



## Pre-emptive Prescribing for the Last Days of Life for patients in Doncaster

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Target audience:	All clinical staff; Trust(s) and GP wide within Doncaster region

### Scope

This guidance should be used alongside NICE guidance for care of patients in the last days of life (<https://www.nice.org.uk/guidance/ng31>) and The Palliative Care Formulary version 7 and above, and regional guidance; [A Brief Guide to Symptom Management in Palliative Care](#), Yorkshire and Humber Palliative and End of Life Care Groups (v7 June 2019). This guidance is intended for both generalist and palliative care prescribers across hospital and community settings.

### General Principles

- Offer oral drugs where the patient can swallow; consider liquid preparations to aid administration.
- Prescribe current and/or anticipatory meds for the 4 key symptoms:
  - pain
  - nausea / vomiting
  - agitation
  - respiratory secretions
- Individualise your prescribing plan considering:
  - likely causes of any symptoms.
  - other medical conditions (including renal failure, heart failure, Parkinson's) and other medications concurrently prescribed.
  - previous response to medications
  - patient preferences.
- Review and rationalise other regular medications and consider the risk/benefit of continuing with these (e.g. anticoagulants, antibiotics, antiepileptic, or diabetic medications) and whether medications require a gradual dose reduction (e.g. steroids). Consider discussion with a senior clinician with adequate palliative care knowledge when reducing/stopping disease modifying medications (e.g. cardiac meds).
- Start new medications at the lowest effective dose and regularly review / titrate as required for symptom control.
- Lower doses may be needed in the frail because of altered organ function and increased sensitivity.
- Hourly initial dosing of PRN medications is achieving symptom control: if more than 3 doses are required in 24 hours, the patient may require a review of symptoms. It is important to understand the reason why the PRNs were administered before titrating medications. Telephone for advice, where needed.

**Specialist advice is available within the hours of 08.30a.m.-16.30p.m. from the hospice (Palliative triage is 03000 214666) and/or Consultants in Palliative Medicine via DRI switchboard (queries from GPs, doctors or SPC nurses only required).**



**PRESCRIBING INFORMATION**

DRUG and ampoule strength	Indication(s)	initial SC dose	How often	Maximum dose in 24 hrs / special notes
Morphine 10mg/ml injection (1ml amp) (alternative strength(s) available, please see BNF)	Pain Dyspnoea – 1 <sup>st</sup> line	2.5-5mg if opioid naïve (consider dose reduction in frail or elderly patients). See conversion chart (appendix 1) if on regular opioid.	Up to hourly (note dose limit before specialist advice required)	Max 6 doses in 24 hours, if requiring more seek specialist advice. For eGFR <30, please use oxycodone.
Oxycodone 10mg/ml (1ml & 2ml amp) (alternative strength(s) available, please see BNF)	Pain – if eGFR<30 Dyspnoea, if already on oral oxycodone	1-2.5mg if opioid naïve (consider lowest dose in frail or elderly patients or eGFR <30). See conversion chart (appendix 1) if on regular opioid.	Up to hourly (note dose limit before specialist advice required)	If the patient uses 6 doses or greater/24 hours seek specialist advice.
Haloperidol 5mg/ml Injection (1ml amp)	Antiemetic or Agitation	1.5mg	4hrly	Consider an initial dose of 0.5mg in the frail and elderly. Max. 6mg in 24 hours (3mg if using 0.5mg). Consider use of syringe driver if nausea inadequately controlled. Avoid in Parkinson's Disease.
Hyoscine butyl bromide 20mg/1ml Injection (1ml amp)	Respiratory secretions Bowel Colic	20mg	Hourly as required	Max 120mg/24h * (seek specialist advice). Not physically compatible with cyclizine in syringe driver.
Midazolam 10mg/2ml Injection (2ml amp)	Restlessness, Agitation and/or Dyspnoea – 2 <sup>nd</sup> line	2.5-5mg	Hourly as required	Max. 30mg/24 hours*; seek specialist advice if ineffective.

\*Maximum dose is in mg for all medications except for opioids; for opioids it is the number of doses/episodes in 24 hours. Except for those for opioids, the above maximum doses include medication given regular (e.g. in a syringe driver). Repeated PRN dosing often indicates the need for clinical review. Maximum doses or episodes can be increased as per clinical need. See palliative care advice



**APPENDIX 1 – alternative opioids**

For further prescribing guidance (including buprenorphine patch equivalence), please see the local [MPD](#)

**PRESCRIBING OF ALTERNATE OPIOIDS**

For prescribing of alternative opioids see dose conversion table below.

NB:

- Conversion ratios are approximate and every change of drug requires careful monitoring.
- PRN doses for breakthrough pain should be 1/6th of total 24 hour infusion dose regardless of type of opioid prescribed.
- Drug compatibility in syringe drivers may differ from diamorphine.
- In those patients on high doses of oxycodone a large infusion volume may be required. If this is impractical, either convert to a continuous subcutaneous infusion of diamorphine or contact the Specialist Palliative Care Team for advice.
- In those patients with a fentanyl patch in situ who have rapidly escalating pain requiring the addition of a syringe driver, continue to change the fentanyl patch every 72 hours, initiate a continuous subcutaneous infusion of diamorphine, alfentanil or oxycodone via a syringe driver and titrate dose according to response.
- In end stage renal disease, Alfentanil is the strong opioid of choice.

Oral Morphine		Subcutaneous Morphine		Subcutaneous Diamorphine		Oral Oxycodone			Subcutaneous Oxycodone		Subcutaneous Alfentanil		Fentanyl patch
Breakthrough dose (mg)	12 MR dose (mg)	24 total dose (mg)	Breakthrough dose (mg)	24 total dose (mg)	Breakthrough dose (mg)	12 MR dose (mg)	24 total dose (mg)	Breakthrough dose (mg)	24 total dose (mg)	Breakthrough dose (mg)	24 total dose (mg)	Microg/ hour	
5	15	30	2.5	15	1.5	10	2.5	15	7.5	1.25	7.5	0.15	12
10	30	60	5	30	3	20	5	30	15	2.5	15	0.3	25
15	45	90	7.5	45	5	30	7.5	50	22.5	3.75	22.5	0.5	25 <sup>†</sup>
20	60	120	10	60	7.5	40	10	60	30	5	30	0.75	37 <sup>†</sup>
30	90	180	15	90	10	60	15	90	45	7.5	45	1	50 <sup>†</sup>
40	120	240	20	120	12.5	80	20	120	60	10	60	1.25	62 <sup>†</sup>
50	150	300	25	150	15	100	25	150	75	12.5	75	1.5	75
60	180	360	30	180	20	120	30	180	90	15	90	2	100
70	210	420	35	210	25	140	35	210	105	17.5	100	2.5	125
80	240	480	40	240	27.5	160	40	240	120	20	120	2.5	125*
90	270	540	45	270	30	180	45	270	135	<b>Max</b>	135	3	150*
100	300	600	50	300	35	200	50	300	150	<b>Sub</b>	150	3.5	175*
110	330	660	55	330	37.5	220	55	330	165	<b>Cut</b>	165	3.5	175*
120	360	720	60	360	40	240	60	360	180	<b>Vol</b>	180	4	200

<sup>†</sup>These fentanyl conversions do not fully reflect the current BNF recommendations up to 100micrograms of fentanyl. The BNF conversions apply to patients that have been stabilised long term on opioids. Doses should be used as a guide only and should be carefully titrated according to clinical response.

\*fentanyl conversions become less reliable as the dose of morphine (or equivalent) increases. Ensure adequate breakthrough doses are prescribed to enable titration. Patients on fentanyl patches over 150microg/hr (or equivalent opioid dose) should receive specialist palliative care input.

**Breakthrough Pain:**

Patients prescribed regular slow release or continuous subcutaneous infusions of strong opioids should also be prescribed a breakthrough pain dose of immediate release opioid.

The breakthrough pain dose is calculated as 1/6 total daily dose regular strong opioid.

Breakthrough pain doses should be given when the pain occurs NOT by the clock. However, sufficient time should be allowed for the dose administered to work. There is no limit to the number of breakthrough doses that may be administered, however, if more than 2 doses are required in 24 hours it is usually an indication that the dose of regular strong opioid needs increasing.



Appendix 2 – Referral form for Out of Hours GP Service

PALLIATIVE CARE REFERRAL TO OUT OF HOURS GP SERVICE DONCASTER

PRIMARY CARE



Patient's name:	Preferred name:
Date of birth:	NHS number:
Telephone number(s):	
Address:	
Next of kin/carer's name:	
Contact number if different:	
<b>Referred by</b> Name:	<b>Own GP</b> Name: Practice:
Contact number:	Contact number:
Diagnosis:	
Health situation to date:	
Community Nurse involvement? YES / NO (delete as appropriate) If yes, name and contact number:	
Palliative Care Nurse involvement? YES / NO (delete as appropriate) If yes, name and contact number:	
Palliative Care Specific Medication:	Syringe driver? YES / NO (delete as appropriate)
Pre-emptive black box? YES / NO (delete as appropriate)	Advanced Care Plan? YES / NO (delete as appropriate)
DNACPR in place? YES / NO (delete as appropriate)	Coroner to be informed? YES / NO (delete as appropriate)
<b>Last seen by</b> Dr (Name): GP / Hospital (delete as appropriate) Date:	<b>Specific requests</b>
	Patient/carer wishes to stay at home? YES / NO (delete as appropriate)
Review date (by person referring):	Date emailed to <a href="mailto:fcms.oohdoncaster@nhs.net">fcms.oohdoncaster@nhs.net</a> :
Date Out of Hours notified of death:	By (name):



Appendix 3 – Pre-emptive prescribing instruction

**INSTRUCTION TO ADMINISTER MEDICATION PRO-FORMA      NON-SYRINGE DRIVER ADMINISTRATION**

A	PATIENT DETAILS			
	Name: .....	Address: .....		
	DOB: .....	.....		
	NHS No: .....	.....		
		Please tick		
B	<b>DRUGS AND DOSING DETAILS</b> <i>(please tick whether each drug is for stat or repeated dosing)</i>		Single dos e ON LY	For Rep eat dosi ng
	<b>DRUG 1</b>  Drug name: ..... Route : ..... Dose.....per administration <i>(please state units e.g. milligram, microgram, units etc)</i> Dose Frequency: ..... Maximum daily dose: ..... Start Date: ..... Stop Date: .....		<input type="checkbox"/>	<input type="checkbox"/>
	<b>DRUG 2</b>  Drug name: ..... Route : ..... Dose .....per administration <i>(please state units e.g. milligram, microgram, units etc)</i> Dose Frequency: ..... Maximum daily dose: ..... Start Date: ..... Stop Date: .....		<input type="checkbox"/>	<input type="checkbox"/>
	<b>DRUG 3</b>  Drug name: ..... Route : ..... Dose .....per administration <i>(please state units e.g. milligram, microgram, units etc)</i> Dose Frequency: ..... Maximum daily dose: ..... Start Date: ..... Stop Date: .....		<input type="checkbox"/>	<input type="checkbox"/>
	<b>DRUG 4</b>  Drug name: ..... Route : ..... Dose .....per administration <i>(please state units e.g. milligram, microgram, units etc)</i> Dose Frequency: ..... Maximum daily dose: ..... Start Date: ..... Stop Date: .....		<input type="checkbox"/>	<input type="checkbox"/>
	<b>ADDITIONAL INFORMATION</b>  Review date ..... <i>(please stipulate if you want a specific time limit otherwise <b>the patient will be reviewed by the attending clinician at each attendance and, where there has been a change of circumstances, will refer to the prescriber for any necessary treatment changes or need for review.</b></i>			
C	Test 1: ..... Frequency: .....	Test 3: ..... Frequency: .....		
	Test 2: ..... Frequency: .....	Test 4: ..... Frequency: .....		
If you have any doubts with regards the clarity or intention of this direction, please contact me or the duty doctor at the surgery.				
D	Prescribers name: .....	Time: .....		
	BLOCK CAPITALS	Date: .....		
Prescribers signature: .....				

*When filling out the pro-forma, please PRINT details clearly, complete sections A, B and D fully and section C if relevant. Indicate if medicine is for a single or repeated administration. Any unused boxes must be scored through*

**non-SYRINGE DRIVER INSTRUCTION**



**SUBCUTANEOUS SYRINGE DRIVER v AND OBSERVATION CHART FOR MCKINLEY T34**

**PRESCRIPTION DETAILS [for completion by the prescriber] – a separate form must be completed for each syringe driver**

		Drug	Dose	Diluent	Pharmacy <sup>a</sup>	Allergy Status	PATIENT DETAILS [Affix label if available]
Date		1.		Please circle			NHS Number: ..... Surname: ..... Forename(s) ..... Address: ..... DOB: .....
Route	SC	2.		Water for injection			
Duration of flow	Please circle 12 hours 24 hours	3.		or			
		4.		Normal Saline			
<i>The patient will be reviewed by the attending clinician at each attendance and, where there has been a change of circumstances, will refer to the prescriber for any necessary treatment changes or need for review. If, as the prescriber, you wish to review the patient on a particular date, please stipulate below -Review date: .....</i>							
Prescriber name: ..... Signature: ..... Practice: .....							a. Pharmacy: Only complete if this form is used on a ward. NOT required for community use.

**ADMINISTRATION & OBSERVATION DETAILS [for completion by administering clinician]**

WARD OR BASEPOINT NAME

The patient will be reviewed by the attending clinician at each attendance and, where there has been a change of circumstances, will refer to the prescriber for any necessary treatment changes or need for review.

ADMINISTRATION <sup>1</sup>		Day and Date	OBSERVATIONS <sup>2</sup>	Time [HH:MM]						
<b>DAILY SET UP</b>	Start time of infusion:		<b>MONITORING PROGRESS</b>	Site appearance <sup>6</sup> :						
	Syringe size used <b>20ml</b> or <b>30ml</b>	17ml infusion in 20ml syringe 22ml infusion in 30ml syringe		Syringe/line contents clear <sup>3</sup> - OK to continue? [Y/N]						
	Syringe Driver serial No.:                      Battery Status [%]:			Infusion rate setting – as at set up? [Y/N]						
	Infusion rate [ml/hr]:			Infusion time remaining [HH:MM]						
	Site used <sup>5</sup> :	Site Appearance <sup>6</sup> :		Volume still to be infused (vtbi) [ml]						
	Drawn up by:    Checked by:			Is the VTBI correct for time remaining [Y/N]						
	Details of any problems & actions taken: <b>If syringe contents discarded:</b> Volume discarded:                                      Date & time: Discharged by:    Checked:			Volume infused [ml]						
		Battery status [%] <sup>4</sup>								
		Is the keypad locked? [Y/N]								
		Observer's initials								

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>To be completed each time syringe driver is loaded</li> <li>WARD - Completed 30 minutes after loading and then every 4 hours<br/>COMMUNITY – Complete at set up, at each subsequent visit and at syringe change</li> <li>If contents of syringe look cloudy, precipitation has occurred. STOP infusing and contact prescriber. Refer to policy for guidance on checking compatibility</li> </ol> | <ol style="list-style-type: none"> <li>Change battery when less than 10% (ward ) or 40% (community)</li> <li>Document insertion site of winged infusion</li> <li>Appearance: Use code below<br/>               NP (no problem)    P (pain)                      I (inflammation)<br/>               SW (swelling)        B (bleeding)        H (hardening)             </li> </ol> |
|---|--|

**GUIDANCE FOR SYRINGE DRIVER PRESCRIBING** - In general, please try and ensure that syringe driver prescribing, and stock checks are carried out within regular working hours Monday to Friday