

**‘JUST IN CASE’ BOX PROTOCOL  
STANDARD OPERATING PROCEDURE**

Version:	2.3
Ratified by:	Patient Safety and Quality Assurance Committee Somerset Clinical Commissioning Group
Date ratified:	
Name of originator/author:	Dr Chris Absolon, Clinical Governance GP
Name of responsible committee/individual:	Director of Quality and Patient Safety/ Patient Safety and Quality Assurance Committee
Date issued:	
Review date:	
Target audience:	Somerset Partnership NHS Foundation Trust staff, General Practitioners, Nursing Home, Hospice and Acute General Hospital staff.



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## VERSION CONTROL

### SOMERSET CLINICAL COMMISSIONING GROUP

#### 'JUST IN CASE' BOX PROTOCOL

Number assigned to document:

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<b>Version:</b>	2.3

<b>DOCUMENT CHANGE HISTORY</b>		
<b>Version</b>	<b>Date</b>	<b>Comments</b>
1.0	September 2006	Mendip PCT, Clinical Audit & Effectiveness Committee
1.1	June 2007	Amended by Dr C Absolon and Julie Vale for Somerset PCT
1.2	April 2011	Reviewed by Dr Chris Absolon, Amanda Smith Senior Locality Manager Somerset Community Health & District Nurse Leads, Nina Vinal Senior Nurse for Clinical Practice. Dr Brenda Ward and Dr Chris Higgs, Consultants in Palliative Medicine. Shaun Green Associate Director Medicines Management NHS Somerset. David Partlow Senior Quality Patient Experience Manager South West Ambulance Trust.
1.3	27 June 2011	Amendments incorporated by Chris Absolon following comments from SQUID
1.4	June 2013	Reviewed to update for adoption by Somerset Clinical Commissioning Group. Comments from: Head of Community Services Programmes, OOH's Clinical Lead and Interim Professional Lead District Nursing and Senior Nurse for Clinical Practice from Somerset Partnership Foundation Trust. Chair Somerset CCG Cancer

		Clinical Programme Group.
1.5	July 2013	SCCG Patient Safety and Quality Assurance Committee.
1.6	December 2015	Review in light of: <ul style="list-style-type: none"> <li>• NICE guidance on the care of dying adults in the last days of life 2015</li> <li>• Priorities for Care of the Dying Person Published June 2014 by the Leadership Alliance for the Care of Dying People</li> <li>• Changes in local specialist guidance – cyclizine replaced by levomepromazine as recommended anti emetic.</li> </ul>
2.1	February 2016	Liz Berry, Chris Absolon. Addition of possibility for carers to administer sub cutaneous injections. Sean Green Associate Director of Medicines Management Somerset CCG – refer to generic oxycodone only. Dave Partlow Clinical Development Manager South Western Ambulance Service NHS Foundation Trust, increased range of professionals in SWASFT who can use JiC drugs. Derek Lott, Somerset RCPA, increased reference to Care Homes.
2.2	June 2016	Janet Gillet Associate Specialist Palliative Care Dr Somerset Partnership NHS Foundation Trust – change in terminology from drivers to pumps; symptom control guidance now part of District Nursing notes, symptom control guidance.
2.3	December 2016	Review by Somerset Partnership Foundation Trust.

<b>Sponsor Director:</b>	Sandra Corry Director of Quality & Patient Safety
<b>Author(s):</b>	Dr Chris Absolon
<b>Document Reference</b>	

## **CONFIRMATION OF EQUALITY IMPACT ASSESSMENT FOR SOMERSET CCG DOCUMENTS / POLICIES / STRATEGIES AND SERVICE REVIEWS**

**Main aim of the document:**

To provide a process for anticipatory prescribing for patients with palliative care needs, to ensure that all patients have access to appropriate timely palliative care medicines at all times.

**Outcome of the Equality Impact Assessment Process:**

Neutral impact on equality

**If relevant, outcome of the full impact assessment:**

**Actions taken and planned as a result of the equality impact assessment, with details of action plan with timescales / review dates as applicable:**

Review in April 2018

**Groups / individuals consulted with as part of the impact assessment:**

2007: Countywide Palliative Care Partnership which incorporates all key stakeholders and includes user representation.  
Val Janson, Chris Absolon, Helen Weldon  
2010: Chris Absolon; Amanda Smith Senior Locality Manager Somerset Community Health; Nina Vinall Senior Nurse for Clinical Practice Somerset Community Health; District nurse Leads

## 1 INTRODUCTION

- 1.1 Patients with a terminal illness often experience new or worsening symptoms. This protocol seeks to avoid distress caused by delayed access to medicines by anticipating need, and providing a 'Just in Case' box in the care setting, (home or Care Home). Drugs in the Just in Case box are intended to deal with sudden deterioration, and use should be followed by reassessment of medication. The process is summarised in appendix 1.

## 2 PURPOSE

- 2.1 To ensure that:
- common symptoms in the terminal phase, for example pain, secretions, nausea and vomiting, agitation and shortness of breath are anticipated
  - small quantities of appropriate medicines are prescribed for the patient and stored in a special container, the 'Just in Case' box, at the patient's home
  - carers and patients are re-assured that the prescribed medicines have been prescribed 'Just in Case', and may not be needed
  - relatives and carers are able to administer sub-cutaneous injections for urgent symptom control if this has been agreed by the team looking after the patient, and appropriate training has been given.
- 2.2 To provide a safe framework for the use of palliative care medicines in the care setting.
- 2.3 To provide a stock taking record of medication, including controlled drugs, in the care setting – see appendix 2.
- 2.4 To provide symptom control guidelines, with the Just in Case box. These now form part of the Somerset Partnership District Nursing palliative care notes – see appendix 3.
- 2.5 To provide guidance on opioid conversion – see appendix 4.

## 3 SCOPE

- 3.1 Any patient with a terminal illness should be considered for having a 'Just in Case' box in the care setting. Possible exceptions are:
- patients where there is a history or suspicion of drug misuse among carers or visitors to the house
  - patients who are themselves unwilling to participate, or with carers who are unwilling to participate (although nurses and doctors will be able to provide re-assurance in most cases).

- 3.2 The health professionals involved are:
- General Practitioners (GPs)
  - Specialist Palliative Care Nursing team
  - District Nurses and Community Nurses
  - Nurses in Care Homes
  - Community Pharmacists and dispensing staff
  - Specialist Palliative Care teams in Hospices, Community and Acute General Hospitals
  - Paramedics, Specialist Paramedics, Nurses and Specialist Nurses working within SWASFT.
  - Emergency Care Practitioners and Doctors from the Urgent Care Service

- 3.3 Timing:  
These drugs should be available when the palliative care needs of the patient are changing; if the patient is entering the terminal phase, (last days or weeks of life), or if their clinical situation is deteriorating. For this to be achieved, the Just in Case box should be issued in anticipation of need, with the aim for it to be in place several months before it is likely to be needed.

#### 4 SYRINGE PUMPS

- 4.1 If a syringe pump is in use, it is still necessary for anticipatory medication to be available, since a syringe pump will only relieve known symptoms. Anticipatory medication and medication for the syringe pump will be written up on the same Somerset Partnership Medication Administration Record. Syringe pump medication is written up as "Regular medication"; Just in Case, or anticipatory medication, is written up as "As required or variable dose medication". In Care Homes, medication is written on a medication administration record issued by the dispensing pharmacy or on a blank provided.

- 4.2 All injectable medication prescribed, whether for a Just in Case box or a syringe pump, will be recorded on the same stock card, with one sheet for each separate medication, to give a clear record of procurement and use, with a running balance of stock in hand (see appendix 2). When a syringe pump is started, any additional prescribed medication is added to the appropriate stock card.

- 4.3 Once a syringe pump is started, the blue Just in Case box is unlikely to be large enough to hold all required medication, in which case all medication should be kept together in one container, **but all anticipatory medication should remain in the care setting, kept together with any syringe pump medication in one container, and all prescribing, whether for anticipatory medication, regular medication, or syringe pump medication will be on the same Medication Administration Record.**

If a syringe pump is started, the blue Just in Case box may be kept in the care setting, so that the symptoms control guidelines, and the patient information sheet, remain available.

- 4.4 Once a syringe pump is in use, staff should be mindful of weekends and Bank Holidays, and ensure an early "in hours" prescription is generated and dispensed, to avoid any shortage of ongoing medication.

4.5 Although Just in Case medication is intended to be used for immediate symptom control by stat subcutaneous injection, it could also be used for the initial setting up of a syringe pump.

## 5 KNOWN RISKS

5.1 As with all drugs open to abuse, medicine supplies in patients' homes may be subject to misuse. If there is concern about this following a risk assessment, a sticky label, signed and dated, may be fixed across the opening of the box to indicate if tampering has taken place.

5.2 Patients and/or carers may misinterpret anticipatory prescribing as provision for euthanasia, or experience increased anxiety that death is near. However, good communication and the explanatory leaflet should allay any fears.

5.3 It should not be assumed that the presence of a Just in Case box means that no active intervention is appropriate. Each patient will need to be assessed individually, and action taken as required.

5.4 Patient Safety:

When prescribing and administering opiates, Clinicians should be aware of, and adhere to, the following National Patient Safety Agency alerts:

“Reducing dosing errors with opioid medicines”, reference NPSA/2008/RRR005  
<http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59888&q=0%ac2%acopiates%ac2%ac>

“Ensuring safer practice with high dose ampoules of diamorphine and morphine”  
Reference: NPSA/2006/12  
<http://www.nrls.npsa.nhs.uk/resources/type/alerts/?entryid45=59803&q=0%ac2%acopiates%ac2%ac>

“Patient Safety Alert Stage Two: Resources Support to minimise the risk of distress and death from inappropriate doses of naloxone  
<https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/10/psa-naloxone-stage2.pdf>

In particular clinicians should:

Confirm any recent opioid dose, formulation, frequency of administration and any other analgesic medicines prescribed for the patient.

Ensure where a dose increase is intended, that the calculated dose is safe for the patient, (e.g. for oral morphine or oxycodone in adult patients, not normally more than 50% higher than the previous dose).

Ensure they are familiar with the following characteristics of that medicine and formulation: usual starting dose, frequency of administration, standard dosing increments, symptoms of overdose, and common side effects.

Ensure that patients should be observed for the first hour after their first dose of an opioid injection.

Naloxone should only be used in severe respiratory depression, as this will cause reversal of analgesia with sudden severe pain, (The Palliative Care Handbook 8<sup>th</sup> edition).

## 6 PROCESS

6.1 District Nurses, Care Home staff, Specialist Palliative Care Nurses, Hospital Staff or GPs identify relevant patients ahead of need. The need for a 'Just in Case' Box should be part of the regular review of patients on the palliative care register during General Practice Gold Standard Framework meetings.

A Just in Case box should be considered when the palliative care needs of the patient are changing, or the patient is entering the terminal phase (last days/few weeks of life), or their clinical situation is deteriorating. Good practice would be for the Just in Case box to be in the patient's home well before it is actually needed.

6.2 The patient's GP will prospectively prescribe appropriate as required medications for the individual patient's needs based on the locally agreed symptom control guidelines (see appendix 3: Symptom Control Guidance), or recommendations from palliative care specialist medical or nursing staff, on form FP10 with appropriate instructions for use.

The Palliative Care Handbook, (Wessex & ASWCS Palliative Care guidance), is a valuable resource for help with common problems and drug treatment in terminal care and use of drugs in syringe pumps. It has been widely distributed in hard copy, and is available electronically on the Somerset CCG website:

<http://www.somersetccg.nhs.uk/about-us/how-we-do-things/palliative-care/>

Suggested medication for inclusion in a Just In Case Box is:

- Morphine or diamorphine 10mg x 5 amps for pain
- Levomepromazine 25mg x 5 amps for nausea and vomiting
- Midazolam 5mg/ml 2ml amps (10mg) x 5 amps for agitation
- Hyoscine butylbromide (Buscopan) 20mg x 5 amps to reduce respiratory secretions
- Water for injection as appropriate for dilution of diamorphine

6.3 If a Just in Case box is initiated in a hospice or acute hospital, a Medication Administration Record correctly completed by a doctor has full validity in the community. Best practice would be to use a Somerset Partnership Administration chart, in line with the Somerset Partnership Pathway for approval for administration of red drugs by district nursing service<sup>1</sup>. These have been made available to Acute Trusts. Community Nurses and nurses in Care Homes have authority to administer medication prescribed, and there would be no need to have the Medication Administration Record rewritten by a GP.

6.4 Appropriate doses for anticipatory prescribing for opioid naive patients are as follows, **but doses of opioid for patients already taking oral opioids will need to be calculated, and the doses for all medication will need to be tailored to the specific patient's needs. The dose of opioid for anticipatory prescribing will need to be reviewed when a patient's regular analgesia is changed.**

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<sup>1</sup> Somerset Partnership Medicines policy appendix M <http://www.sompar.nhs.uk/media/2852/medicines-policy-v8feb-2016.pdf>



- Morphine or diamorphine 2.5mg – 5mg by subcutaneous injection 2-4 hourly as required for pain or shortness of breath
  - Levomepromazine 6.25mg by subcutaneous injection as required for nausea or vomiting, maximum 24 hour dose 25mg
  - Midazolam 2.5mg-5mg by subcutaneous injection for terminal restlessness and agitation 2-4 hourly as required
  - Hyoscine butylbromide (Buscopan) 20mg by subcutaneous injection to reduce respiratory tract secretions 4 hourly as required
- 6.5 This list is not exhaustive and patients may have different medication needs depending on their condition. For example, patients with heart failure may require subcutaneous furosemide; and sublingual lorazepam may be helpful for anxiety or breathlessness.
- 6.6 The GP delegates authority to the community nurses or care home registered nurses to administer “as required doses” of these drugs if symptoms arise. This is done by GPs or Non-medical prescribers using the Somerset Partnership NHS Foundation Trust Medication Administration Record, using the “As required or variable dose medication” section. This remains in the patient’s home.
- 6.7 The GP will give the prescription to the patient’s carer, or to care home staff, who will take it to a pharmacy or dispensing practice, and collect the dispensed medications.
- 6.8 In extraordinary situations, in compliance with the Somerset Partnership Medicines policy, the District Nurse or Care Home registered nurse can take medication from a pharmacy or dispensing practice directly to the patient.
- 6.9 In parallel to anticipatory prescribing, the healthcare professional should also consider breakthrough medication for the patient/carer to administer (following an assessment of competence and appropriate guidance from the health care professional). For example, administration of oral morphine or sub-cutaneous injections.
- 6.10 Just in Case prescribing is intended to be in place for the final phase of life, but if the patient is still alive after 6 months, the prescription should be reviewed by the GP in line with the Somerset Partnership Foundation Trust’s Medication Policy. This can be done by the visiting District Nurse bringing the MAR chart to the General Practice, discussing the patient with the GP, and the GP, after checking whether or not the prescription needs to be altered, writing on the chart that it has been reviewed, with a date and signature. This could be written in the main prescription section which for most patients with community Just in Case MAR charts is not usually used.

If the patient’s medication or condition significantly changes before 6 months, then this should trigger a review of the Just in Case prescription.

## **7 LEAVING THE JUST IN CASE BOX IN THE CARE SETTING**

- 7.1 The District Nurse takes a 'Just in Case' box to the family, containing the leaflet "Guide to your 'Just in Case' Box", (see appendix 5), copies of the local symptom control guidelines, and the Medication Administration Record, that has been completed and signed by the GP.
- 7.2 The dispensed medicines will be collected from the pharmacy or dispensing practice by the patient's carer and subsequently packed into the 'Just in Case' box by the District Nurse and patient's carer.
- 7.3 The District Nurse should:
- Complete the Stock Cards for each separate medication in the Just in Case box
  - Ensure the patient's carer is aware of the safe storage requirements for the Just in Case box. For example, if there are children or vulnerable people who could obtain access to the patient's home or medications
  - Inform others that the 'Just in Case' box is in the care setting and document in the patient's District Nursing notes (in the home), and on RiO, to inform other visiting nurses and doctors.  
Either the District Nurse or the GP should inform the GP Out of Hours Service, by adding the patient to the Somerset Electronic Palliative Care Coordination System, (EPaCCS), (see appendix 6 & 7 for details) using the Adastra software.
  - Give instructions to the patient's carer to return the drugs to the pharmacy or dispensing practice and the empty box to the District Nurse when the 'Just in Case' box is no longer needed.

## **8 ADMINISTRATION BY CARERS OR RELATIVES**

- 8.1 A small number of relatives have been trained to administer sub-cutaneous injections for urgent symptom control if this has been agreed by the team looking after the patient, and appropriate training has been given. This is a new development, and something for the health community to continue to work on. Given the rurality of Somerset, and the delays that may occur before a trained health care professional can attend to administer an injection for urgent symptom control, particularly in the out of hours period, this could have significant advantages.
- 8.2 The main principles are:
- Risks assessed including safeguarding
  - Consent from patient and agreement from GP
  - Family/carer assessed as competent. This is documented in the patient's notes
  - Family/carer to record in home nursing documentation including MAR
  - DN to review symptom control and medication daily and report daily to GP or more frequently if required
  - Care plan outlining family/carer involvement of administration of medication to be documented on RiO care plan
  - OOHs to be informed

## **9 WHEN ITEMS ARE USED**

- 9.1 The nurse/GP/Emergency Care Practitioner must record when items are used in the District Nursing Notes, or in the last days of life care plan if in use, sign the Medication Administration Record, and complete the Stock Card of medication in the 'Just in Case' box (appendix 2) showing the drugs used and the balance remaining in the box.
- 9.2 The GP should be informed by the nurse of the use of the palliative care medicines and re-assess need and prescribe appropriate replacements where relevant via form FP10. A review of patient symptoms will be required at this stage as a change in dosage or medicines supplied may be needed. This may include provision of a syringe pump.
- 9.3 Any new medications required should be prescribed on form FP10, the Medication Administration Record should be updated, and the new stock added to the appropriate medication stock card.
- 9.4 GPs, who administer from their own bag stock, should also make a record of such administration in the patient's notes.

## **10 PROCESS FOLLOWING THE PATIENT'S DEATH**

- 10.1 The patient's relative should return the unused drugs to the dispensing community pharmacy or dispensing practice for destruction.
- 10.2 If the patient is admitted to a hospice, nursing home, or hospital and does not return home before their death, the process in point 10.1 should be followed.
- 10.3 If any drugs are not accounted for at the patient's house, after appropriate enquiry of the family and health care team, the nurse must inform their line manager. The NHS England and Somerset Partnership Accountable Officers for controlled drugs must be informed, who will decide on appropriate action, which may include informing the Police.
- 10.4 The 'Just in Case' box is to be returned to the District Nurse, cleaned in line with the Trust's Infection Control Policy, re-supplied with blank medication stock control sheets, and the symptom control guidelines and patient leaflet if necessary, and kept ready for re-use.

## **11 RESPONSIBILITY**

- 11.1 The medicines in the 'Just in Case' box are prescribed for the named patient only and must never be used for any other patient.

- 11.2 Care should be taken to avoid the medicines going out of date. This is unlikely to happen but may occur if the patient's condition improves before deteriorating. The visiting nurse is responsible for checking the expiry date of the medicines held within the 'Just in Case' box and recording in the patient notes that the check has taken place. If any medicine is out of date he/she should:
- request a review by the GP of the need for 'Just in Case' medications
  - if required, any new medications should be prescribed, signed and recorded on FP10 and Medication Administration Record as before
  - out of date medicines should be returned by the family or carers to the dispensing pharmacy or dispensing practice for destruction.
- 11.3 It is the responsibility of the nurse to check the contents of the 'Just in Case' box at each visit, checking the sticky label is in place if one has been used, (see 5.3), to ensure that nothing has been removed from the box, without a record being made in the patient's notes. If any drugs cannot be accounted for, after appropriate enquiry of the family and health care team, the nurse must inform the line manager. The NHS England and Somerset Partnership Accountable Officers must be informed, who will decide on appropriate action, which may include informing the Police. In all instances contact should be made with the Somerset Partnership Foundation Trust Safeguarding Service on 0300 323 0035 and a Datix completed with the Safeguarding box ticked to ensure any safeguarding concerns are fully considered
- 11.4 Patient's anticipatory needs may change during the course of the illness. An identified doctor or nurse must be responsible for ensuring that regular review of required drugs takes place, (at least once a month, and/or after any known change in circumstances). This will help to ensure that drugs in the 'Just in Case' box are appropriate and relevant both in terms of strength and type.
- 11.5 If the 'Just in Case' box is no longer required, the "Process following the patient's death" must be followed.

## **12 TRAINING**

- 12.1 The importance of anticipatory prescribing is regularly highlighted through educational events and communication with GPs. Somerset Partnership will ensure that the ongoing training needs of staff will be identified at appraisal and addressed on induction.
- 12.2 Any relatives or carers, who agree to administer sub-cutaneous injections for urgent symptom control, where this has been agreed by the team, will be trained to do so by the patient's District Nurse.

## **13 MONITORING FOR SOMERSET PARTNERSHIP STAFF**

- 13.1 Incidents, complaints and feedback relating to JICB medications will be monitored by the Somerset Partnership Best Practice End of Life Group. Good practice and lessons learned will be shared with the appropriate Best Practice Groups, and in

What's On.

Team leaders will carry out local monitoring to ensure appropriate use of JICB medications. Use of JICB medications outside of this guidance must be reported through DATIX.

In all instances contact should be made with the Trust Safeguarding Service on 0300 323 0035 and a DATIX completed with the Safeguarding box ticked to ensure any safeguarding concerns are fully considered.

## 14 REVIEW

- 14.1 This policy, version 2.2, is a review of the original Just in Case policy first approved by Mendip Primary Care Trust in 2006, and adopted by Somerset Primary Care Trust in 2007. It was reviewed by members of the Somerset Palliative Care Partnership in 2011, and was ratified by NHS Somerset and Somerset Community Health. In June 2013 references to Somerset PCT and Somerset Community Health were updated.

It was further reviewed in March 2016 by the Somerset CCG Palliative care and End of Life programme group in March 2016, and will be reviewed in August 2018.

## 15 REFERENCES

- 15.1 Safer Management of Controlled Drugs: The Government's response to the Fourth Report of the Shipman Inquiry 2004

Medicines, Ethics & Practice: A guide for pharmacists; Royal Pharmaceutical Society of Great Britain, July 2016

Controlled drugs: safe use and management  
NICE guideline [NG46] Published date: April 2016

Reducing dosing errors with opioid medicines National Patient Safety Agency  
Reference number 1066 Central Alert System (CAS) reference  
NPSA/2008/RRR005  
Issued 04.07.2008

Ensuring safer practice with high dose ampoules of diamorphine and morphine  
National Patient Safety Agency  
Reference: 0295 issued 25.5.2006

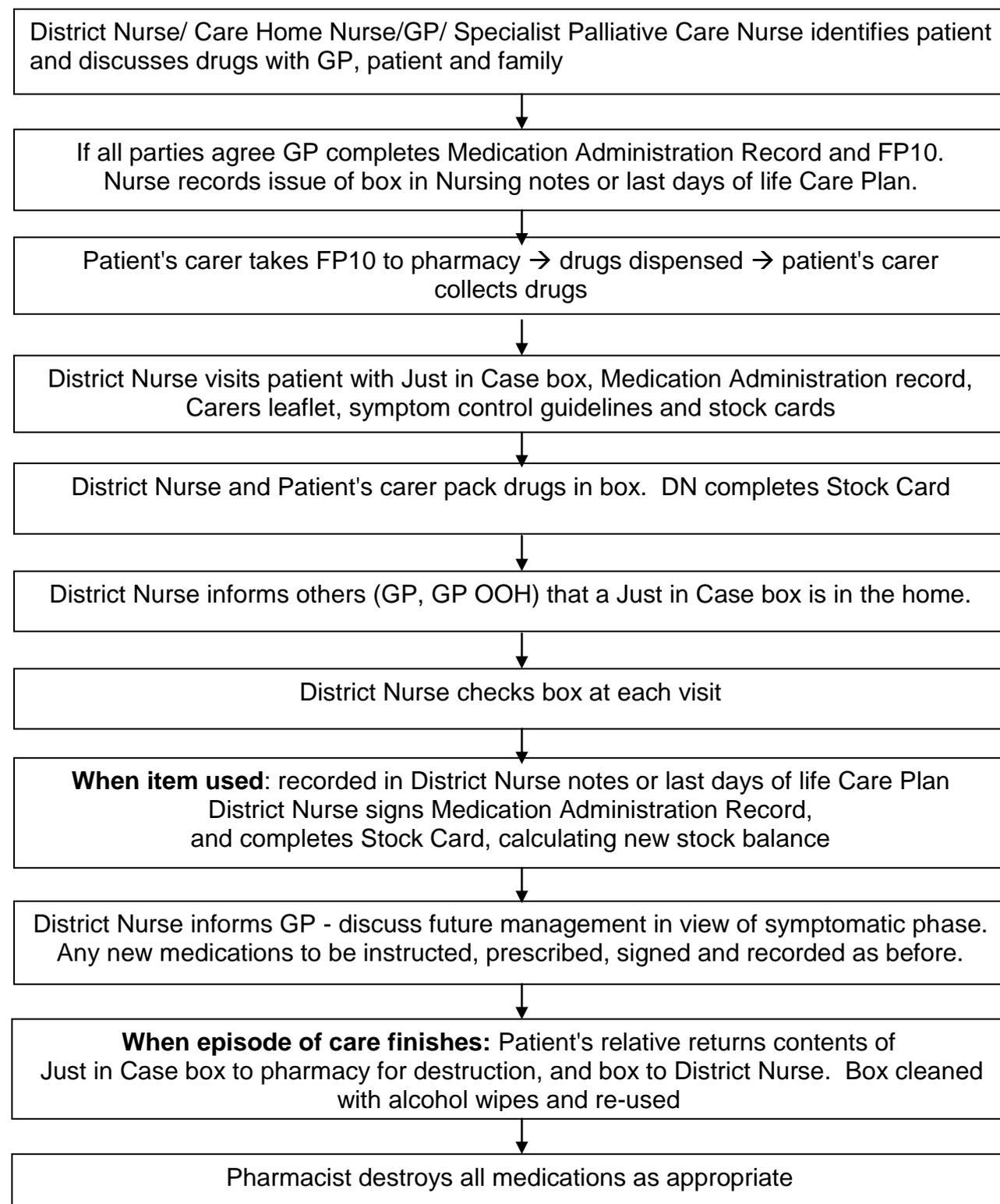
The Palliative Care Handbook – a good practice guide – Wessex Palliative care  
Physicians 8<sup>th</sup> edition 2014

Gold Standards Framework

## PROCESS FLOW CHART 'Just in Case' box

### Process for anticipatory prescribing for patients with a terminal illness

Patients with a terminal illness often experience new or worsening symptoms. A 'Just in Case' box can be provided in advance where a need for medication is anticipated. This process should be followed by all professionals in line with the best practice guidelines.









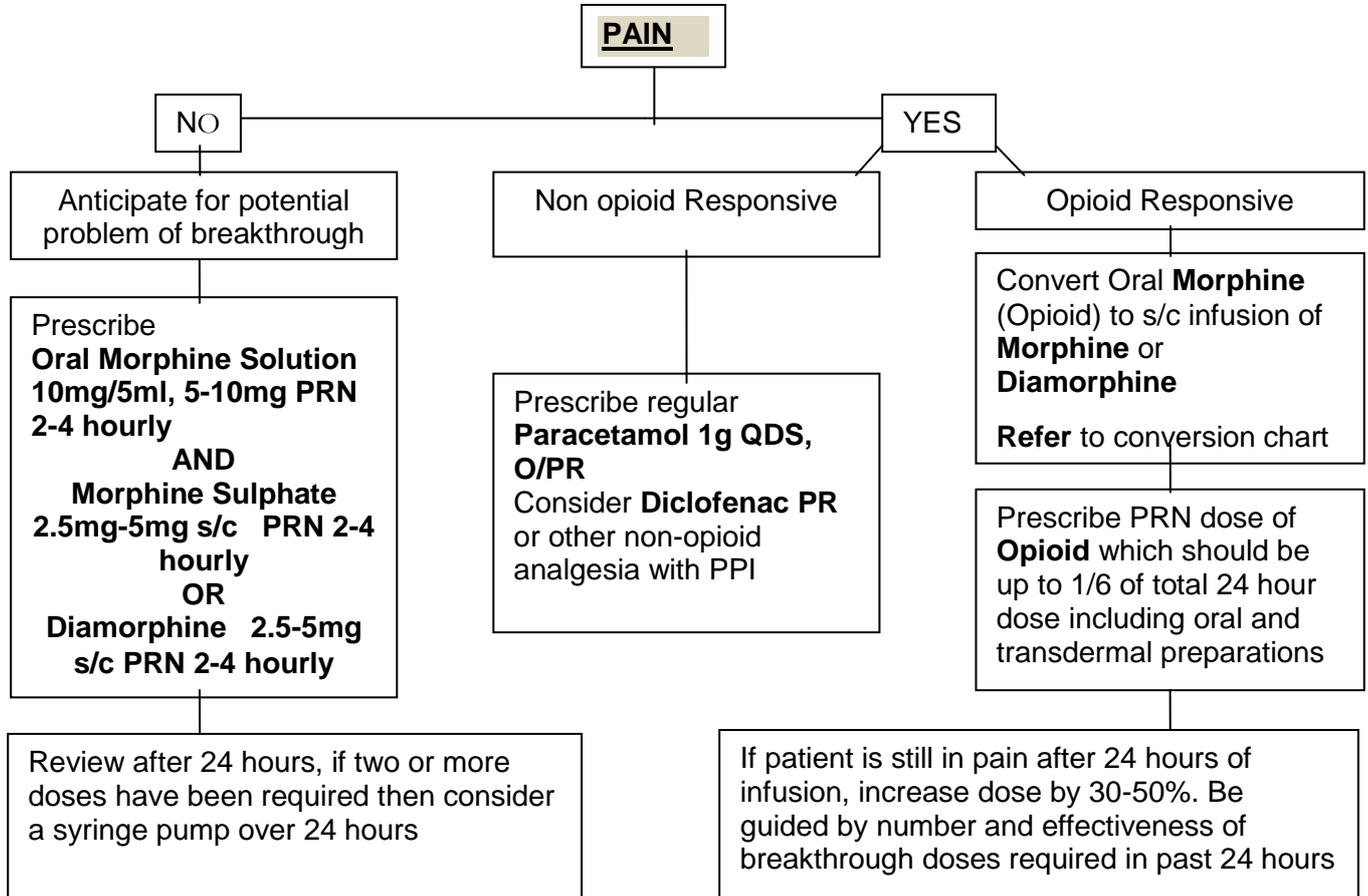






**END OF LIFE SYMPTOM CONTROL GUIDELINES**

**APPROVED FOR USE BY DOROTHY HOUSE HOSPICE, MUSGROVE PARK HOSPITAL, NHS SOMERSET, SOMERSET PARTNERSHIP NHS FOUNDATION TRUST, ST MARGARET'S HOSPICE AND WESTON HOSPICE**



**Fentanyl and buprenorphine patches**  
 If patient is using an analgesic patch but requires additional pain relief, continue with patch at usual dose and consider the use of morphine or diamorphine in a syringe pump in addition. If needed, consult with the Palliative Care Team for further advice/ information

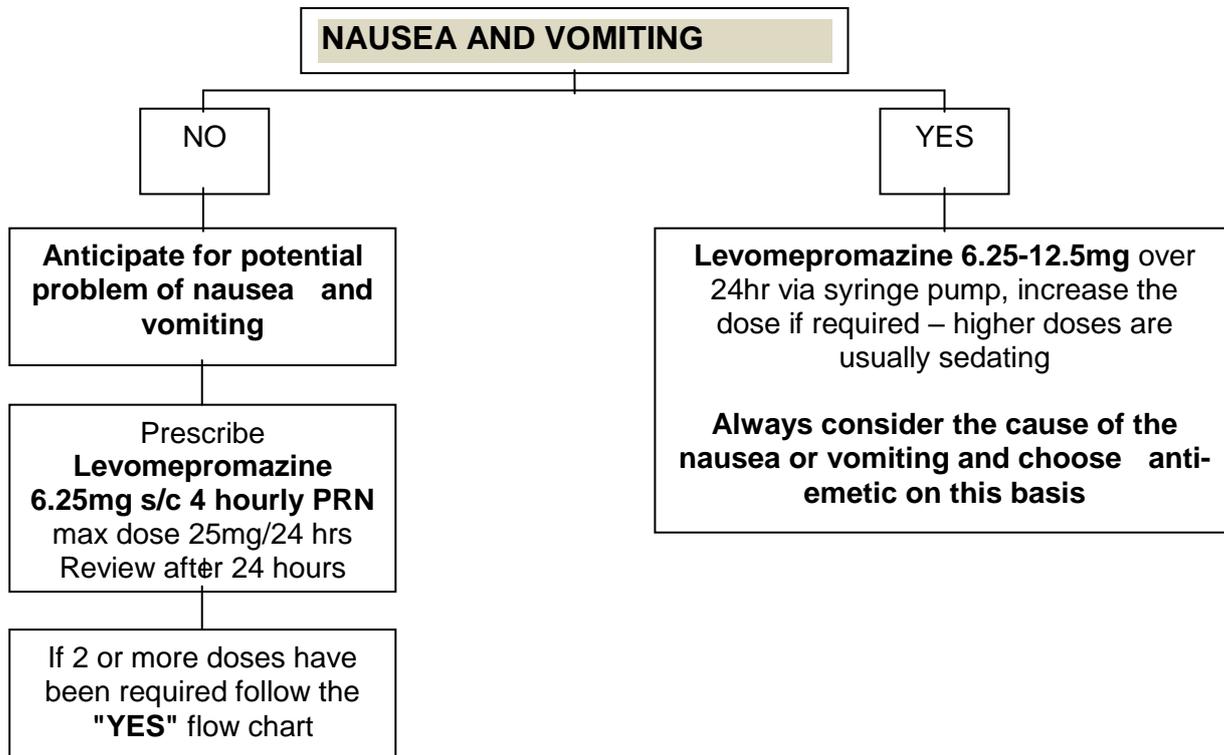
**NB:** Patients already taking regular opioid analgesia will not routinely require the addition of an anti-emetic in a syringe pump unless nausea/ vomiting are also a problem.  
**Renal impairment:** Caution is required when prescribing opioids; consider taking specialist advice.

**IF SYMPTOMS PERSIST PLEASE CONTACT:**

**Specialist Palliative Care Team 24 hour Helplines**  
 St Margaret's Hospice - 0845 0708 910  
 (Somerset Palliative Care advice line)  
 Weston Hospice - 01934 423912  
 Dorothy House Hospice - 01225 722999

## Appendix 3

### SOMERSET SYMPTOM CONTROL GUIDELINES



#### SUPPORTIVE INFORMATION

If a patient has been taking an oral anti-emetic effectively but can no longer swallow, use the equivalent dose of this anti-emetic in syringe pump (**Total oral 24hr dose = S/C 24hr dose**)

Generally **levomepromazine** may be used first line for nausea and vomiting, however in some circumstances an alternative anti-emetic may be more appropriate, e.g.:

- **Metoclopramide s/c 10mg tds (30mg-60mg via syringe pump over 24hrs)** if gastric stasis suspected. (Do not use if intestinal colic or obstruction present)
- **Haloperidol 0.5mg-2.5mg s/c prn, ( 2.5mg-5mg via syringe pump over 24 hrs )** can be helpful if toxins suspected – e.g. opioids, cytotoxics, radiotherapy, liver or renal failure etc.

#### BOWEL OBSTRUCTION:

Aim to stop nausea and pain and to reduce the frequency of vomits to once a day. Total cessation of vomiting may be impossible in complete obstruction. Give **Hyoscine Butylbromide (Buscopan®) 20mg s/c 4 hourly** for antispasmodic and antisecretory effects. If 2 or more doses required use **40mg-80mg** via syringe pump over 24 hours. (Can increase to **120mg/ 24 hours** but seek Specialist Palliative care advice). Octreotide may be helpful but seek specialist advice.

#### IF SYMPTOMS PERSIST PLEASE CONTACT:

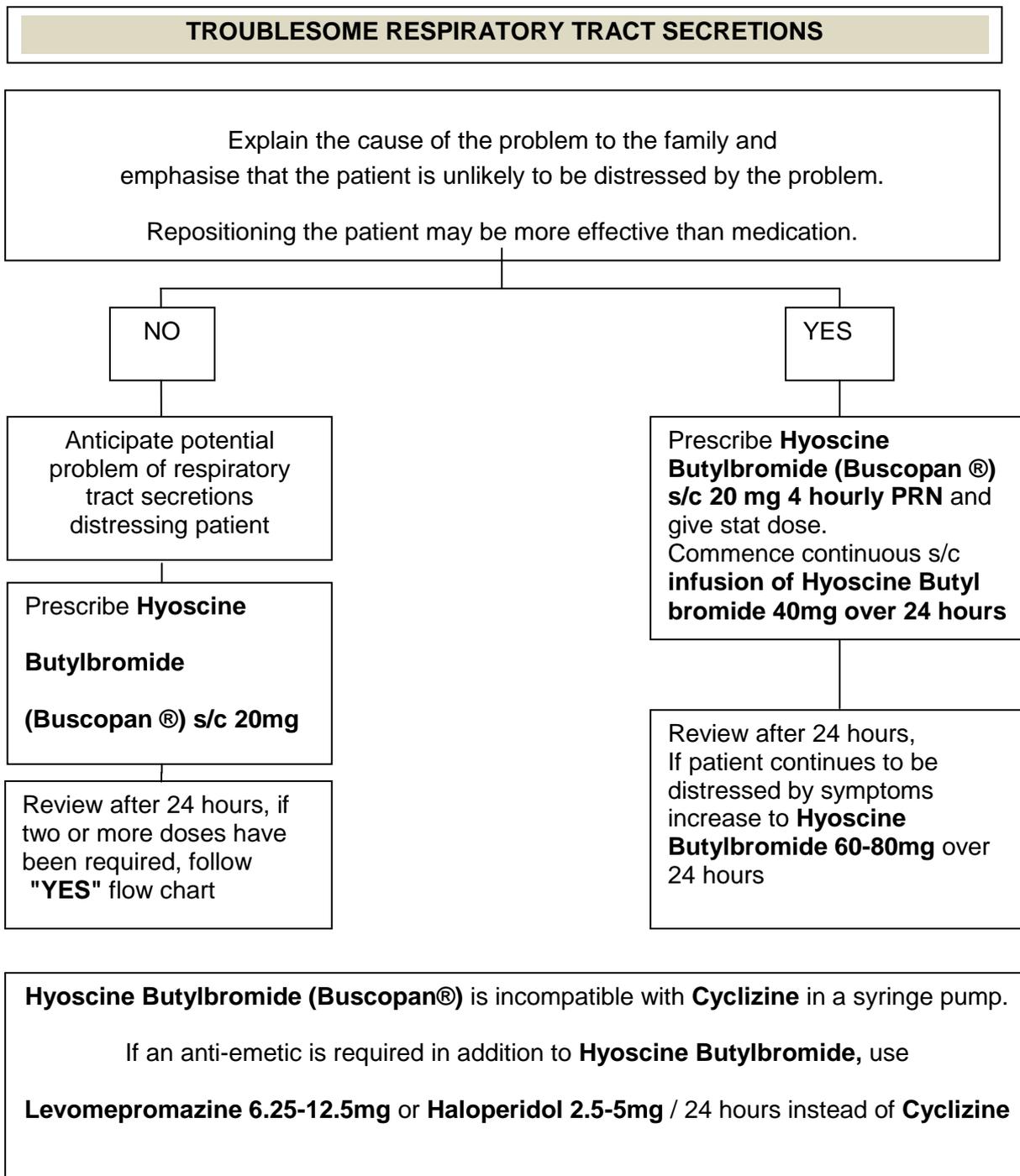
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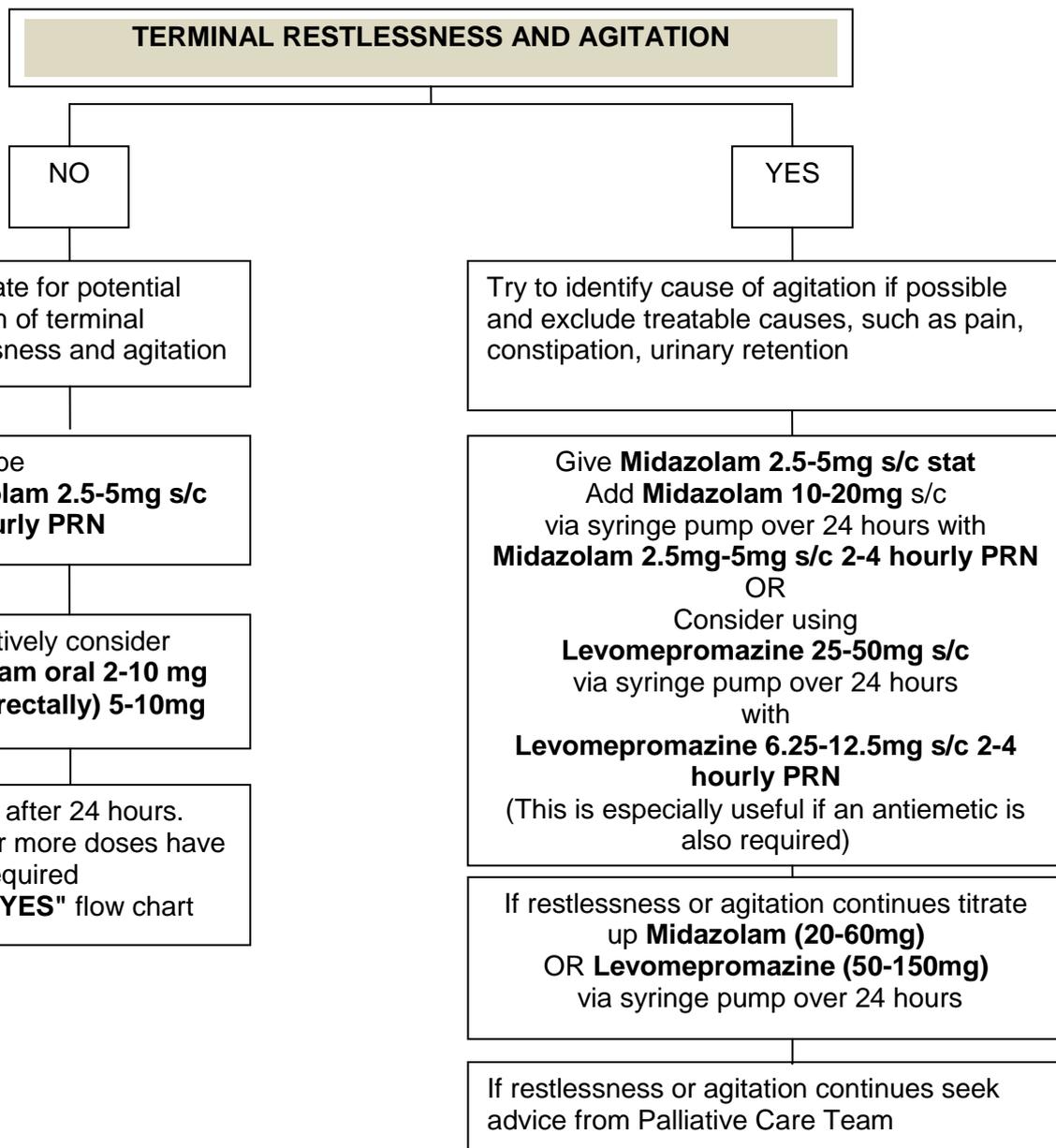
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**SOMERSET SYMPTOM CONTROL GUIDELINES**



**ANTICONVULSANTS:**

If patient usually takes regular anticonvulsants but is no longer able to swallow, consider **Midazolam 10-30mg s/c** via syringe pump over 24 hours (increasing if necessary to maximum of **60mg/ 24 hours**, seek specialist advice)  
 If patient is taking **Levetiracetam (Keppra)** this may continue to be given via syringe pump sc over 24 hours, oral:sc is 1:1.  
 If patient fitting, then seek urgent specialist advice, consider **Diazepam PR (rectally) 10-20mg** OR **Midazolam 5-10mg** buccally or IM

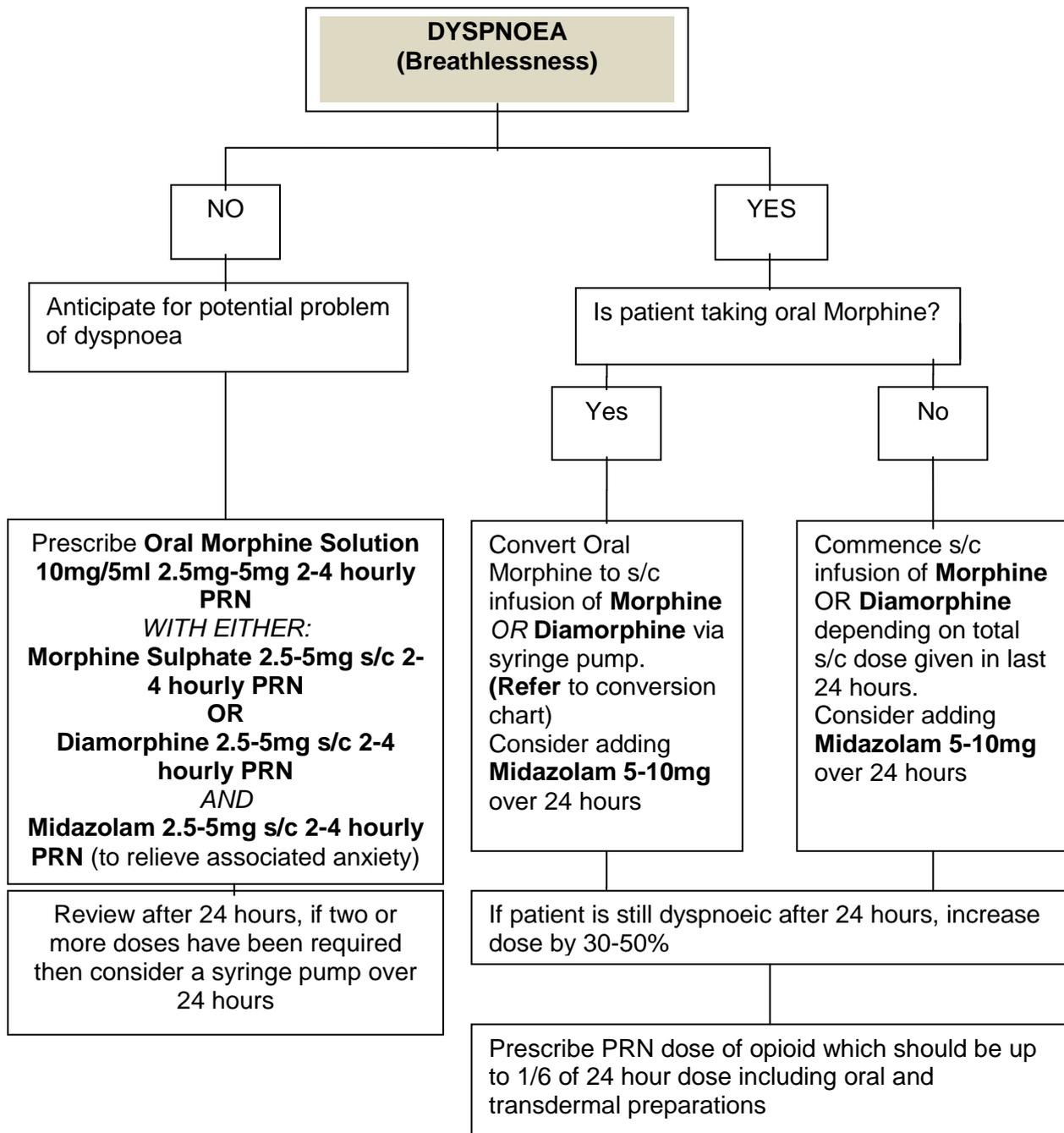
**STEROIDS:**

Continue with steroids if considered essential for symptom control, otherwise reduce and discontinue. Steroids may be given via a second syringe pump, or as a single daily s/c dose, maximum of 6.6mg as single s/c dose. (Oral dose of **Dexamethasone** is the same as by injection but ampoule is 3.3mg/ml)).

**IF SYMPTOMS PERSIST PLEASE CONTACT:**

**Specialist Palliative Care Team 24 hour Helplines**  
 St Margaret's Hospice - 0845 0708 910 (Somerset Palliative Care advice line)  
 Weston Hospice - 01934 423912  
 Dorothy House Hospice - 01225 722999

**SOMERSET SYMPTOM CONTROL GUIDELINES**



**Supportive measures:**  
Also consider change of the patient's position, the use of an electric fan, Oxygen as required

**IF SYMPTOMS PERSIST PLEASE CONTACT:**

**Specialist Palliative Care Team 24 hour Helplines**  
St Margaret's Hospice - 0845 0708 910  
(Somerset Palliative Care advice line)  
Weston Hospice - 01934 423912  
Dorothy House Hospice - 01225 722999

# SOMERSET HEALTH COMMUNITY

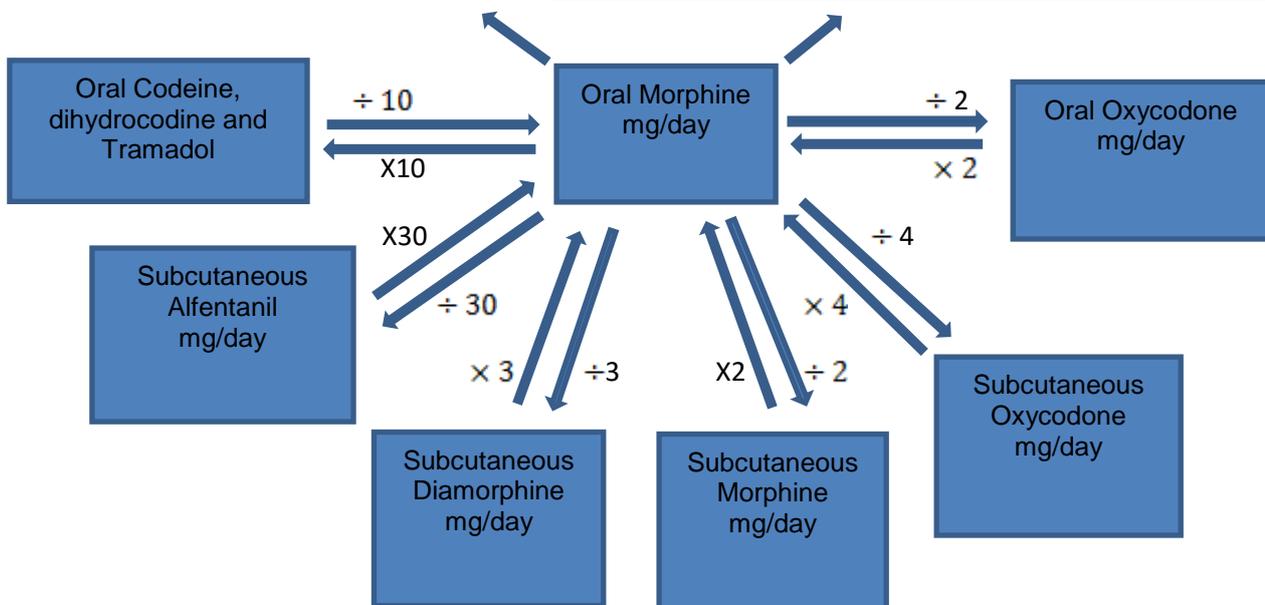
## OPIOID DOSE CONVERSION

### Fentanyl patches – 72 hour patches

Morphine 30mg daily = fentanyl '12' patch  
 Morphine 60mg daily = fentanyl '25' patch  
 Morphine 120mg daily = fentanyl '50' patch  
 Morphine 180mg daily = fentanyl '75' patch  
 Morphine 240mg daily = fentanyl '100' patch

### Buprenorphine patches

Morphine 12mg daily = Buprenorphine '5' patch 7-day  
 Morphine 24mg daily = Buprenorphine '10' patch 7-day  
 Morphine 48mg daily = Buprenorphine '20' patch 7-day  
 Morphine 84 mg daily = Buprenorphine '35' patch 4-day  
 Morphine 126 mg daily = Buprenorphine '52.5' patch 4-day  
 Morphine 168 mg daily = Buprenorphine '70' patch 4-day



#### Note:

- These conversions are a guide only.
- If switching opioid consider a dose reduction, particularly at higher doses.
- When converting from syringe pump to patch, stop the pump 6 hours after patch application.
- Morphine equivalences for traditional preparations are approximated to allow comparison with available preparations of oral morphine.
- The PRN dose of opioid is 1/6 of the 24H total opioid dose given 4 hourly.
- Buprenorphine patches are available as 3 day patches, (Hapoctasin); 4 day patches, (Transtec); and 7 day patches, (Butec).
- **If unsure, phone for specialist advice:**
- St Margaret's Hospice - 0845 0708 910 (Somerset Palliative Care advice line)
- Weston Hospice - 01934 423912
- Dorothy House Hospice - 01225 722999

## Guide to your 'Just in Case' box



- ☎ 01935 384000
- 📄 01935 384079
- 📧 Somerset Clinical Commissioning Group,  
Lufton Way, Lufton, Yeovil, Somerset, BA22 8HR
- 🌐 Web: [www.somersetccg.nhs.uk](http://www.somersetccg.nhs.uk)

This leaflet can be provided in other formats or languages by phoning 01935 385020

March 2016

## What is a Just in Case box?

A Just in Case box is exactly what it says – it contains a small supply of medicines that is kept in your home just in case you need it one day. The drugs it contains can be difficult to get in a hurry, particularly at night or at weekends. It is therefore sensible to have them ready – just in case. The medicines are usually only given by a nurse, doctor, or Paramedic Emergency Care Practitioner.

## What is in a Just in Case Box?

In your Just in Case box there are some small boxes containing ampoules of several different medicines, and some information for the nurses and doctors. There may also be a medicine administration sheet, authorising your District Nurse or a Paramedic Emergency Care Practitioner to give you medication by injection if you need it.

## What are the different medicines for?

The medicines in the box will vary from patient to patient. You may not need any of them, but just in case, the common ones are shown in the blue box opposite.

Diamorphine	for pain and shortness of breath
Cyclizine	for sickness
Levomepromazine	for sickness and restlessness
Hyoscine	for secretions in the throat
Midazolam	for restlessness and shortness of breath

## How do I look after my Just in Case Box?

The medicines in your box have been prescribed for you, and should not be given to anyone else. They don't need to be kept in the fridge, but should be kept in a safe place, out of the reach of children.

If the medicines are not required, they should be returned to your chemist.

## Any questions?

If you have any questions about your Just in Case box, do feel free to ask your District Nurse or GP.

Appendix 6

## Somerset End of Life Care Register User Account Request Form

**This form should be used by any member of staff who requires access to the Somerset End of Life Care Register**

<b>Your email address:</b>	
<b>Your name:</b>	
<b>Job Title:</b>	
<b>Organisation:</b>	
<b>Department:</b>	
<b>Contact Telephone Number:</b>	
<b>Level of Access to EoLR required: e.g. All or practice level</b>	
<b>User Access Required: e.g. View or Editing</b>	
<b>* Authoriser name:</b>	
<b>Authoriser's Job Title/Role:</b>	
<b>Authoriser's email address:</b>	
<p><b>* Notes for Authorisers:</b> By approving this user account request for access to the Somerset End of Life Care Register you are confirming that you have the authority to approve the user request and level of access requested.</p>	
<p>This form should be emailed to <a href="mailto:somersetspn@vocare.nhs.uk">somersetspn@vocare.nhs.uk</a> for approval and account creation.</p>	

<b>SDUC Use Only:</b>	
<b>Date added to register:</b>	
<b>Date new user informed of login and password:</b>	

## Appendix 7

# How Do I ...

## Quick Start Guide for the Electronic Palliative Care Coordination System - EPaCCS

### Log onto EPaCCS

Log on <https://www.nduc.nhs.uk/awa/login.aspx>

Enter username and password and change password as requested the first time you log in.

**Please only use the Somerset EPaCCS template.**

### Add patient to EPaCCS

- From welcome page, select 'Note Edit' from menu.
- Check patient is not already on EPaCCS using the search box, making sure you choose the patient's GP Surgery from the Provider Group drop down box, or 'all provider groups' if this is unknown.
- If the patient is not already on EPaCCS select 'Add New Note'.
- Search for patient using 'Search Criteria' – if found select 'Create Note' located before patient name.
- If patient is not found, select 'Add Patient'.
- Under Note Settings tick box, 'Exclude this patient from the patient experience questionnaire?'
- If Somerset EPaCCS template is not displayed, click 'Alter template', & select from drop down list.
- Select Yes to 'Has patient given consent for information sharing' question. Offer patient leaflet.
- Complete as much as you can, but this is not a 'tick box' exercise & can be done on several occasions.
- Enter notes at bottom of page. It is important to start each note with the date, enter the note detail, then complete with your name and role at the end.
- When all information has been added, select Add to save.

### View or Edit an Existing Entry

Select patient as above, click on 'Access' on the left hand side of the patient's name. Edit details if required and select Add to save changes. Select 'Cancel' if no changes have been made.

### Discharge a Patient

- Select patient by clicking 'Access' on the left hand side of the patient's name.
- Under Note Settings, tick box to mark this patient as hidden.
- In End of Life section select 'Discharge' in 'Reason for Patient Leaving Service' and enter date of discharge.
- Select Update to save changes.

### Decease a Patient

- Select patient by clicking 'Access' on the left hand side of the patient's name.
- Under 'Note Settings', tick box to mark this patient as hidden.
- In End of Life section select location of Actual Place of Death and complete Reason for Variance if applicable. Select 'Died' in 'Reason for Patient Leaving Service' and enter date of death.
- Select Update to save changes.

### Change Patient's GP – contact End of Life Care Co-ordination Centre

- Select patient by clicking 'Access' on the left hand side of the patient's name.
- Under Patient Demographics, delete practice information under 'Provider group', and pick from drop down box.
- Select GP from drop down list next to Doctor. Select Update to save changes.