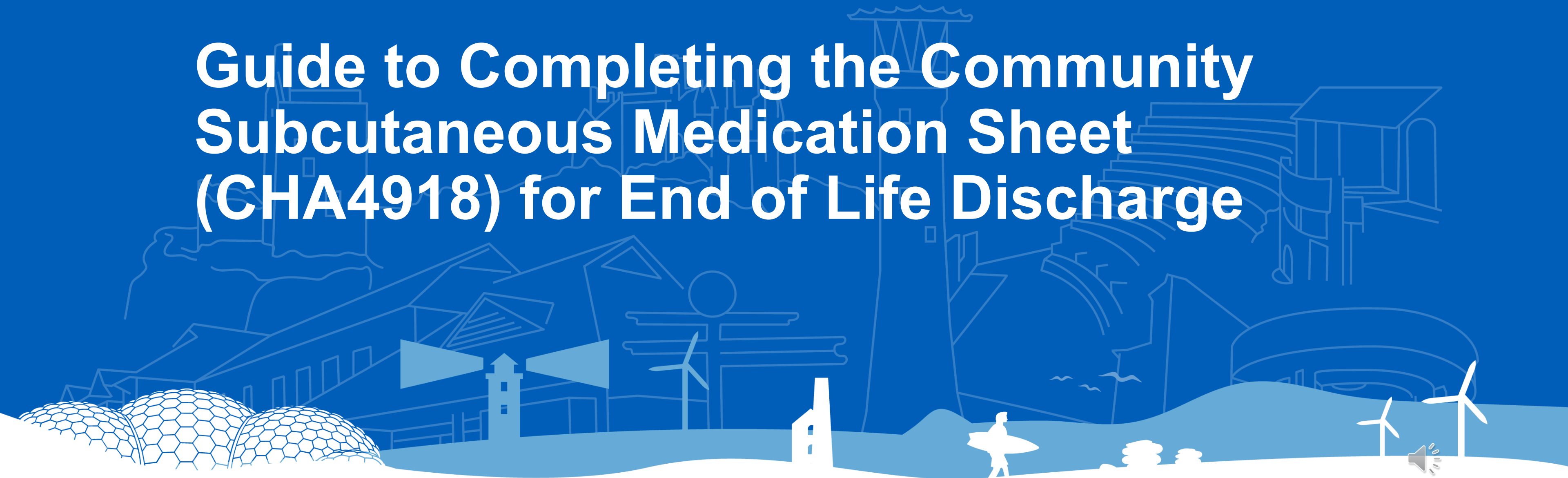


Guide to Completing the Community Subcutaneous Medication Sheet (CHA4918) for End of Life Discharge



- ☐ Complete STRATA (include Hospital at home), Fast track application and OT referral.
- ☐ Book ambulance on 01302 787499 'End of life imminent and/or Fast track'.
- ☐ For patient's requiring palliative oxygen therapy complete HOOF**.

Actions for the doctor

- ☐ Short prognosis- Ward doctor to ring GP to handover and request visit.
- ☐ Update TEP (to travel with the patient).
- ☐ Expected death form* to GP and OOHs.
- ☐ Special Patient Note* to GP and OOHs.
- ☐ Use prescription sheet CHA4918 for anticipatory prescribing of EOL drugs (paper chart to be checked by pharmacy).
- ☐ Use form CHA1525 for any other medication i.e. Oromorph.
- ☐ Use GREAT discharge guide to update E-discharge summary/care plan.

Actions for the nurse

- ☐ If a syringe driver is in situ, ensure this will not need renewing OOHs. Complete MD11 form and email to: rch-tr.MedicalEquipmentLibrary@nhs.net
- ☐ Ensure all medication and prescription sheets travel with the patient.
- ☐ Check any equipment has been delivered and any POC is due to start.
- ☐ Nurse to District nurse/hospital at home/care home staff verbal handover.
- ☐ 'Out-of-hours treatment for patients with palliative care needs' leaflet to patient/family (RCHT1686- documents library).
- ☐ Notes to travel with the patient to the hospice or community hospital (Cornwall only).

The patient should have a medical review <2hrs prior to discharge to ensure that they are safe to transfer. For patients at risk of death in transit discuss this with the patient/ family. Depending on the length of journey **Patients/families may still choose to transfer if this is/was the patient's wish.**

- Ensure 7 days' supply of injectable medication is prescribed according to local anticipatory prescribing guidance or in accordance with the patient's current regime (see End of Life Transfers and discharges Pharmacy recommendations on the EOLC shelf).
- Medication must travel with patients discharged to home, nursing home, hospice, or community hospital setting.
- Hoof - <https://www.airliquidehomehealth.co.uk/hcp/hoofa> (link on EOL shelf).
- *Expected death form and special patient note are located on the EOL care shelf. Email these to kernowhealthcic.patientnotes@NHS.NET and to the GP.
- Please refer to the specialist palliative care team if advice is required to support a complex discharge. Maxims referral, 0740714093 or bleep 3055 for urgent advice.



Out-of-hours treatment for patients with palliative care needs



One + all | we care



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1. Review
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- 24/7 palliative care advice line: **01736 757 707**
- Royal Cornwall Hospitals NHS Trust Specialist Palliative Care Team: bleep **3055**, 7 days 8am to 4pm
- Community Specialist Palliative Care Team: **01308 351 300**, 7 days 9am to 4.30pm

[illegible][illegible]

Authorisation to administer and record as required medication

Review prescribing after 28 days

Prescriber		
Indication: Pain or breathlessness		
Drug: Morphine	Dose: 2.5-5mg.	Route: S.C.
Signature, name, date: S. Brown S. Brown 04/05/26	Frequency: Hrly	Max dose in 24 hours: 30mg
Indication: Agitation or confusion		
Drug: Midazolam	Dose: 2.5mg	Route: S.C.
Signature, name, date: S. Brown S. Brown 04/05/26	Frequency: Hrly	Max dose in 24 hours: 60mg
Indication: Nausea or vomiting		
Drug: Haloperidol	Dose: 1mg	Route: S.C.
Signature, name, date: S. Brown S. Brown 04/05/26	Frequency: 1mg	Max dose in 24 hours: 10mg

Review date:

If frequent PRN doses are needed seek a clinical review

Authorisation to administer and record as required medication

Review prescribing after 28 days

Prescriber		
Indication: Respiratory secretions		
Drug: Glycopyrronium	Dose: 200mcg	Route: S.C
Signature, name, date: S. Brown S. Brown 04/05/26	Frequency: 4 hrly	Max dose in 24 hours: 1200mcg
Indication: Nausea		
Drug: Cyclizine	Dose: 50mg	Route: S.C
Signature, name, date: S. Brown S.Brown 04/05/26	Frequency: tds	Max dose in 24 hours: 150mg

Batch no:								
Expiry date:								
Given by:								

Reviewers signature:

If frequent PRN doses are needed seek a clinical review

Administrator						
Date:						
Time:						
Dose:						
Batch no:						
Expiry date:						
Given by:						
Date:						
Time:						
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Batch no:								
Expiry date:								
Given by:								

Guidance for Anticipatory Prescribing and Symptom Control at the End-Of-Life in Adults

This table shows symptoms people commonly experience at the end of life with medications and suggested starting doses. When prescribing subcutaneous medication to support comfort at the end of life, the person's existing medication, current symptoms and medications to be used as needed (PRNs), should be reviewed and final prescription adjusted according to the person's needs. **If the person has renal impairment with eGFR<30, see renal anticipatory prescribing guidance.**

Symptom	Drug	As needed (PRN) subcutaneous dose for symptoms that commonly occur	Syringe Driver starting dose to be prescribed subcutaneously over 24 hours via syringe driver	Maximum dose to be given subcutaneously over 24 hours	Vial Strengths
1. Pain/Breathlessness NB If already on oral opioids, see below for conversion from oral to subcutaneous dose. As needed (PRN) dose is 1/6 th of the total opioid dose in 24 hours.	Morphine	2.5 mg to 5 mg 1 hourly (if not already taking opioids)	10 mg (if not already taking opioids)	Guided by symptoms	10 mg/ml
	Diamorphine	Diamorphine should only be used on specialist advice when morphine is not clinically indicated. There are ongoing long term stock shortages of Diamorphine.			
2. Nausea/vomiting First line: Opioid or centrally induced	Haloperidol	0.5 mg to 1.5 mg three times per day	1.5 mg	10 mg	5 mg/ml
	Cyclizine*	25 mg to 50 mg three times per day	75 mg	150 mg	50 mg/ml
First line: Prokinetic	Metoclopramide	10 mg three times per day	30 mg	80 mg	10mg/2ml
Second line	Levomepromazine	6.25 mg four times per day	6.25 mg	25 mg	25 mg/ml
3. Agitation With anxiety	Midazolam	2.5 mg to 5 mg 1 hourly	10 mg	60 mg	10 mg/2ml
With hallucinations or confusion	Haloperidol	0.5 mg to 1.5 mg three times per day	1.5 mg	10 mg	5 mg/ml
Second line	Levomepromazine	6.25 mg to 12.5 mg four times per day	6.25 mg	100 mg	25 mg/ml
4. Respiratory tract secretions First line	Glycopyrronium Bromide	200 micrograms 4 hourly	600 micrograms	1200 micrograms	600 mcg /3ml
Second line These medications should be prescribed separately, not in combination.	Hyoscine Hydrobromide	400 micrograms 4 hourly	1200 micrograms	2000 micrograms	400 mcg/ml
	Hyoscine Butylbromide*	10 mg to 20 mg 4 hourly	60 mg	120 mg	20 mg/ml

* Cyclizine is not compatible with Hyoscine Butylbromide or Oxycodone in a syringe driver.

Advice is available 24 hours a day, 7 days a week to any healthcare professional from the SPECIALIST PALLIATIVE CARE ADVICE LINE 01736 757707

Renal Anticipatory Prescribing Guidance for Symptom Control in Opioid Naïve Patients with Renal Impairment EGFR <30

Symptom	Drug	Subcutaneous prn dose/ Doses for anticipatory symptoms	Starting dose over 24 hours in syringe driver (subcutaneous)	Maximum dose to be given subcutaneously over 24 hours	Supporting information
1. Pain / Breathlessness	Alfentanil	50 micrograms - 100 micrograms hourly	500 micrograms	Guided by symptoms	Alfentanil has a short half-life. In some circumstances, it may be more suitable to use Oxycodone 1 mg sc prn hourly i.e. recurrent prn dosing in a community setting. Please seek specialist palliative care advice. For patients already on a Fentanyl or Buprenorphine patch it is usually recommended that the patch is not removed. Continue to change the patch at prescribed intervals. Additional opioid is given, as appropriate, via a syringe driver. Please seek specialist palliative care advice.
	Oxycodone	1 mg – 2 mg hourly	5 mg		
2. Nausea / vomiting	Haloperidol (1st line)	0.5 mg – 1 mg three times per day	1.5 mg	5mg	For patients with a low eGFR it is not imperative to switch opioid if symptoms are well controlled without toxicity. For breathlessness unrelieved by opiates, consider Midazolam 2.5mg s/c prn hourly. Consider syringe driver of Midazolam 5-10mg s/c over 24 hours.
	Levomepromazine (2nd line)	6.25 mg two times per day	6.25mg	12.5 mg	
3. Agitation +anxiety	Midazolam	2.5 mg 1 hourly	5mg	30mg	Hyoscine hydrobromide is not recommended in patients with an eGFR <30.
+hallucinations or confusion	Haloperidol	0.5 mg – 1 mg three times per day	1.5mg	5mg	
4. Noisy breathing due to respiratory tract secretions*	Glycopyrronium Bromide	200 micrograms 4 hourly	600 micrograms	1200 micrograms	
	Hyoscine Butylbromide	10 mg – 20 mg 4 hourly	40 mg	120mg	

Please do not hesitate to seek advice if you have any questions about symptom control, side effects or management. 24 hour advice at Cornwall Hospice Care 01736 757707

Syringe driver prescribing and administration

- It is important to consider all causes of clinical deterioration and assess the patient's symptoms prior to prescribing or commencing a syringe driver.
- Starting opioid dose of a syringe driver should reflect any previous regular oral dose plus any additional PRN doses required over the previous 24 hours.
- A single starting dose should be prescribed for each medication. It is an incremental increase with a maximum dose.
- Syringe driver opioid dose increases should not generally exceed 30%.
- When increasing the syringe driver dose, review PRN doses to ensure they are not required.
- Water for injection is the diluent of choice for most commonly used medications.
- Where there may be concerns in regard to drug compatibility, consult the book.pallcare.info/index.php

24 hour syringe driver prescribing (prescriber to complete)

Diluent of choice:

Dilute to a volume of 23mls in a 30ml syringe.

Indication: Pain or breathlessness

..... injection mg over

24 hours by continuous subcutaneous infusion. If required increase in incremental steps of mg to maximum of mg over 24 hours.

Indication: Agitation

..... injection mg over

24 hours by continuous subcutaneous infusion. If required increase in incremental steps of mg to maximum of mg over 24 hours.

Indication: Nausea or vomiting

..... injection mg over

24 hours by continuous subcutaneous infusion. If required increase in incremental steps of mg to maximum of mg over 24 hours.

Indication: Secretions

..... injection mg over

24 hours by continuous subcutaneous infusion. If required increase in incremental steps of mg to maximum of mg over 24 hours.

Indication:

..... injection mg over

24 hours by continuous subcutaneous infusion. If required increase in incremental steps of mg to maximum of mg over 24 hours.

24 hour syringe driver prescribing (prescriber to complete)

Diluent of choice: Water for injection

Dilute to a volume of 23mls in a 30ml syringe.

Indication: Pain or breathlessness

Morphine injection 20 mg over

24 hours by continuous subcutaneous infusion. If required increase in incremental steps of 10 mg to maximum of 40 mg over 24 hours.

Indication: Agitation

Midazolam injection 10 mg over

24 hours by continuous subcutaneous infusion. If required increase in incremental steps of 5 mg to maximum of 40 mg over 24 hours.

Signature: S. Brown
Name: S. Brown
Designation: F2 Doctor
Date: 04/05/26

Signature: S. Brown
Name: S. Brown
Designation: F2 Doctor
Date: 04/05/26

Signature: S. Brown
Name: S. Brown
Designation: F2 Doctor
Date: 04/05/26

Signature:
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Always consult the conversion

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- Patients should be assessed
- Assess and document the
- For opioid naive patients
- For rapid symptom control
inform any future syringe
- For patients prescribed a
- A patient specific range /
- Patients with severe uncontrolled
dose at a shorter time interval
- If 2 or more subcutaneous
consider starting a syringe

- When initiating a syringe to achieve symptom relief
- For patients requiring a syringe Consider a lower starting dose
- The starting opioid dose may require additional PRN doses required
- A single starting dose should increase with a maximum of 4-6 mg
- A syringe driver takes 4-6 hours to start
- If a syringe driver has been prescribed but not yet been commenced
- When increasing the syringe dose prescribed.

- Syringe driver opioid dose increases should not generally exceed 30-50% of the total previous dose.
- Repeat PRN doses may be administered using a device such as a Saf T Intima according to local guidance. PRN doses should not be administered via the syringe driver port.
- Water for injection is the diluent of choice for most commonly used anticipatory medications.
- The mixing of medicines in a single syringe driver is supported by compatibility data. If more than 3 medications are required, or where there is any doubt regarding suitability or compatibility, consult the [PallCare Matters](#) resource.

Always consider non-pharmacological interventions for symptom relief

Ensure that the patient and family know what medication is being given and why

Ensure that the potential adverse effects are known to the patient and family

Explain to the patient and family about the purpose of the syringe driver administration

PAIN

Opioid naïve patients

- Unless otherwise indicated Morphine is the first line opioid of choice.
- The lowest dose should always be selected to achieve effective symptom relief ie Morphine 2.5 mg up to hourly as required.

Patients taking a regular opioid

- Patients taking regular oral opioids who are no longer able to swallow usually require this to be converted to continuous subcutaneous infusion.
- A subcutaneous dose of Morphine is calculated at half the usual oral dose. For example 60 mg of oral morphine daily = 30mg of morphine SC over 24hrs.
- A prn dose of opioid is usually calculated at $1/6^{th}$ of the 24hr dose. ie a patient receiving 30mg of morphine/24hrs will require a prn morphine dose of 5mg. Any increase in the syringe driver dose will require a recalculation of the prn dose.

If frequent prn doses are needed, or if symptoms remain uncontrolled, seek Specialist palliative care advice

01736 757707

