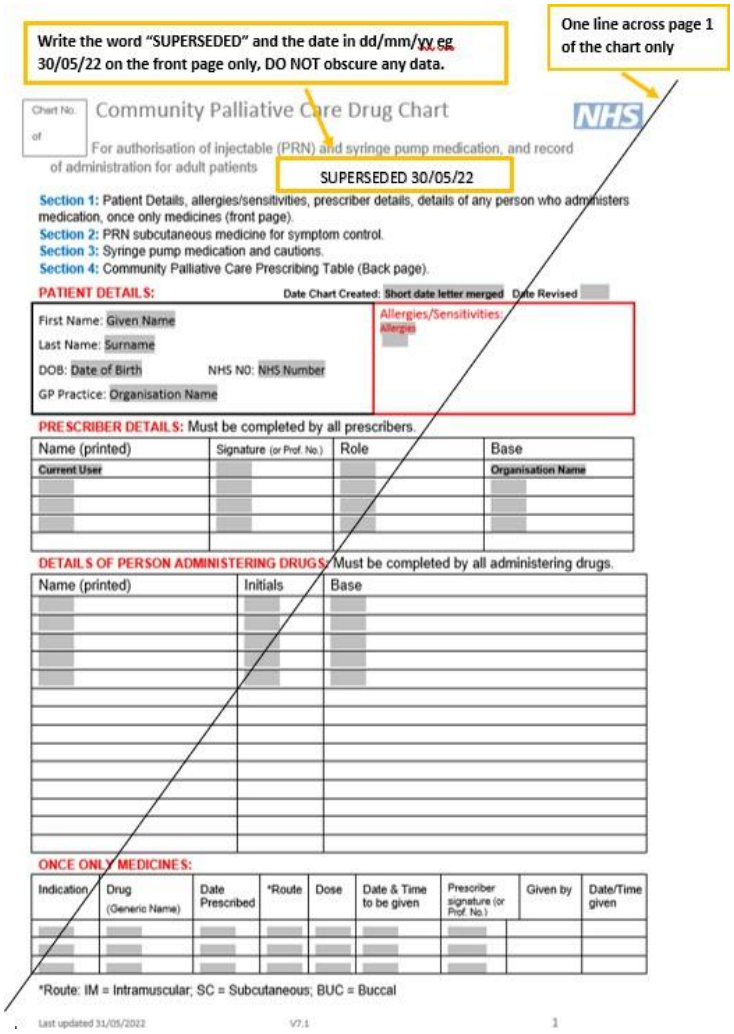
13. Following administration of 'Just in Case' medication

The patient must be reviewed by a suitably qualified healthcare professional to assess symptom control, and this review documented in the records. How quickly this review is required should be defined by the clinician administering the medication. If a community clinician has made 2 or 3 changes to a syringe pump, based on an authorised range, and feels further changes may be needed, a review by a GP or suitably experienced community clinician is recommended and advice from a hospice/palliative care healthcare professional may be considered.

If a patient has on-going symptoms a review by a suitable community clinician is recommended and advice from a hospice healthcare professional should be considered (e.g. Hospice Community Nurse Specialist or Hospice Advice Line). Following clinical assessment any new SC medications required should be prescribed, and authorised on the Community Palliative Care Drug Chart as before.

14.1 Superseded Community Palliative Care Drug Chart

When a replacement updated chart is issued by a prescriber it is acceptable for a community clinician who is not a prescriber to discontinue the old chart(s) by drawing a single line diagonally from bottom left corner to top right corner on the front page only. 'SUPERSEDED' should then be written at the top with the date in dd/mm/yy format e.g. 'SUPERSEDED 30/05/22', with the expectation the old chart is **removed within 48 hours**. This is because we cannot rely solely on electronic records to have the most up to date information and clinicians require the preceding doses for 24hrs to review any syringe pump medication.



14.2 Discontinued Community Palliative Care Drug Chart

When a chart is to be discontinued a prescriber must record this clearly on the patient's record, drawing a single line diagonally from bottom left corner to top right corner on the front page only with the word DISCONTINUED with the date in dd/mm/yy format e.g. 'DISCONTINUED 30/05/22'. Arrange for the CPCDC to be removed from the patients' home, or filed in the patients record if in a Sirona Rehab Unit or Hospice setting. A copy of the discontinued CPCDC should be saved into EMIS so all clinicians are aware the most recent CPCDC has been withdrawn and is discontinued. Medications are the property of the patient who should be advised to return them to a pharmacy for safe destruction, please refer to the Controlled Drug Policy and Controlled Drug Balance Chart for specific guidance on safe handling and destruction of Controlled Drugs. A

healthcare professional should advise and sign over the controlled medication to the patient, relative/carer to return the unused drugs to a community pharmacy for destruction. This should be documented in the patient's-controlled stock sheets. Controlled drugs (e.g. opioid or midazolam).

15. Process for disposal of 'Just in Case' medication if no longer required.

If the patient's condition improves, they are no longer actively deteriorating and medication is no longer required. A healthcare professional should advise the patient, relative/carer to return the unused drugs to a community pharmacy for destruction. This should be documented in the patient's clinical record. Controlled drugs (e.g. opioid or midazolam) are also recorded on the Controlled Drug Running Balance Record, where the 'Disposal of Controlled Drugs' section must be completed. Sirona clinicians should refer to the Controlled Drugs Policy for further information regarding the disposal of controlled drugs.

If the patient dies the medication becomes part of the estate and should be disposed of by the family. A healthcare professional should advise the next of kin / relative / carer to return the unused drugs to a community pharmacy for destruction. This should be documented in the patient's clinical record. Controlled drugs (e.g. opioid or midazolam) are also recorded on the Controlled Drug Running Balance Record, where the 'Disposal of Controlled Drugs' section must be completed. Sirona clinicians should refer to the Controlled Drugs Policy for further information regarding the disposal of controlled drugs.

If the patient is admitted to a hospice, care home, hospital or rehab unit, the medications should go with the patient.

If a JiC box or bag was in use it should be returned to Sirona's Community Team, cleaned in line with the Infection Control Policy and kept ready for re-use.

16. Risk management / liability

As with all drugs open to abuse, medicine supplies in patient's homes may be subject to misuse. If factors related to the patient, carer or environment suggest an increased risk then healthcare professionals should carry out individual risk assessment relating to the provision of 'Just in Case' medication.

Patients and/or carers may misinterpret anticipatory prescribing as a way of hastening death. Good communication and the provision of the explanatory leaflet should improve understanding.

Professionals will need to explore fears and provide appropriate support. Anticipatory prescribing should be tailored to the individual person and circumstances, taking into account risks and benefits of prescribing in advance. Prescribing medication in advance is only safe if those prescribing and administering the medication have the appropriate skills, knowledge and competencies (see section 17).

Prescribers should note that prescribing injectable medicines for subcutaneous injection is an unlicensed route but is supported by established clinical practice. Further information is available from the Medicines Healthcare Regulatory Agency (MHRA) and in the Palliative Care Formulary.

Any incidents or near misses concerning anticipatory prescribing, and remedial action taken must be reported through the local incident reporting systems, for Sirona clinicians this is via Ulysses and any areas of concern will be incorporated into the annual audit programme. Any learning from such incidents should be shared with relevant colleagues to reduce the likelihood of the incident re-occurring.

In the event of a medication incident or an adverse drug reaction, immediate care will need to be undertaken to minimise harm to the patient. The standard process using the yellow card system should be followed where applicable.

17. Training and competence

This policy / standard operating procedure (SOP) will be made available to all relevant healthcare staff.

All healthcare staff to whom it applies are required to read the policy / SOP including new staff on induction.

Staff should seek further advice from their clinical manager or medicines management team if there are any aspects of the policy / SOP that they do not fully understand.

All healthcare professionals who may be involved in administering subcutaneous medication via syringe pumps for palliative care patients in the community must attend syringe pump and other relevant training as directed by their respective organisations and have adequate knowledge of the administration and titration of medication at the end of life.

Every member of the healthcare team has a responsibility to check that the intended dose of an opioid medicine is safe for the individual patient. When opioid medicines are prescribed, dispensed or administered, the healthcare practitioner concerned should be familiar with the usual starting dose, frequency of

administration, standard dosing increments, symptoms of overdose and common side effects.

Medicines should only be prescribed, dispensed and administered by staff that have the necessary knowledge and skills and are confident and competent to carry out this practice. Healthcare staff must identify their own training needs and inform their manager if training needs are identified.

The requirements for safe management of medicines may change due to changes in legislation or best practice guidance. It is therefore essential that all healthcare staff keep up to date with current practice. Clinicians employed by Sirona care and health must have attended Syringe Pump Training (Introductory) and demonstrated associated competencies and thereafter attend the 3 yearly updates with self-assessment.

Staff should reflect on their medicines-related learning needs when discussing their Personal Development Plans with their manager.

18. Ordering the Community Palliative Care Drug Chart – Booklet

Requests for the booklet version of the Community Palliative Drug Chart are made via the CHC Fast Track team who can be contacted at bnssg.fasttrack@nhs.net. The CHC Fast Track team will place an order via the single appointed printer (Whitehall Printing) and distribute to all partners.

19. Dissemination and Implementation

Within Sirona care & health:

1. Circulate to Associate Locality Directors for dissemination
2. Update colleagues in the digital team to update EMIS template
3. Advertise the new policy on Sirona's intranet.
4. Deliver webinar, which will be recorded, to highlight changes to the policy
5. Use of Link Practitioners to share within localities and teams, providing ongoing awareness
6. In-reach to provide ongoing awareness
7. Audit to monitor use of correct chart

Across the Integrated Care System:

1. Dissemination from EOL Programme Board (membership includes representatives from health and social care professionals across the ICB such as Hospices, Social Services, GPs, Continuing Health Care,

SWAST, BrisDoc)

2. Escalation to the ICB from EOL Programme Board
3. Use of GP Teamnet to advertise and inform
4. Webinars and Vimeo's available across the ICB to communicate changes
5. Remedy update

20. Monitoring compliance

A Bristol, North Somerset and South Gloucestershire Integrated Care System working party will undertake a review of the policy every 2 years. Reviewing the effectiveness and safety of this SOP and guidance. Ongoing evaluation will include:

- Audit of Community Palliative Care Drug Charts and patient's community notes.
- Evaluation of number of complaints relating to symptom control or provision of medication for symptoms at the end of life.
- Evaluation/audit of medication errors/clinical incidents.

Minimum requirement to be monitored	Lead	Frequency of Report of Compliance	Reporting arrangements	Lead(s) for acting on Recommendations
Sirona: Provision of staff training	EOL SASS	Monthly	Summary of training undertaken and feedback	EOL SASS
Sirona: Audit of patient records	EOL SASS	Monthly	Audit records using a combination of data via BI Dashboard and Ulysses audit tool	EOL SASS

Sirona: Feedback from incidents, complaints and bereavement survey	EOL SASS	Monthly	Collating information received via compliments, complaints, incident reports and bereavement survey	EOL SASS
Accuracy of links and information	EOL SASS	Quarterly	Checking of links and information	EOL SASS

21. Related to procedural documents

- Recognising and escalating the deteriorating patient
- Resuscitation Policy
- Clinical Competency Policy
- Management of Queries, Concerns, Complaints and Compliments – Policy
- Patient safety incident response policy
- Verification of death and medical examiner policy
- Syringe Pump (Micrel) Policy
- Consent Policy and Procedure: Incorporating Mental Capacity Act Guidance
- Duty of Candour Policy
- End of Life Policy
- Care after death policy
- Controlled Drugs Policy
- Controlled Drug Destruction and Disposal SOP
- Informal Carer Administration of Subcutaneous Injections in the Community for End-of-Life Care

All of the above can be found on Sirona's intranet.

22. References

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Parliamentary and Health Service Ombudsman (2015) Dying without dignity. Dying_without_dignity.pdf (ombudsman.org.uk)

St Peters Hospice (2022) Clinical Guidelines Clinical Guidelines - St Peter's Hospice (stpetershospice.org)

Wessex Palliative Physicians (2019) Palliative Care Handbook. Ninth edition. Microsoft Word - GB 9th ed Final June 2019.docx (ruh.nhs.uk)

Wilcock, A., Howard, P., Charlesworth, S. (2022) Palliative Care Formulary. Eighth Edition. PCF8.

Palliative Care Formulary, accessed on line 2025.

Further reading:

http://www.stpetershospice.org.uk/Clinical-Guidelines

Guidelines on the management of pain due to cancer in adults: Bristol Palliative Care Collaborative

Appendix 1 Policy Implementation Plan

Policy Ref:	
Policy Name:	Policy for anticipatory prescribing of 'Just in Case' medication for symptom control in the last days of life in adult community
Name of Author/Originator:	Dr Dida Cornish Karla Smith-Bishton
Date Ratified at Professional Council/Quality	13/02/23

A Policy needs to be communicated clearly and easy to interpret if it is to be implemented effectively.

To guide the implementation that will be needed, you should consider the following questions:

a) Does the Policy require a change to current practices? Yes

b) Who are the key stakeholders that need to be informed of the Policy?
All health and social care providers across BNSSG; Primary care and GP's, out of hours services including BrisDoc, SWAST, Sirona care and health, St Peter's Hospice, Weston Hospice, secondary care, care homes including residential and nursing homes.

c) How do you get staff engaged ensuring that they have read and understood the Policy?
Within Sirona; for dissemination via Associate Locality Directors, Workplace communication, webinars, during in-reach, EOL Link Practitioner & Champion roles and meetings.
Across BNSSG; via the ICB for a system wide communication to disseminate to all services and update on Remedy.

d) How are you going to monitor that the Policy has been implemented into practice effectively? As outlined in section , Monitoring Compliance.

e) Do you have an Audit tool attached to the Policy? YES - Sirona 'Measurements of Person-Centred Care' audit within Ulysses

f) How will the policy and processes be accessible to the end user? (Consider the Accessible information Standard). The policy is available electronically which can be printed and interpreted if required. The drug Community Palliative Drug Chart will be available in electrical (protected word document), printed booklet and as a template which can be completed within EMIS and printed.

Implementation processes

Sirona care & health.

1. Group key stakeholders together and educate/upskill them to inform and communicate new policies to their teams and staff via webinar and in-reach teaching sessions.
2. The policy will involve communicating changes to existing work practices that could impact on staff time management or require changes in behaviour. EOL Champions will be updated to support with this along with EOL SASS in-reach. Information will be shared via Workplace.
3. Webinar to support the changes specific to the new community palliative care drug charts
4. EOL SASS undertake monthly audits via Ulysses and in-reach to check the correct completion of the new drug chart and highlight concerns with the prescriber.

Implementation Plan
Sirona care & health: 1) Circulate to Associate Locality Directors and Integrated Neighbourhood Team Managers for dissemination 2) Advertise the new policy on Workplace 3) Deliver a webinar, which will be recorded, to highlight changes to the policy Across the Integrated Care System: 1) Dissemination from EOL Programme Board (membership includes representatives from health and social care professionals across the ICB such as Hospices, Social Services, GPs, Continuing Health Care, SWAST, BrisDoc) 2) Escalation to the ICB from EOL Programme Board 3) Use of GP Teamnet to advertise and inform Webinars and Vimeo's available across the ICB to communicate changes

Completed By (Policy Lead):	Karla Smith-Bishton
Date:	13/02/23

Appendix 2 Equality & Health Inequality Impact Assessment Tool

Name of the policy: Policy for anticipatory prescribing of 'Just in Case' medication for symptom control in the last days of life in adult community palliative and end of life care patients.
Please confirm that the full Equality & Health Inequalities Impact Assessment has been completed: *Previous full assessment has been refreshed*
Author(s) or Lead Person who carried out this assessment: Karla Smith-Bishton
Job title(s) and directorate: Clinical and Operational Lead, Sirona End of Life Specialist Service
Date the assessment was completed: 10/07/25

Due Regard

Summarise how Equality considerations have been incorporated in the document.

Patients with a terminal illness, who are deteriorating often experience new or worsening symptoms as they approach the last days of life and may be unable to swallow oral medication. This guideline seeks to avoid distress caused by delayed access to medicines by anticipating need and providing appropriate medication in the home (GSF 2006, Wilcock et al 2020). For palliative care patients who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home for the management of symptoms which commonly occur in the last days of life (NICE 2015). A range of subcutaneous (SC) medication should be prescribed and authorised on the Community Palliative Care Drug Chart to allow clinicians working in the community, to administer if the patient is unable to take oral medication. The policy is applicable to all patients who would meet the criteria of needing anticipatory

medications equitably.
The following considerations have been taken to ensure this policy meets the requirements of the Public Sector Equality Duty (PSED) and the organisations commitment to equality and inclusion:

Section	Page	Details of consideration taken	Relevant protected characteristics or other groups
Example *Section x*	*Page x*	*Specific consideration included to ensure people with physical impairments can gain entry to the building*	*Disability and age*

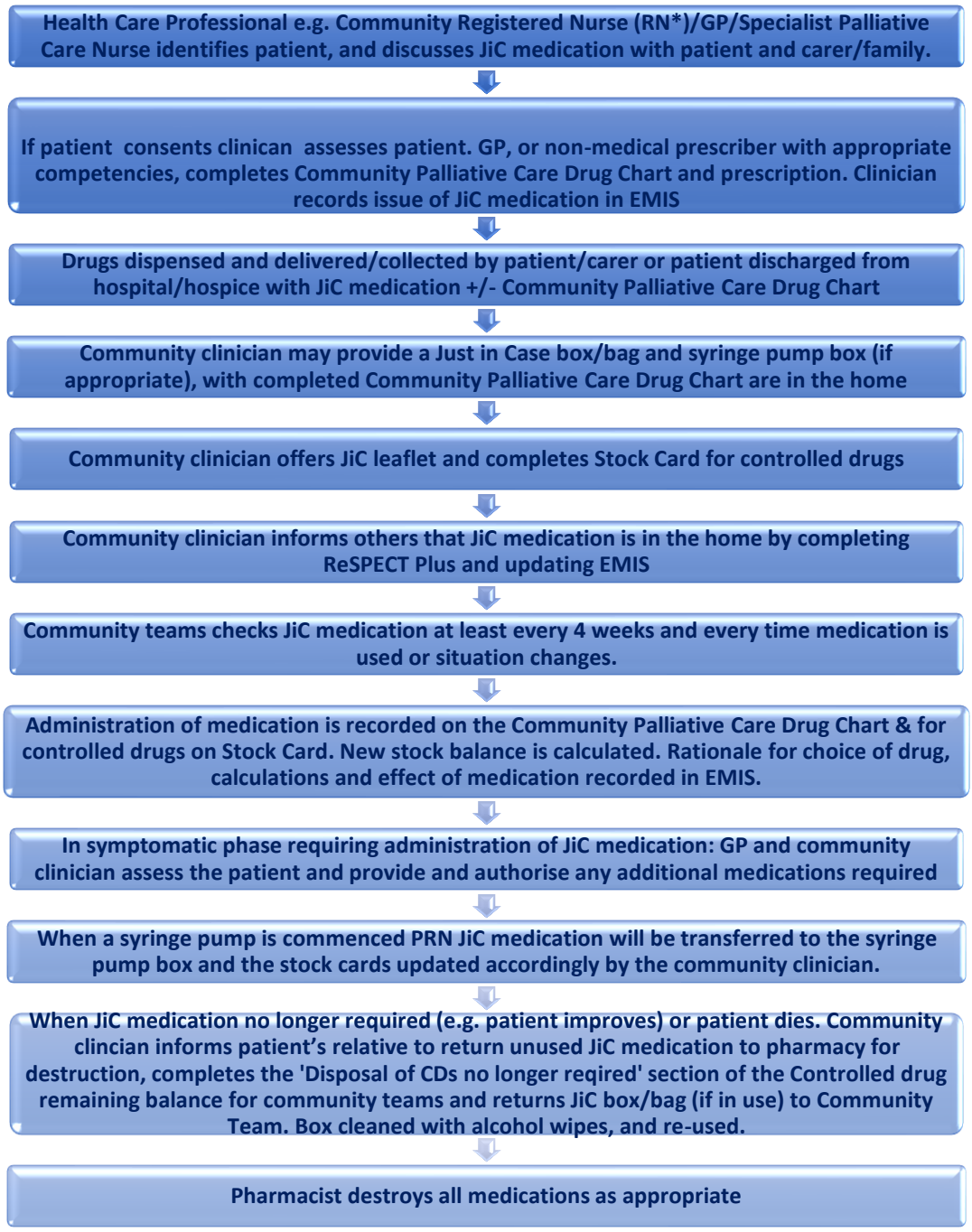
Please copy the following summary information from Section 4 of the completed EHIIA Template:

4.1 What are the main conclusions of this equality and health inequalities impact assessment? Share a brief summary of the positive impact the proposal will make and any negative impact and mitigations e.g. what steps you have taken to improve accessibility. Explain how the EHIA has informed, influenced or changed the proposal.
This policy ensures any patient and their family, next of kin and/or carers are treated equally using a standardised approach. All patients should be able to access Just in case medications, information around just in case medications is available in a range of formats and languages if required.

4.2 Outline how the proposal will support our Public Sector Equality Duty responsibilities:		
To eliminate discrimination, harassment and victimisation. All patients are able to access the same treatment in end of life.	Positive Negative No effect	☒ ☐ ☐
Please describe:		
To advance equality of opportunity between people who share a protected characteristic and those who do not.	Positive Negative No effect	☐ ☐ ☒
Please describe: N/A		
To foster good relations between people who share a protected characteristic and those who do not	Positive Negative No effect	☒ ☐ ☐
Please describe: All patients are able to access the same treatment in end of life.		

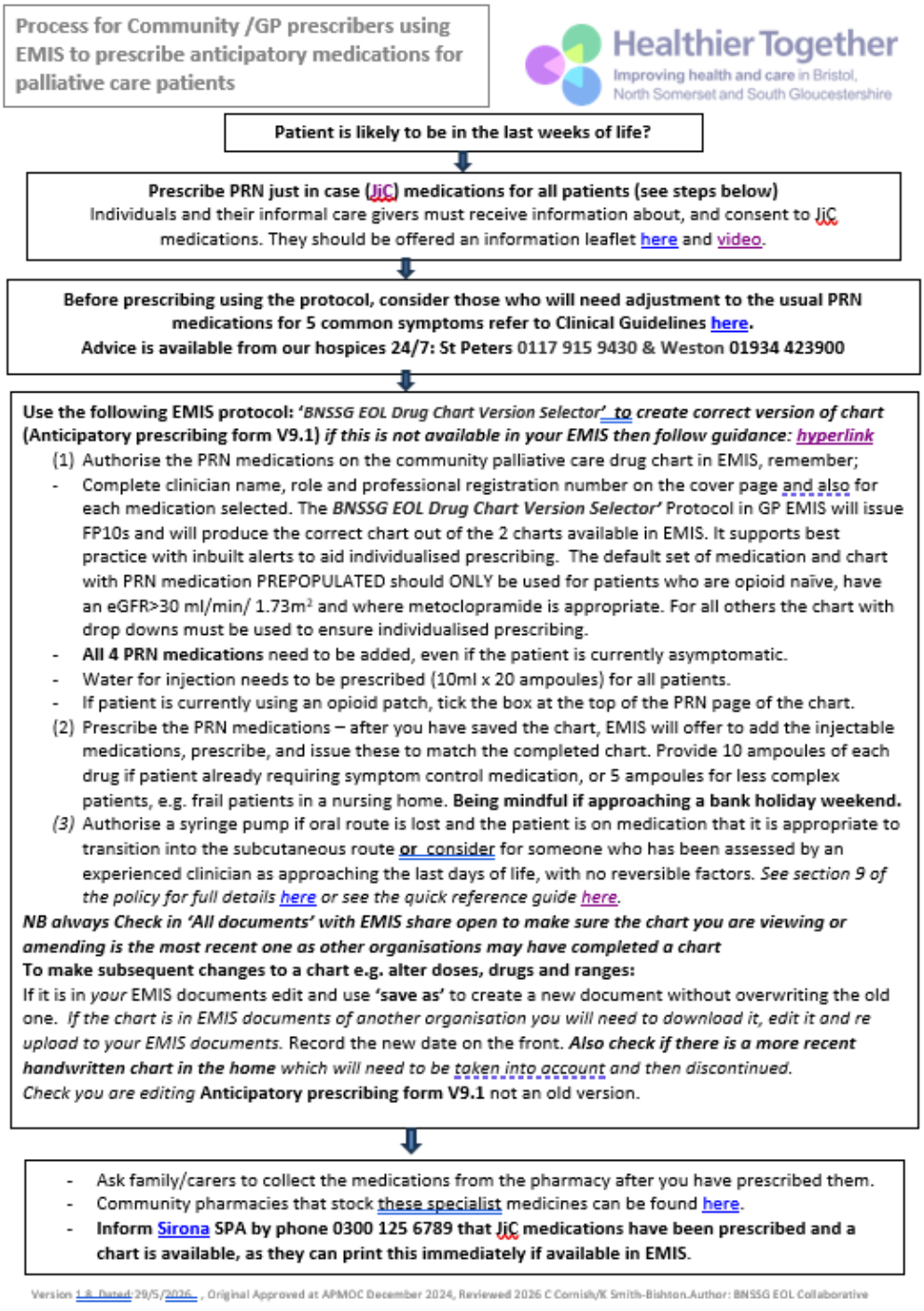
Appendix 3 Process Flow Chart

For palliative care patients who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home, for the management of symptoms which may occur at the end of life.



Appendix 4 Process for the prescribing of anticipatory medications for Community / GP Prescribers using EMIS

NB The PDF version with working hyperlinks can be obtained from sirona.endoflifeteam@nhs.net



Process for Community /GP prescribers using EMIS to prescribe anticipatory medications for palliative care patients

Healthier Together
Improving health and care in Bristol, North Somerset and South Gloucestershire

Patient is likely to be in the last weeks of life?

Prescribe PRN just in case (JiC) medications for all patients (see steps below)
Individuals and their informal care givers must receive information about, and consent to JiC medications. They should be offered an information leaflet here and video.

Before prescribing using the protocol, consider those who will need adjustment to the usual PRN medications for 5 common symptoms refer to Clinical Guidelines here.
Advice is available from our hospices 24/7: St Peters 0117 915 9430 & Weston 01934 423900

Use the following EMIS protocol: *'BNSSG EOL Drug Chart Version Selector' to create correct version of chart* (Anticipatory prescribing form V9.1) *if this is not available in your EMIS then follow guidance: hyperlink*

(1) Authorise the PRN medications on the community palliative care drug chart in EMIS, remember;
- Complete clinician name, role and professional registration number on the cover page and also for each medication selected. The ***BNSSG EOL Drug Chart Version Selector'*** Protocol in GP EMIS will issue FP10s and will produce the correct chart out of the 2 charts available in EMIS. It supports best practice with inbuilt alerts to aid individualised prescribing. The default set of medication and chart with PRN medication PREPOPULATED should ONLY be used for patients who are opioid naïve, have an eGFR>30 ml/min/ 1.73m^2 and where metoclopramide is appropriate. For all others the chart with drop downs must be used to ensure individualised prescribing.
- **All 4 PRN medications** need to be added, even if the patient is currently asymptomatic.
- Water for injection needs to be prescribed (10ml x 20 ampoules) for all patients.
- If patient is currently using an opioid patch, tick the box at the top of the PRN page of the chart.

(2) Prescribe the PRN medications – after you have saved the chart, EMIS will offer to add the injectable medications, prescribe, and issue these to match the completed chart. Provide 10 ampoules of each drug if patient already requiring symptom control medication, or 5 ampoules for less complex patients, e.g. frail patients in a nursing home. **Being mindful if approaching a bank holiday weekend.**

(3) Authorise a syringe pump if oral route is lost and the patient is on medication that it is appropriate to transition into the subcutaneous route **or** consider for someone who has been assessed by an experienced clinician as approaching the last days of life, with no reversible factors. *See section 9 of the policy for full details here or see the quick reference guide here.*

NB always Check in 'All documents' with EMIS share open to make sure the chart you are viewing or amending is the most recent one as other organisations may have completed a chart

To make subsequent changes to a chart e.g. alter doses, drugs and ranges:
If it is in *your* EMIS documents edit and use **'save as'** to create a new document without overwriting the old one. *If the chart is in EMIS documents of another organisation you will need to download it, edit it and re upload to your EMIS documents.* Record the new date on the front. ***Also check if there is a more recent handwritten chart in the home*** *which will need to be taken into account and then discontinued.*
Check you are editing **Anticipatory prescribing form V9.1** not an old version.

- Ask family/carers to collect the medications from the pharmacy after you have prescribed them.
- Community pharmacies that stock these specialist medicines can be found here.
- **Inform Sirona SPA by phone 0300 125 6789 that JiC medications have been prescribed and a chart is available, as they can print this immediately if available in EMIS.**

Version 1.8 Dated 29/5/2026 , Original Approved at APMOC December 2024, Reviewed 2026 C Cornish/K Smith-Bishton.Author: BNSSG EOL Collaborative

Appendix 5 Community Palliative Care Drug Chart

Community Palliative Care Drug Chart

NHS

Chart No. ___ of ___

For authorisation of injectable (PRN) and syringe pump medication, and record of administration for adult patients (Expires after 6 months)

Hospital pharmacist discharge check: sign: name: date:

Section 1: Patient Details, allergies/sensitivities, prescriber details, details of any person who administers medication, once only medicines (front page).
Section 2: PRN subcutaneous medicine for symptom control.
Section 3: Syringe pump medication and cautions.
Section 4: Community Palliative Care Prescribing Table (Back page).

Tick if this chart is being used for non end of life symptom control ☐

PATIENT DETAILS: Date Chart Created: Short date letter merged Date Revised

First Name: Given Name
Last Name: Surname
DOB: Date of Birth NHS NO: NHS Number
GP Practice: Organisation Name

Allergies/Sensitivities:
Allergies

Either a wet signature or electronic GMC / NMC number is required.

PRESCRIBER DETAILS: Must be completed by all prescribers.

Name (printed)	Signature (or Prof. No.)	Role	Base
Current User			Organisation Name

DETAILS OF PERSON ADMINISTERING DRUGS: Must be completed by all administering drugs.

Name (printed)	Initials	Base

ONCE ONLY MEDICINES:

Drug (Generic Name)	Indication	Date Prescribed	*Route	Dose	Date & Time to be given	Prescriber signature (or Prof. No.)	Given by	Date/Time given

Patient Name: Full Name NHS No: NHS Number

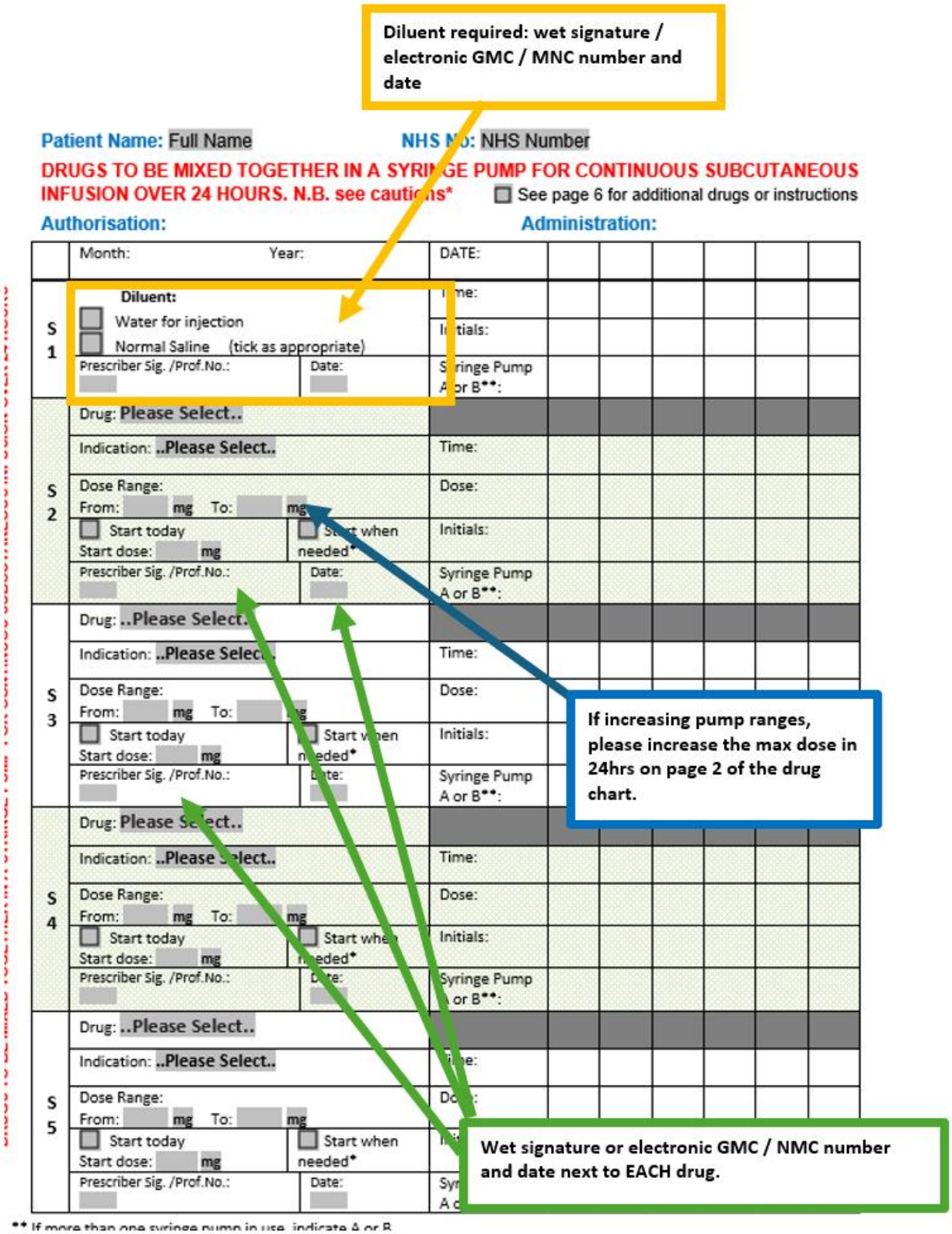
AS REQUIRED PRN DRUGS (TICK if on opioid patch ☐ Details)

Authorisation: Administration: ☐ Additional instructions page 6

PRN 1	Drug: Please Select		Date:								
	Indication: Please Select		Time:								
	Dose Range: mg	Max Frequency:	Dose:								
	Route: SC	Max in 24hrs including pump: mg	Route:								
	Prescriber Sig. /Prof.No.:	Date:	Initials:								
PRN 2	Drug: Please Select		Date:								
	Indication: Please Select		Time:								
	Dose Range: mg	Max Frequency:	Dose:								
	Route: SC	Max in 24hrs including pump: mg	Route:								
	Prescriber Sig. /Prof.No.:	Date:	Initials:								
PRN 3	Drug: Please Select		Date:								
	Indication: Please Select		Time:								
	Dose Range: mg	Max Frequency:	Dose:								
	Route: SC	Max in 24hrs including pump: mg	Route:								
	Prescriber Sig. /Prof.No.:	Date:	Initials:								
PRN 4	Drug: Please Select		Date:								
	Indication: Please Select		Time:								
	Dose Range: mg	Max Frequency:	Dose:								
	Route: SC	Max in 24hrs including pump: mg	Route:								
	Prescriber Sig. /Prof.No.:	Date:	Initials:								
PRN 5	Drug:		Date:								
	Indication:		Time:								
	Dose Range: mg	Max Frequency:	Dose:								
	Route: SC	Max in 24hrs including pump: mg	Route:								
	Prescriber Sig. /Prof.No.:	Date:	Initials:								
PRN 6	Drug:		Date:								
	Indication:		Time:								
	Dose Range: mg	Max Frequency:	Dose:								
	Route: SC	Max in 24hrs including pump: mg	Route:								
	Prescriber Sig. /Prof.No.:	Date:	Initials:								

Apply a wet signature OR if electronic GMC / NMC number and date.

If increasing the pump range, increase the PRN dose to reflect 1/6th of total SC background opioid in 24 hours except for alfentanil (PRN is 1/10th)


Diluent required: wet signature / electronic GMC / MNC number and date
Patient Name: Full Name
NHS No: NHS Number
DRUGS TO BE MIXED TOGETHER IN A SYRINGE PUMP FOR CONTINUOUS SUBCUTANEOUS INFUSION OVER 24 HOURS. N.B. see cautions*
See page 6 for additional drugs or instructions
Authorisation:
Administration:
Month:
Year:
DATE:
S 1
Diluent:
Water for injection
Normal Saline (tick as appropriate)
Prescriber Sig. /Prof.No.:
Date:
Time:
Initials:
Syringe Pump A or B**:
S 2
S 3
S 4
S 5
Drug: Please Select..
Indication: ..Please Select..
Dose Range:
From: mg To: mg
Start today
Start dose: mg
Start when needed*
Dose:
If increasing pump ranges, please increase the max dose in 24hrs on page 2 of the drug chart.
Wet signature or electronic GMC / NMC number and date next to EACH drug.
** If more than one syringe pump in use, indicate A or B

Appendix 6 Anticipatory prescribing (AP) of Just in Case (JiC) medication for symptom control in adult palliative care patients in last days of life: BNSSG quick reference guide.

For palliative care service users who are actively deteriorating and are in the last weeks or days of life it is good practice to provide anticipatory or 'Just in Case' (JiC) medication in the home for the management of symptoms which commonly occur in the last days of life. Individuals who deteriorate or develop uncontrolled symptoms will always require full clinical assessment to ensure there is appropriate treatment of any reversible factors and a clear management plan. Anticipatory prescribing should be tailored to the individual person and circumstances, taking into account risks and benefits of prescribing in advance. This is a quick reference guide, for more detail refer to full Standard Operating Procedure. For prescribing guidance refer to '*Community palliative care prescribing table: symptom control in last days of life for adults'* all available on St Peter's Hospice Guidelines page: https://www.stpetershospice.org/for-professionals/resources-for-professionals/clinical-guidelines/

Prescribing JiC medication and using Community Palliative Care Drug Chart to authorise administration

- Issue a prescription and authorise for administration on the chart. There are 2 versions of the chart in use:
    - 1. Electronic version (typed in EMIS, or rich text document completed by Out of Hours or occasionally in acute trusts) and printed on paper-often in black and white
    - 2. Colour card booklet version which is completed by hand (orders: bnssg.fasttrack@nhs.net)
- For both versions of the chart the prescriber and clinician administering medications must add their details to the front of the chart.
- The Anticipatory Drugs Protocol in GP EMIS will produce prescriptions and a chart. It supports best practice with inbuilt alerts to aid individualise prescribing. The default set of medication and prepopulated chart should only be used for patients who are opioid naïve, have an eGFR>30 ml/min/ 1.73m^2 and where metoclopramide is appropriate.
- For all other patients it is important to select 'no' when asked if you want to issue the default set of medication and then the protocol will launch the chart with drop downs to select individualised drugs.
- For the electronic version ensure: each drug is 'signed' by typing professional number and date, chart is printed off (preferably double sided) and stapled into booklet version with administration pages aligned. A wet signature is not required.
- Sirona staff can print the chart from EMIS or if emailed by out of hours, to take into the home, but the prescriber must always communicate clearly what is needed by telephoning the Sirona Single Point of Access.
- If urgent ensure the local pharmacy has enough stock to dispense the prescription or refer to the list of pharmacies which stock Palliative Care Medication on St Peter's Hospice Guidelines page.
- ***NB always Check in 'All documents' with EMIS share open to make sure the chart you are viewing or amending is the most recent one as other organisations may have completed a chart***
- A prescriber can update charts by editing the previous version in EMIS and using 'save as' to create a new document if it is in their EMIS. They should record the date on the front of the chart. See resources on St Peters Hospice Guidelines page e.g. 'teams- net' site and 'process' document for more instructions on editing charts.
- A non-prescribing community clinician can discontinue any old charts by putting a line through the front with the words 'superseded' and the date.

JiC medication in last weeks of life

- Prescribe and authorise as required (PRN) medication for each of the 5 symptoms commonly experienced at the end of life listed here with the 1st line drug: pain, dyspnoea (opioid for both), nausea/vomiting (individualised antiemetic), agitation (midazolam) and respiratory tract secretions/colic (Hyoscine butyl bromide).
- Convert their usual PO PRN opioid to appropriate SC dose. If an individual is on a regular antiemetic provide this as SC PRN if available. Otherwise choose antiemetic according to cause of nausea. (See prescribing table) Cyclizine is not used first line unless specifically indicated, e.g. in brain malignancies.
- Do not authorise medication for syringe pump in advance until approaching last days of life
- Provide **10 doses** of each drug if patient already requiring symptom control medication or **5 doses** for less complex patients, e.g. frail patients in a nursing home. >10 doses may be needed if very complex/symptomatic.
- Prescribe water for injection 10ml x 20 so it is available should a syringe pump be needed
- You can now add additional instructions to the free text box on page 6 and tick a box on page 2 if this relates to PRNS or page 4 if relates to syringe pumps to show that you have done this.

JiC medication when approaching or in last days of life

- If an individual has lost their oral route convert any medication needed for symptom control to a syringe pump using the prescribing table and conversion factors and tick box 'start today' on chart
- Consider **appropriate ranges** (see cautions): For opioid or midazolam a conservative syringe pump range allows for incorporation of 2 PRN doses (e.g. morphine 30 - 40mg/24 hours, PRN 5mg SC) and the usual maximum syringe pump range allows for incorporation of 4 PRN doses (e.g. morphine 30 - 50mg/ 24 hours). ***Seek specialist advice if considering a wider range.***
- If likely to be needed in a few days, consider authorising syringe pump medications in advance with ranges for each of the 5 common symptoms and tick box 'to start when needed' BUT **see cautions**
- **Remember to prescribe and authorise diluent usually water for injection.**
- Prescribe enough medication for 7 days if starting a syringe pump or for at least 3 days if authorising pump to 'start when needed'.

Cautions regarding authorisation and administration of syringe pumps

- Authorising syringe pumps ***in advance to start when needed*** is usually only appropriate if an individual is ***approaching last days of life*** and their deterioration is not reversible OR occasionally for a patient who is at high risk of a specific symptom. e.g. vomiting in recurrent bowel obstruction.
- If a syringe pump is authorised for symptom control for an individual with a longer prognosis than weeks or days, tick the box 'non end of life' on front of the chart and do **not** authorise other syringe pump drugs for last days of life such as midazolam 'to start when needed'.
- Some nursing home staff may not be trained in the use of ranges or pumps in advance, consider tighter ranges, no ranges or PRNS only after making a careful assessment.
- When selecting a dose from a range for syringe pump administration start on the lowest dose unless assessment of PRN requirements indicates the need for a higher dose. Rationale for the chosen dose should be documented.
- Consider titrating doses in syringe pump according to PRNS in last 24 hours but it is **not** always appropriate to incorporate all PRNS from previous 24 hours when titrating a syringe pump dose. Seek specialist advice when increasing total 24 hour dose by more than 50% of previous 24 hour dose in the syringe pump.
- If the individual has ongoing symptoms or a community clinician has made 2-3 changes to a syringe pump dose based on an authorised range consider a GP review and advice from a hospice health care professional before increasing the range.

Communication and advance care planning

- Individuals and their informal care givers must receive information about AP and consent to JiC medications. They should be offered an information leaflet.
- It is important to consider advance care planning, and include information on AP in the electronic 'ReSPECT plus' record, available to health care services in all settings.

Anticipatory Prescribing in specific circumstances

Individuals on opioid patches

- The dose of opioid patch is not usually titrated in last days of life, as the slow absorption would result in delays achieving required increases. The patch is kept in place and changed as usual. Tick the box if on opioid patch on the PRN page of the chart and complete details.
- PRN subcutaneous analgesic (converting their usual oral PRN opioid) should be prescribed at a dose appropriate to the patch strength. If a person is approaching last days of life consider authorising a syringe pump to start when needed for the 5 common symptoms. The dose range for the opioid can be the calculated equivalent to approximately two-four SC PRN doses of opioid.

Patch type	Patch strength Micrograms/hr	Equivalent 24 hour dose oral morphine	Equivalent 24 hr dose subcutaneous morphine	PRN SC dose of morphine	Syringe pump 'to start when needed'
Fentanyl	25mcg/hr	60-90mg/24hrs	30-45mg/24hrs	5-7.5mg 1 hourly	Morphine 15-30mg/24 hrs
Buprenorphine	20mcg/hr	36-65mg/24hrs	~15-30mg/24hrs	2.5-5mg 1 hourly	Morphine 10-20mg/24 hrs

- If several PRN doses are needed, a syringe pump can be set up containing appropriate opioid, which can easily be titrated, alongside the patch. PRN doses must be adjusted to take into account patch and syringe pump opioid.

Steroids (Additional guidance is available on St Peter's Hospice Guidelines page.)

- Continue steroids if considered essential for symptom control otherwise consider discontinuation or gradual reduction.
- Dexamethasone 4mg orally is considered equivalent to dexamethasone 3.3mg injection
- Dexamethasone may be given as a single daily SC injection, preferably in the morning, if dose is 6.6mg or less (Ampoules are 3.3mg in 1ml or 6.6mg in 2ml as dexamethasone base). For higher doses give via a syringe pump. It is incompatible with most other drugs so a second syringe pump is usually required.

Seizures/anticonvulsant drugs

- For individuals on anticonvulsant drugs for the control of seizures who are unable to take oral medication (or those likely to become unable to take oral medication in the next few days): prescribe and authorise midazolam 20-30mg/24 hours SC via syringe pump for control of seizures (seek advice about using lower doses e.g. 10-15mg/24 hours in frailer/very low weight patients with good seizure control on monotherapy).
- Prescribe Midazolam 10mg SC/IM or Buccal PRN for treatment of a prolonged seizure >5 minutes, which can be repeated after 10 minutes in status epilepticus (seek advice about using lower doses in frailer/very low weight patients).

- Some antiemetics lower the seizure threshold. If patient has a primary brain tumour/history of seizures consider cyclizine as 1st line antiemetic and glycopyrronium as the anti secretory for anticipatory prescribing (hyoscine butyl bromide does not mix with cyclizine in a pump).

If at risk of major hemorrhage

- Consider authorising Midazolam 10mg IM/Buccal on the front of the chart as a once only medication.

Parkinson's Disease and other movement disorders

- Additional guidance is available on St Peter's Hospice Guidelines page
- Avoid use of anti-emetics such as haloperidol and metoclopramide. Due to risk of side effects consider Ondansetron 1st line, Cyclizine 2nd line and levomepromazine 3rd line for nausea and vomiting.
- Seek advice on managing rigidity from Parkinson's Disease Specialist Nurse if available or use guidance to convert oral medications to a patch using Home | PDMedCalc

Inoperable complete gastro-intestinal obstruction

- Seek specialist advice from the local hospice team. Metoclopramide may be used in a syringe pump if there is incomplete obstruction and absence of colic.
- Avoid metoclopramide in complete obstruction or in the presence of colic. Hyoscine butyl bromide can be used via a syringe pump for colic and to reduce volume of GI secretions.

Renal failure

- If < eGFR <30 ml/min/1.73m^2 and there is a clinically relevant risk of side effects consider adjustments in the doses of some JiC medications as per prescribing table.
- When prescribing opioid if eGFR <30 ml/min/1.73m^2 see guidance on fentanyl and alfentanil available on St Peter's Hospice guidelines web page. It is important to weigh up the risk of side effects from more commonly used opioids against the risk of prescribing drugs such as fentanyl/alfentanil where community staff are less familiar with their use and there is more risk of administration errors. Seek specialist advice from hospice teams.

Liver impairment

- For those with severe impairment, classified as Charles-Pugh score of C (e.g. advanced cirrhosis/liver failure) and there is a clinically relevant risk of side effects consider adjustments in the doses of some JiC medications as per prescribing table.
- It is not usually necessary to adjust the JiC opioid but seek specialist advice if there are concerns about side effects.

C Cornish 6/2026 review 2029

Appendix 7 Community Palliative Care Prescribing Table

Community palliative care prescribing table: symptom control in last days of life for adults

Anticipatory Prescribing (AP): ***Last weeks of life*** authorise at least 1 PRN drug for symptoms 1-4
If ***approaching last days*** consider authorising syringe pump to 'start when needed' with appropriate ranges, but note ***cautions on syringe pump page*** & remember diluent: **usually water for injection**.

AP: *supply the following number of doses:* PRN drugs only:10. Complex symptoms or authorising syringe pump in advance: >10 e.g. 3 days supply. Non complex/no symptoms: 5				**Starting dose range over 24 hours via subcutaneous syringe pump**	**Usual total maximum dose/24 hours**
Symptom	**Injectable Drug**	**Subcutaneous (SC) as required (PRN) dose and minimum interval:**	**Ampoule Strengths**		
SYMPTOM 1: PAIN/DYSPNOEA					
If on oral opioids see table for conversion[¥] If eGFR <30 seek guidance[**]	Morphine 1st Line	2.5-5mg 1 hourly if opioid naïve OR 1/6th 24 hour SC dose 1 hourly	10, 15, 20 or 30mg/ml in 1ml or 2ml amps	if opioid naïve: 10-15mg *5-15mg[FL]*	No upper limit but prescriber may indicate a max dose
	Oxycodone	*1-2mg 1 hourly if opioid naïve[RF]* OR 1/6th 24 hour SC dose 1 hourly *Seek advice for use in renal failure[**]*	10mg/1ml, 20mg/2ml, 50mg/ml	*If opioid naive 2.5-7.5mg[RF]*	
SYMPTOM 2: NAUSEA AND VOMITING					
Opioid or chemical	Haloperidol	1-1.5mg 6 hourly *0.5-1mg 6 hourly [RLF]*	5mg/ml	1.5-5mg *1-3mg [RLF]*	5mg *3mg [RLF]*
Prokinetic	Metoclopramide	10mg 6 hourly *5-10mg 6 hourly [RL]*	10mg/2ml	30-60mg *20-30mg [RL]*	80mg+ *30mg [RL]*
Centrally induced	Cyclizine* Not 1st line for AP	50mg 6 hourly: if not on regular *Avoid in severe liver impairment[L]*	50mg/ml	150mg	150mg
Broad Spectrum	Levomepromazine	5mg 6 hourly	25mg/ml	5-25mg	25mg
Parkinson's or 3rd line	Ondansetron	4mg 6 hourly *4mg 8 hourly[L]*	4mg/2ml	8-16mg *4-8mg[L]*	24mg *8mg[L]*
SYMPTOM 3: AGITATION IN LAST DAYS OF LIFE					
1st line	Midazolam	2.5-5mg 1 hourly	10mg/2ml	10-20mg *5-15mg [RLF]*	60mg
+ hallucinations or confusion	Haloperidol	1-1.5mg 6 hourly *0.5-1mg 6 hourly [RLF]*	5mg/ml	1.5-5mg *1-3mg [RLF]*	10mg *5mg [RLF]*
2nd line	Levomepromazine	12.5-25mg 4 hourly	25mg/ml	12.5-25mg	100mg
SYMPTOM 4: RESPIRATORY TRACT SECRETIONS IN LAST DAYS OF LIFE					
Chest/gastro-intestinal secretions or colic	Hyoscine Butylbromide *	20mg 2 hourly -1st line If prescribing cyclizine use glycopyrronium	20mg/ml	60-140mg	240mg
	Glycopyrronium	200 micrograms 2 hourly-2nd line *Avoid if possible if eGFR<30ml/min[R]*	200 microgram/ml	600-1200 micrograms	1.2mg

[RLF]Consider dose adjustments if clinically relevant: R: eGFR <30 ml/min/1.73m²; L: Severe liver impairment: Child-Pugh C; F: Severe frailty: clinical judgement or very low BMI/weight

[¥]Conversion of oral to subcutaneous opioids via syringe pump/24hrs (Do not change patient's opioid drug unless indicated)		
Oral morphine ⟶	s/c morphine	Divide oral total 24hr dose by 2
Oral oxycodone ⟶	s/c oxycodone	Divide oral total 24hr dose by 2
Oral morphine ➡	SC diamorphine (use if volume too high: seek advice)	Divide oral total 24hr dose by 3

+Specialist advice suggested for metoclopramide doses >60mg

*Cyclizine is incompatible with hyoscine butylbromide and has dose related incompatibility with oxycodone in a syringe pump

****See guidance /seek advice for:**

- Patients on opioid patches: do not discontinue, prescribe SC PRN opioid and syringe pump if needed
- Opioids if eGFR <30ml/min/1.73m²: consider SC fentanyl or alfentanil if appropriate: seek advice or see specific guidance[**]
- Parkinson's Disease antiemetics: 1st ondansetron, 2nd cyclizine, 3rd levomepromazine. Avoid haloperidol & metoclopramide.

[**]For AP guidance notes, specific guidelines e.g fentanyl or alfentanil if eGFR<30, full SOP plus link to pharmacies stocking AP/palliative care medication see https://www.stpetershospice.org/for-professionals/resources/clinical-guidelines/
Hospice 24 hour telephone advice: St Peter's Hospice: 0117 9159430; Weston Hospice: 01934 423900
Community Nurse 24 hour contact Sirona Single Point of Access: 03001256789

Dr C Cornish/Dr K Davies 2026 with adjustments based on local trust guidelines, PCF and BNSSG consensus. Review 2029
Last updated 16/04/2026 v9 8

Appendix 8 Pharmacies providing specialist medication

Available via Remedy.

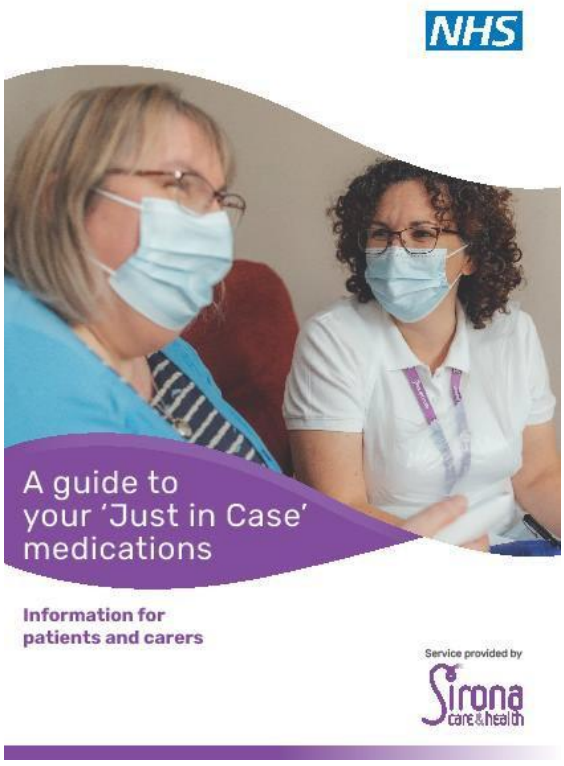
16. Palliative Care Guidelines (Remedy BNSSG ICB)

Appendix 9 Medications to be held by participating pharmacies

NHS England Southwest Enhanced Service for the availability of specialist medicines, list of medications to be held in stock.

16. Palliative Care Guidelines (Remedy BNSSG ICB)

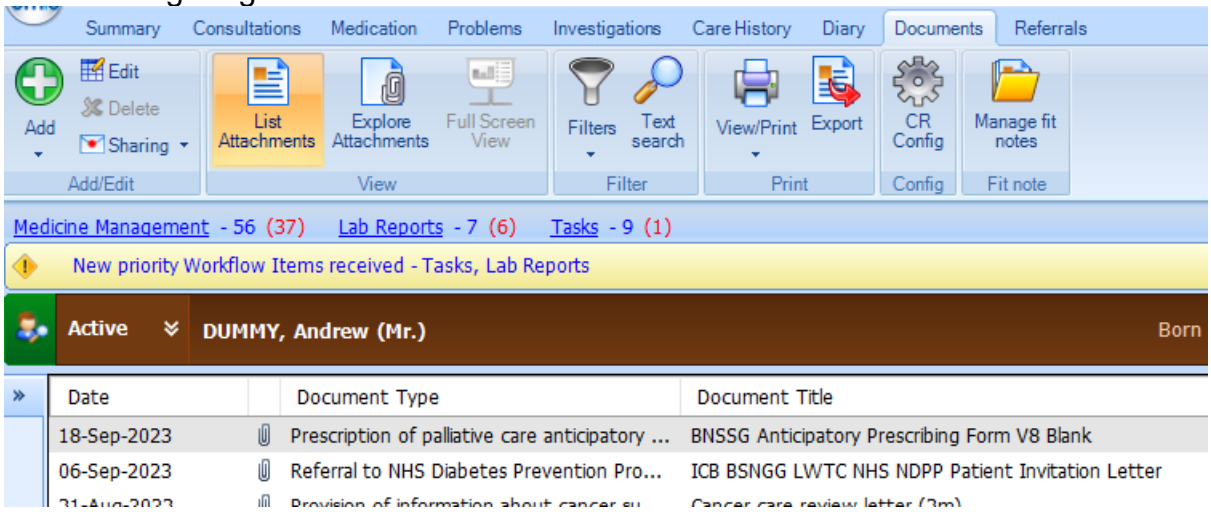
Appendix 10: A guide to your 'Just in Case' medications: Information for patients and carers.



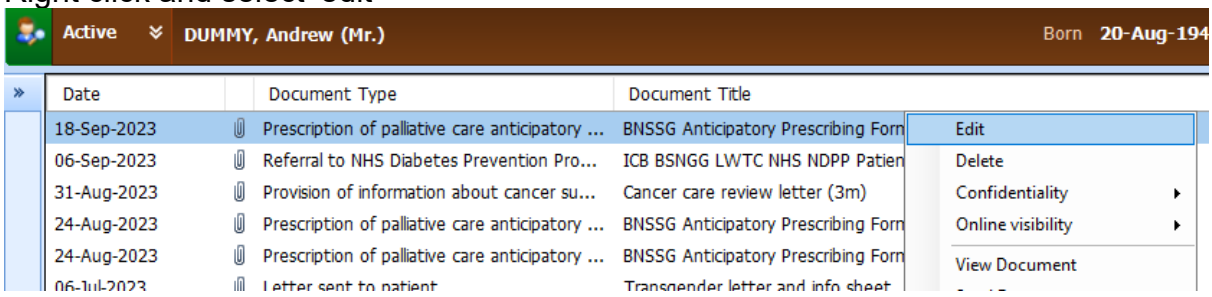
Appendix 11: Information for editing a CPCDC in EMIS.

Updating an existing Anticipatory Drugs Chart and saving using the 'Save As' function

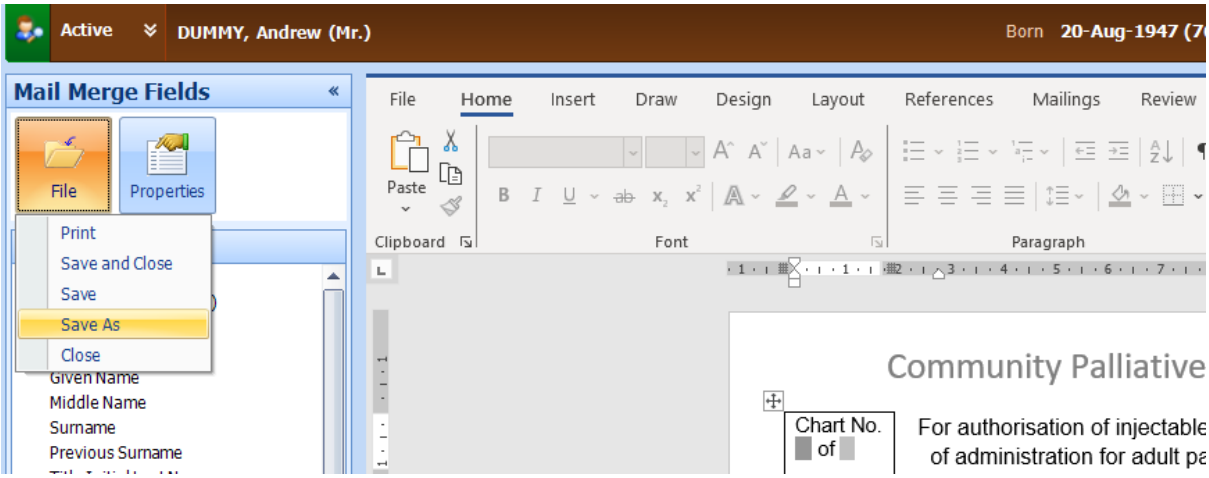
Find existing drugs chart on documents screen



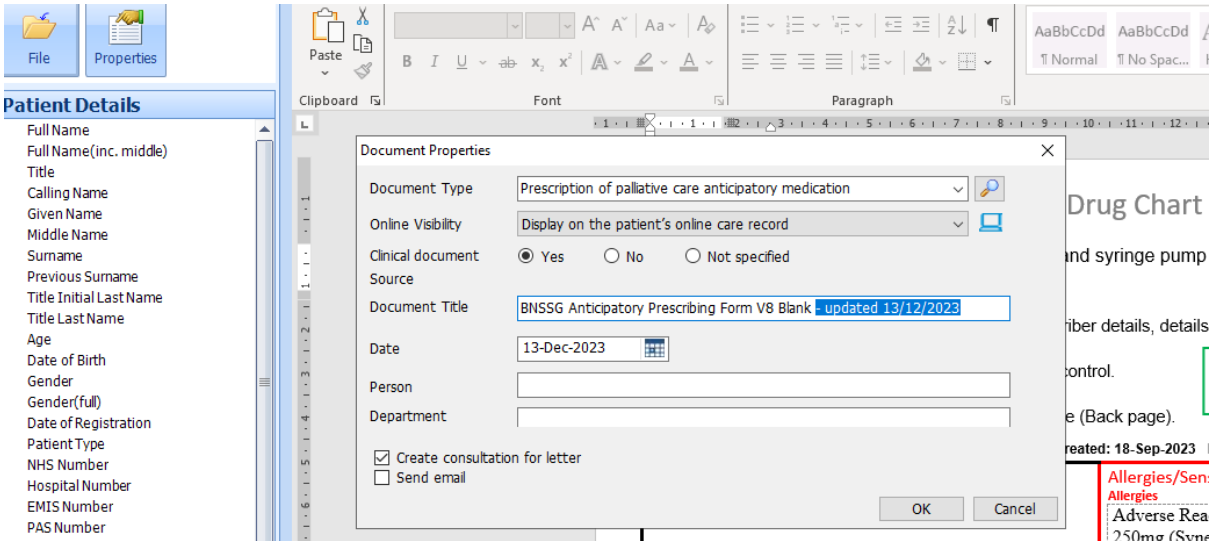
Right click and select 'edit'



Click on 'File' then 'Save As'

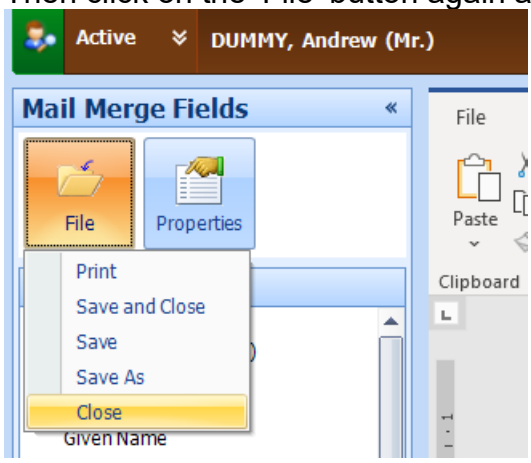


A window then appears, in the ‘Document Title’ field, add a suffix to show when the drugs chart was edited



Then click OK

Then click on the ‘File’ button again and select ‘Close’



The updated document appears in the ‘Document’ window