

Focus on anticipatory prescribing for end of life care

GPC guidance, April 2012

Introduction

Many patients approaching the end of their lives express a desire to die at home, and this has been recognised in the National End of Life Care (EOLC) Strategy published in July 2008. Providing a good death at home is a vital part of modern General Practice, but presents unique problems for the Primary Care Team, especially during the out-of-hours period when access to the patient's own general practice and regular pharmacy may not be possible.

Anticipatory prescribing is designed to enable prompt symptom relief at whatever time the patient develops distressing symptoms, and is based on the premise that although each patient is an individual with individual needs many acute events during the palliative period can be predicted and management measures put in place in advance.

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

Although the benefits of anticipatory prescribing are well recognised, some GPs have concerns about prescribing in this way, and this guidance is designed to help GPs with their prescribing in this important field.

<p>This document is not intended to be used as clinical guidance, but to clarify the issues around anticipatory prescribing and end of life care.</p>
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Anticipatory prescribing: 'Just in Case' boxes

Anticipatory prescribing is designed to ensure that there is a supply of drugs in the patient's home, combined with the apparatus needed to administer them, with the intention that they are available to an attending clinician for use after an appropriate clinical assessment. Once prescribed these drugs belong to the patient and have the same legal status as other prescribed controlled drugs.

In certain situations it might be appropriate for drugs to be prescribed with the intention that they are to be administered by a patient's family, although in such cases clear instructions are required; an example might be the provision of rectal diazepam for a patient at risk of convulsions.

These supplies are normally provided in a specially marked container, commonly called a 'Just in Case' box. GPs are not the only health professionals able to provide the 'Just in Case' medications. Nurse Prescribers, particularly those specialising in palliative care, can also provide them, but many GPs find that the time of supplying these medications is a good opportunity to discuss with the patient and family their hopes and fears about the coming weeks.

An example of a drugs administration document used for just in case boxes is available in appendix 1.

Difficult issues with 'Just in Case' boxes

There have been a number of concerns raised about anticipatory prescribing

- 1) **Drugs remaining in the community for extended periods of time:** Many, if not most, anticipatory drugs will not be required. Consequently, there is the danger that drugs may end up discarded in the community with very little supervision of their use or disposal.
- 2) **Prescribing for the future:** Normal good medical practice has the provision of a prescription as one of the last elements of the consultation, following and not preceding clinical assessment. Anticipatory prescribing inevitably involves uncertainty and risk concerning the drug's correct use, and prescribers are properly wary of providing drugs with less control over their use than is normal.
- 3) **Inappropriate administration:** Doctors who prescribe drugs in this way have very little control over what will happen when the drug is actually administered, and some have expressed concerns about their responsibilities should such a drug be administered inappropriately. There has been a concern that the availability of such drugs might encourage their administration without proper assessment (for example midazolam supplied for terminal restlessness might be authorised for administration over the phone when a visit and examination might have revealed a distended bladder as the cause of the patient's distress)

Guidance for best practice

- 1) The health professional authorising administration of a pre-supplied anticipatory drug has to accept responsibility for that decision. The availability of such medication in the patient's home is in no way a substitute for proper clinical evaluation at the time of a change in the patient's condition.
- 2) The list of usual anticipatory drugs supplied should be agreed locally, with input from the Local Medical Committee (LMC), other lead GPs, and specialist palliative care professionals such as the local hospice and Macmillan Teams
- 3) The normal starting doses should be agreed and available on a pre-printed sheet to minimize the chance of prescribing error.
- 4) Quantities supplied needs to be balanced between adequate supply and waste. For example, as a minimum, sufficient quantities should be provided for a patient over a bank holiday weekend.
- 5) 'Just in Case' boxes should contain as a minimum the anticipated drugs, administration equipment, written instructions as to dose and indications, and a means for recording administration.
- 6) The prescriber needs to be satisfied that the patient and carers understand the reasons for the provision of the medications at that time. This is a good time to explore with the patient and family the prognosis, and to ensure they understand how to access care appropriately in the event of deterioration in the patient's health (also see 'DNAR' section below).
- 7) The Out of Hours service, and all others involved in the care of the patient, must be made aware of the clinical situation and of the availability of drugs.

Do Not Attempt Resuscitation (DNAR) or Allow Natural Death (AND)

Whilst discussing the prognosis with the patient and family, it may also be appropriate to have discussions about allowing natural death and decisions about cardiopulmonary resuscitation.

The BMA's joint statement [Decisions relating to cardiopulmonary resuscitation](#) advises that 'DNAR decisions should be reviewed in advance of the procedure. Ideally this should be discussed with the patient, or their representative if they lack capacity, as part of the consent process'¹.

The GMC advises in their [Treatment and care towards the end of life](#) guidance that:

'You must make it clear to the healthcare team and, if appropriate, the patient and those close to the patient that a DNACPR decision applies only to CPR. It does not imply that other treatments will be withdrawn or withheld.'²

There is currently no nationally available DNACPR form, although the Resuscitation Council (UK) provides a template³ and there is a unified form available in Scotland⁴. In addition, there are some regional initiatives such as in the East of England⁵.

Note: The term 'Allow Natural Death' (AND) may be used instead of 'DNAR'.

¹ Cardiopulmonary resuscitation: helping you make decisions (2007):

<http://bma.org.uk/practical-support-at-work/ethics/ethics-a-to-z>

² http://www.gmc-uk.org/guidance/ethical_guidance/end_of_life_after_a_DNACPR_decision.asp

³ <http://www.resus.org.uk/pages/DNARrstd.htm>

⁴ <http://www.scotland.gov.uk/Publications/2010/05/24095633/15>

⁵ https://www.eoe.nhs.uk/page.php?page_id=2168

Further reading

BMA joint statement *Decisions relating to cardiopulmonary resuscitation*

<http://bma.org.uk/practical-support-at-work/ethics/ethics-a-to-z>

GMC *Treatment and care towards the end of life care guidance*

www.gmc-uk.org/static/documents/content/End_of_life.pdf

Gold Standards Framework (GSF)

www.goldstandardsframework.org.uk

The Gold Standards Framework guidance is designed to provide a “systemic evidence based approach to optimising the care for patients nearing the end of life delivered by generalist providers”.

Useful guidance specifically for the protocol for ‘Just in Case’ boxes can be found in the ‘Primary Care’ - ‘Out of Hours’ section, as in the link below.

<http://www.goldstandardsframework.org.uk/GSFInPrimary+Care/OOHs>

This guidance gives information regarding:

- [How to develop ‘Just in Case’ boxes in a local area](#)
- [Suggested contents for a ‘Just in Case’ box](#)
- [Examples of good practice resource guide for ‘Just in Case’ boxes](#)

GSF after death analysis audit tool

<http://www.goldstandardsframework.org.uk/GSFAuditTool>

This is a web-based audit and improvement tool based on the Gold Standards Framework and is in alignment with the Department of Health draft quality markers. Its purpose is to help GPs and care homes attempt to measure the quality of their end of life care, and so improve their service.

Appendix 1 - Example of a drugs administration document used for 'just in case' boxes

RECORD OF CONTROLLED DRUG AND ADDITIONAL DRUGS ADMINISTERED

PATIENT NAME _____
PATIENT DOB _____

NHS NUMBER _____
GP NAME _____

**DRUGS ARE TO BE GIVEN ACCORDING TO SYMPTOMS.
 THIS SHEET MUST BE SIGNED AND DATED BY A DOCTOR/NURSE INDEPENDENT PRESCRIBER**

SUBCUTANEOUSLY VIA SYRINGE DRIVER OVER 24 HOURS						AS REQUIRED (PRN) DOSE				
Symptom	Drug	Possible range over 24 hours	Actual dose	Prescriber's signature (and print name)	Date	Drug	Possible range	Actual dose and frequency	Prescriber's signature (and print name)	Date
Agitation/terminal restlessness	Midazolam	Initially 10mg				Midazolam	2.5mg-5mg (if frail 2.5mg) S/C			
Nausea & vomiting or agitation	Haloperidol	Initially 5mg				Haloperidol	1mg S/C			
Excess chest secretions	Hyoscine Butylbromide	Initially 60mg				Hyoscine Butylbromide	20 mg S/C			
Pain relief	Diamorphine Hydrochloride	If opiate naïve 10mg				Diamorphine Hydrochloride	If opiate naïve 2.5mg			

