ANTICIPATORY PRESCRIBING MEDICATION ADMINISTRATION RECORD

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

SURNAME: _____

FORENAMES: _____

ADDRESS: _____

_____

URN: _____ DOB: _____

ADDRESSOGRAPH

GP NAME	
GP SURGERY	Tel no.
PALLIATIVE CARE KEY WORKER	Tel no.
WEIGHT (Kg)	

DRUG ALLERGIES & SENSITIVITIES

PLEASE CIRCLE AS APPROPRIATE

NONE KNOWN YES

SIGNED: ……..

NAME: ……..

DATE: …… ROLE: ……

THIS SECTION SHOULD BE COMPLETED PRIOR TO ADMINISTRATION OF ANY MEDICINE

DRUG / ALLERGEN (describe reaction)

PRESCRIPTIONS FOR ONCE ONLY MEDICATIONS

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

JUST IN CASE BOX INFORMATION (please tick)

JUST IN CASE BOX IN PLACE:

YES ☐ NO ☐

BOX NO. ……

DETAILS OF SUPPLEMENTARY CHARTS (please tick)

☐ SYRINGE PUMP

☐ SUPPLEMENTARY INFUSION CHART

☐ OTHER (specify) ……

CHART RE-AUTHORISED (every 3 months)

PRESCRIBER SIGNATURE	DATE

AS REQUIRED MEDICINES

DATE	MEDICINE (Approved Name)											
	WATER FOR INJECTIONS											
PRESCRIBER SIGNATURE	INDICATION											
	DILUENT / FLUSH											

DATE				DATE								
				TIME								
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE								
				ROUTE								
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY								

PATIENT'S NAME ……. DOB ……. URN …….

AS REQUIRED MEDICINES

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

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

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

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				TIME										
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HOURS	DOSE										
				ROUTE										
PRESCRIBER SIGNATURE		INDICATION		GIVEN BY										

Anticipatory Prescribing Guidance

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

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

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

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

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

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

Anticipatory Prescribing Guidance

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

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

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

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

Buprenorphine patches:

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

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

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

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

PATIENT'S NAME …… DOB …… URN ……

Just in Case (JIC) Box Security Tag Sheet

The tag should be broken and replaced:

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

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

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

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

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Just in Case (JIC) Box Medication Record Sheet

Jersey Care Federation | Primary Care Body | States of Jersey

MEDICATION NAME	STRENGTH	DOSAGE FORMULATION

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

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

DATE	TIME	NO. OF DOSE UNITS	SIGNATURE	SIGNATURE

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

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

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

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Anticipatory Prescribing Outcome Form

Family Nursing & Home Care | Jersey Hospice Care (your care, your choice, your time) | Jersey Care Federation | Primary Care Body | States of Jersey

SURNAME: _____

FORENAMES: _____

ADDRESS: _____

_____

URN: _____ DOB: _____

ADDRESSOGRAPH

File the original form in the patient notes

A copy should be faxed (fax. 720292) or e-mailed to the JHC MDT co-ordinator
CommunityTeam@jerseyhospicecare.com

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

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

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

Date	Name (print)	Signature	Role