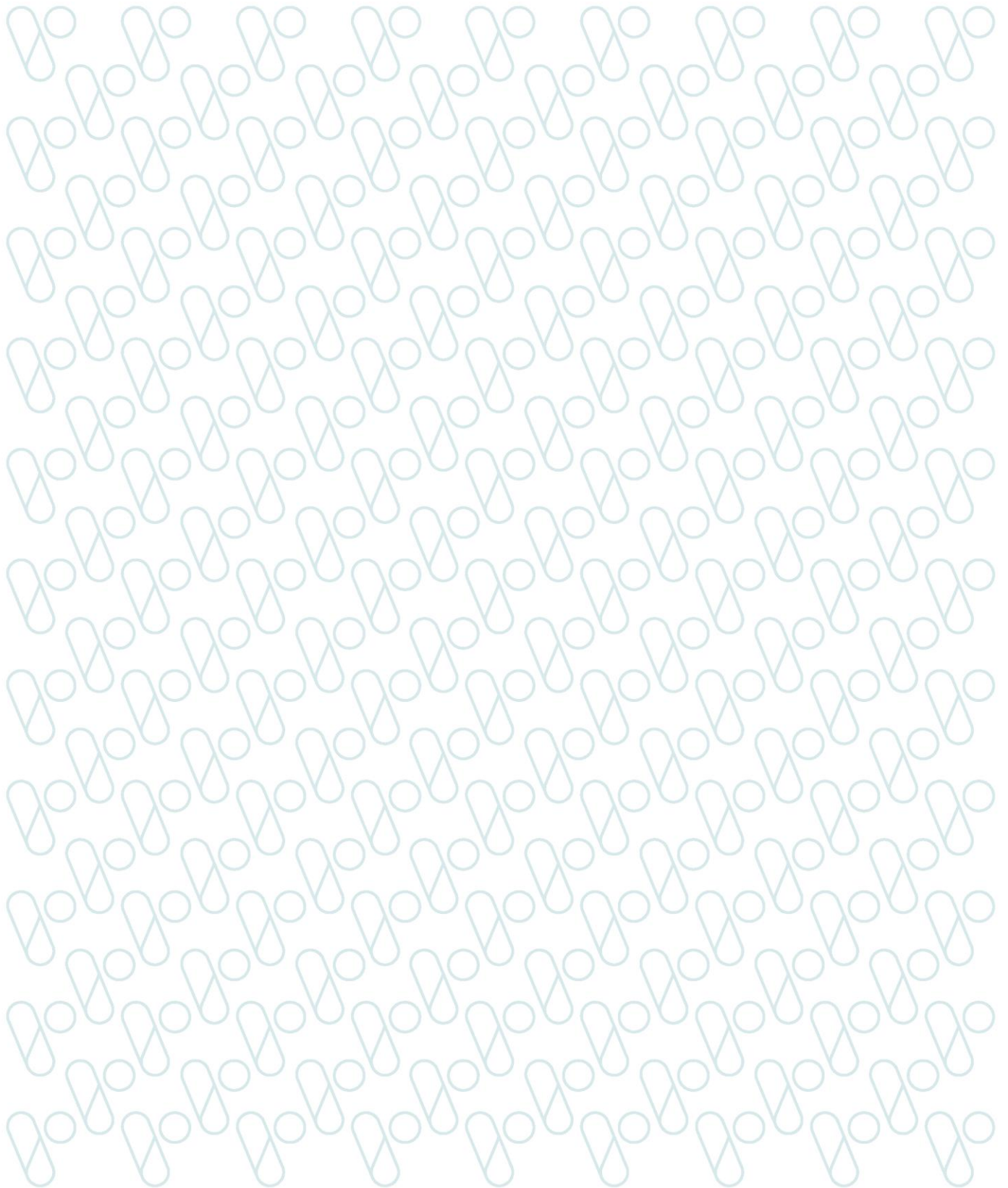


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# Anticipatory medicines

Statewide guidance for Victoria





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# About this document

This document describes the use of anticipatory medicines for people with a life limiting or life threatening illness who are receiving palliative care or end of life care at home. It guides healthcare professionals in prescribing and obtaining supply of anticipatory medicines. It also supports healthcare professionals to assist carers to manage symptoms by using these medicines.

## What are anticipatory medicines?

Anticipatory medicines are injectable or sublingual medications prescribed to a person with a life limiting illness. These medications are prescribed and dispensed in preparation for a time when a person needs them. They are used to manage symptoms in the home with the goals of rapid relief and avoiding unplanned or unwarranted admission to a healthcare facility.

## WHO IS THIS GUIDANCE FOR?

This document is intended for clinicians who support adult Victorians receiving palliative care at home, including people residing in residential aged care facilities and disability group homes. This includes but is not limited to:

- general practitioners
- specialist palliative care professionals
- medical practitioners discharging a patient home for end of life care
- nurse practitioners
- nurses
- pharmacists
- out of hours services
- paramedics.

## HOW TO USE THIS DOCUMENT

Icons are used throughout this document to direct you to additional information.



Find more information in the glossary



Communication point



Within document link



Link to external document/resource

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## PALLIATIVE CARE IN VICTORIA

Specialist palliative care in Victoria comprises community and inpatient palliative care, consultancy teams, outpatient clinics and day hospices. A statewide advice service is now available. There are three ways for health professionals, especially nurses and doctors, to obtain specialist advice when encountering difficulties prescribing or obtaining anticipatory medicines.

### 1. Community palliative care services

- Call your local community palliative care service.
- Consider referral to the service.

### 2. Palliative care consultancy services

- Call your regional palliative care consultancy service; there is one in each rural region.
- In metropolitan Melbourne, there are palliative care consultancy services in every metropolitan health service except for the Royal Victorian Eye and Ear Hospital. The Royal Women's Hospital links with Melbourne Health.

### 3. Statewide specialist palliative care advice service

Healthcare professionals and the general public can call the Palliative Care Advice Service on 1800 360 000 (7am–10pm).

This service is operated by Royal Melbourne Hospital through the Parkville Integrated Palliative Care Service.



[Rural palliative care consultancy services](#)



[Palliative care services directory tool](#)

## WHAT DOES THIS GUIDANCE COVER?

This guidance covers inpatient and community settings that provide a palliative approach or specialist palliative and end of life care to adults. There are some exceptions:

### Children with palliative care needs

This guidance does not cover the use of anticipatory medicines in children.



For anticipatory prescribing for children with palliative care needs, consult with the [Victorian Paediatric Palliative Care Program](#). Phone: 03 9345 5374.

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## Catastrophic events

Detailed management of catastrophic events is not covered in this guidance. These events are exceedingly rare and occur immediately pre-death. Clinicians need to consider whether a person is at increased risk of a catastrophic event and put appropriate non-pharmacological and pharmacological management plans in place. This includes clear communication and preparation with the person and family or carers.

Further information can be found in the Austin Hospital 'Catastrophic Events in Terminal Patients protocol'<sup>16</sup>.



Consult with your [local specialist palliative care service](#) or [rural palliative care consultancy services](#)

The forthcoming statewide 24-hour specialist end of life care and palliative care advice service [name to be advised shortly] will also help you find a local service and with decision making.

## GUIDING PRINCIPLES FOR ANTICIPATORY MEDICINES

- People have a right to be supported, to be cared for and die in the place of their choice.
- The role of the person's family and carers in providing physical, emotional, social and spiritual support and care is appreciated and respected.
- Family and carers are supported to understand the level of care they are able to provide.
- The voluntary nature of the role for the carer must be acknowledged. The carer can be involved in or withdraw at any time from managing breakthrough symptoms using anticipatory medicines.
- The role of anticipatory medicines is discussed with the person (if appropriate) and the family or carers in the context of death and dying, respecting the person's specific spiritual, religious and cultural needs.
- Willing and able carers can be supported to manage breakthrough symptoms using anticipatory medicines within a safe environment and with appropriate training and support.
- All members of the multidisciplinary team support carers who are willing and able to give subcutaneous medicines to help manage breakthrough symptoms.

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# Background

The majority of Australians nominate home as their preferred place of care and death<sup>1</sup>. However, if symptoms such as pain, breathlessness, nausea, fear, confusion, delirium and agitation, or the emotional and physical burden of care are not optimally managed, this can result in a transfer to inpatient settings<sup>2</sup>.

Evidence shows that anticipatory prescribing provides reassurance, controls symptoms effectively and prevents unplanned hospital admissions<sup>3,4</sup>. However, some health professionals have expressed concern about the lack of evidence-based guidance for anticipatory prescribing<sup>5</sup>.

Anticipatory prescribing has been shown to help improve a person's ability to achieve their preferred place of death, positively impacting family and carers<sup>3,6,7,8</sup>. Carer burden can develop, however, when carers have not had a sufficient level of information and education relating to anticipating and managing symptoms<sup>9</sup>.

In rural and remote areas, access to local general practitioners (GPs) and palliative care physicians can be difficult, and community palliative care services and district nursing services commonly assess people at their homes without a face to face medical consultation<sup>3,10</sup>. Nursing staff working in these areas may lack the confidence, knowledge and/or guidance to request anticipatory prescribing from GPs which can lead to crises and/or unplanned hospital presentations<sup>3,9,11</sup>. If we can provide staff in these communities with clear guidance and education on anticipatory medications, then we can significantly improve the overall quality of life for people receiving palliative care<sup>9,11</sup>.

## DEVELOPMENT OF THIS GUIDANCE

This guidance was developed with an expert working group of clinicians from across Victoria and was subsequently tested with a small number of services. The working group adapted guidance and resources from existing local<sup>12,13</sup> and international sources<sup>14,15</sup>. These resources have been adapted for the Victorian context.

This guidance supports the existing caring@home resources at **[www.caringathomeproject.com.au](http://www.caringathomeproject.com.au)**.

## IMPLEMENTING THIS GUIDANCE

The implementation of this guidance should consider local context. We recommend that you use a standardised quality improvement methodology to understand local processes, barriers and solutions for the use of anticipatory medicines.

For more detail relating to the development and implementation of this guidance, please refer to:



[Anticipatory medicines – supplementary document](#)

## Contact us

Has your service used this guidance or developed resources to support it?

Please share by getting in touch with us at **[palliativecare.clinicalnetwork@safercare.vic.gov.au](mailto:palliativecare.clinicalnetwork@safercare.vic.gov.au)**.

**Table 1: Anticipatory medicines pathway**

Step		Find out more information
<b>IDENTIFY</b>		
<b>Symptom management</b>	Identify the person's need for anticipatory medications	<b>Page 8:</b> Symptom management
<b>Eligibility</b>	<ul style="list-style-type: none"> <li>Identify the person's eligibility for anticipatory medicines</li> <li>Communicate eligibility status to care team</li> </ul>	<b>Page 8:</b> Eligibility
<b>Contraindications and risk assessment</b>	<ul style="list-style-type: none"> <li>Perform screening for contraindications to anticipatory medicines</li> <li>Perform risk assessment for home-visiting health practitioners</li> <li>Consider potential barriers</li> </ul>	<b>Page 9:</b> Contraindications, risk assessment <b>Page 9/10:</b> Table 2: Barriers and solutions
<b>Carer support</b>	Identify carer support and/or the support of appropriate healthcare professionals to prepare and/or administer anticipatory medications* <i>*The absence of a carer who is willing and able to prepare and/or administer anticipatory medicines is not a contraindication to having anticipatory medicines at home</i>	<b>Page 11:</b> Carer identification
<b>Services and healthcare practitioners</b>	If the client is not registered with a designated community palliative care service, identify services or healthcare practitioners who can provide: <ul style="list-style-type: none"> <li>telephone support</li> <li>home visits</li> <li>ongoing prescriptions and orders</li> </ul> Under policy and funding guidelines, all funded community palliative care services are required to provide 24-hour telephone support and home visits when required and safe <sup>17</sup>	<b>Page 11:</b> Services and healthcare practitioner identification
<b>COORDINATE</b>		
<b>Carer education</b>	Provide carer with carer education – consider using the caring@home resources	<b>Page 12:</b> Carer education <b>Page 16:</b> Administering medicines <b>Appendix 6:</b> caring@home resources
<b>Service and healthcare practitioners</b>	Notify services or healthcare practitioners that the person requires anticipatory medications and if the carer will be trained to administer medications – consider providing written letter	<b>Page 12:</b> Services and healthcare practitioner coordination <b>Appendix 5:</b> Example letter
<b>Prescribing and ordering medications</b>	<ul style="list-style-type: none"> <li>Coordinate prescriptions, orders and supplies</li> <li>Consider using palliMEDS app and Gippsland symptom management algorithm</li> </ul>	<b>Page 13:</b> Prescribing and ordering <b>Appendix 1:</b> Symptom control algorithms <b>Appendix 2:</b> Drugs commonly used as anticipatory medicines



Step		Find out more information
<b>PROVIDE</b>		
<b>Carer support resources</b>	Provide person and carer with support resources: <ul style="list-style-type: none"> <li>• Telephone support numbers</li> <li>• Community support provider details</li> <li>• Care escalation information/action plans</li> </ul>	<b>Page 13:</b> Carer support resources <b>Appendix 4:</b> Action plan examples
<b>Prescriptions, orders and supplies</b>	Provide person and carer with anticipatory medicines pack containing: <ul style="list-style-type: none"> <li>• prescriptions and pharmacy locations (particularly after hours/regional/Supercare Pharmacies)</li> <li>• medication charts and medicines diary</li> <li>• supplies</li> </ul>	<b>Table 4:</b> Anticipatory medicines pack contents <b>Page 16:</b> Administering medicines
<b>Preparing and administering medicines</b>	Considerations for preparation and administration depending on whether medication is patient's own or stock medication	<b>Table 5:</b> Patient's own medication and stock medication <b>Appendix 3:</b> Six Rights of Safe Medication Administration
<b>REVIEW</b>		
<b>Reassessment</b>	Undertake reassessment of the person and their carer	<b>Page 8:</b> Symptom management <b>Page 19:</b> Assessment and reassessment

# Identify

The use of anticipatory medicines requires timely identification of the person's needs and eligibility, carer preparedness and the care team.

## SYMPTOM MANAGEMENT

People living with incurable, progressive, life limiting illnesses are at risk of experiencing distressing symptoms due to functional deterioration, disease progression, development of new disease or treatment complications. Managing these symptoms supports the person and their carers to maintain care at home and die at home, if that is their wish.

These symptoms may benefit from pharmacological interventions as part of their management. Symptoms include, but are not limited to:

- pain
- breathlessness
- nausea/vomiting
- agitation
- delirium
- respiratory tract secretions.



Symptoms can be both **breakthrough** or **incident**. Anticipatory prescribing is important in both situations.

### Consider anticipatory medicines when:

- the person is admitted to a designated community palliative care service
- the person's condition is deteriorating or terminal
- there are fluctuating levels of symptom distress at home
- there are known problems with gastrointestinal absorption
- the person is expected to lose the ability to swallow
- the person presents to their healthcare provider for symptom management

## ELIGIBILITY

People with palliative care needs are considered eligible for anticipatory medicines if:

- they have carer support and/or the support of appropriate healthcare professionals to administer anticipatory medications. The absence of a carer who is willing and able to administer anticipatory medicines is not a contraindication to having anticipatory medicines at home
- they do not have any contraindications to receiving anticipatory medicines



Communicate eligibility status to the care team





## CONTRAINDICATIONS


Contraindications for anticipatory medicines include:

- the person or carer are unwilling to have anticipatory medicines prescribed or stored in the home
- medications are unable to be safely stored in the home
- there is high risk or reasonable suspicion of medication diversion
- there is active intravenous drug abuse in the home by the person or other residents.

There are sometimes challenges to obtaining anticipatory prescriptions and medicines.

**Table 2: Challenges and solutions to obtaining anticipatory prescriptions and medicines**

Challenges	Solutions
<b>Access</b>  Limited access to general practitioners overnight, on weekends and public holidays  Limited access to pharmacies overnight, on weekends and public holidays  Primary care practitioner may be a hospital-based physician with limited availability	<p>A statewide <b>specialist end of life care and palliative care advice service</b> is now available to help you find a local service and with decision making. The number is 1800 360 000</p> <p> Prior to discharge or transfer of care, supply the patient and their carer with the location of their nearest <a href="#">Supercare Pharmacy or local pharmacy</a></p> <p>Contact the local pharmacy at least 24 hours prior to discharge or transfer of care to ensure that the medications are in stock and ready to be dispensed</p> <p> Hospital-based clinicians and GPs can enlist the help of their <a href="#">local specialist palliative care service</a> or <a href="#">rural and regional palliative care consultancy service</a>. There is a palliative care consultancy service in each rural region</p>
<b>Handover</b>  Patients are discharged home without anticipatory medicines  Patients arrive home days before their GP receives a discharge summary that includes prescribed medications  Locum practitioners have limited knowledge about the patient's illness	<p>Need and eligibility for anticipatory medicines should be assessed during an inpatient admission. If eligible, discharge the patient home with prescriptions and/or supplies for anticipatory medications <b>sufficient to last at least 72 hours</b></p> <p>Prior to discharge or transfer of care, supply the patient with a <b>letter</b> outlining their need for anticipatory prescribing. The letter should include recommendations about drug, dosage and quantity</p> <p> <b>Appendix 5: Example letter</b></p> <p>Provide the person and their carer with <b>action plans</b> outlining pharmacological and non-pharmacological management of their symptoms, and the contact details of other members of the care team. The action plans should be displayed in a prominent location in the person's home</p> <p> <b>Appendix 4: Action plan examples</b></p>

Challenges		Solutions
<b>GP or locum doctor experience and confidence</b>	GP or locum doctor does not have sufficient information about the patient's condition to confidently prescribe injectable medicines	<p><b>If the patient is known</b> to a local specialist palliative care service or rural regional palliative care consultancy service, GPs should contact them for more information</p> <p><b>If the patient is not registered</b> with a specialist care service, GPs should consider referring the patient to the palliative care service in their catchment area, or at a minimum connect with the nearest specialist care service for guidance</p> <p>A statewide specialist end of life care and palliative care advice service is now available to help you find a local service and with decision making. The number is 1800 360 000</p> <p>If nurses in rural designated community palliative care services are having difficulty obtaining anticipatory medicines for their client they should contact their regional palliative care consultancy service for assistance</p>
	GP may not have the experience and/or confidence to prescribe anticipatory medicines such as opioids	<p> <a href="#">Rural and regional palliative care consultancy services</a></p> <p><a href="#">Palliative care services directory tool</a></p> <p><a href="#">palliMEDS</a></p>

## RISK MANAGEMENT WHEN USING ANTICIPATORY MEDICINES

Anticipatory medicines should be tailored to the individual person and their needs, taking into consideration the risks and benefits before prescription.

- Use of anticipatory medicines must occur in conjunction with a management plan that details how to escalate care if symptoms are not being controlled.
- The plan should provide details of their community palliative care service's after-hours phone number that the carer can contact.
- Any incidents or near misses concerning use of anticipatory medicines must be reported to the prescribing practitioner who should report it using their incident reporting system and undertake remedial action. It is recommended that learning from these incidents be shared with relevant colleagues to reduce the likelihood of future incidents.

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## CARER IDENTIFICATION

Refer to the following section of the caring@home document:



[caring@home example policy and procedures](#): 'Supporting carers to help manage breakthrough symptoms safely using subcutaneous medicines in the home – Version 3'. Specifically, Part two: Procedures.

## SERVICES AND HEALTHCARE PRACTITIONER IDENTIFICATION



If the patient is not registered with their designated community palliative care service, identify and communicate with services or healthcare practitioners who can provide:

### Telephone support

- For example, the person's GP, local hospital service, palliative care advice line service provider.

**Home visits** to reassess the person and carer, and identify the need for additional interventions.

- For example, the person's GP.

### Ongoing prescriptions and orders

- For example, the person's GP, specialist physician, and/or nurse practitioner.

# Coordinate

After a person has been identified as eligible for anticipatory medicines, clinicians should undertake the following actions to ensure safe and standardised discharge or transfer of care.

## CARER EDUCATION

If a willing, able and well-informed carer is available to administer medication, the carer can be educated about preparation, storage and disposal of medications.

The caring@home package for carers is designed to help healthcare practitioners teach carers to manage breakthrough symptoms by administering medications. The package can be [downloaded](#) and [ordered](#) from the caring@home website.

Additionally, refer to the following sections of the caring@home document:



[caring@home example policy and procedures](#): 'Supporting carers to help manage breakthrough symptoms safely using subcutaneous medicines in the home - Version 3'. Specifically, Part two: Procedures.

## SERVICES AND HEALTHCARE PRACTITIONER COORDINATION



- Notify services or healthcare practitioners that the person requires anticipatory medications.
- Communicate details regarding plans for, or completed, carer training.
- Consider sending a letter to services and/or healthcare practitioners involved.



Appendix 5: Example letter

## Role of ambulance services

Ambulance Victoria (AV) supports the right of a person with palliative care needs to choose to be cared for and die at home with effective symptom management. Where paramedics attend a person who has expressed a wish to die at home, management should be aimed at the relief of distressing symptoms to facilitate the person's wishes. Paramedics should manage the person according to AV's clinical practice guideline 0712 Palliative Care and:

- support the person or carer to follow the established care plan where they have not already done so
- where the person's existing care plan has failed to provide enough relief from distressing symptoms, consult the community palliative care service for further management
- where the community palliative care service is unavailable, administer medications as appropriate according to their clinical practice guidelines.

Transport to hospital may not be required following management, regardless of the medication administered, unless the person or carer requests it. The administration of medication by paramedics must be recorded on the AV Health Information Sheet, which should be left with the person or carers for the community palliative care service.

## PRESCRIBING AND ORDERING MEDICATIONS

Because people are often unable to swallow, absorb or tolerate oral medications as their condition deteriorates, injectable and/or transmucosal medicines should be immediately available.

These medicines carry much higher risks and burden compared to their oral alternatives and should **only** be used strictly under guidance from an authorised medical practitioner when oral alternatives are ineffective or contraindicated.

Many of these medications carry the risk of being misused for non-medical indications (for example diversion, self-harm). Regular review should be conducted during prescribing and ordering medications.

The following drug classes are recommended as part of anticipatory prescribing.

**Table 3: General drug classes of anticipatory medicines**

Drug class	Route	Quantity to be prescribed and supplied
<b>Opioid</b>		
<b>Benzodiazepine</b>	Injectable* or transmucosal	At least 72 hours (e.g. enough for a weekend)
<b>Anti-emetic</b>		
<b>+/- Anti-secretory</b>		

\* Consider also providing orders for continuous subcutaneous infusions (CSCI) for people already on regular background medications that manage symptoms. The absence of these medications is likely to precipitate symptoms when they are no longer able to be administered orally (e.g. opioids, benzodiazepines, antipsychotics).



Appendix 1: Symptom control algorithms

Appendix 2: Drugs commonly used as anticipatory medicines

Prescribing healthcare practitioners should document using a medication chart that supports the delivery of medication in the community and allows administration of medications by other visiting healthcare practitioners. Healthcare practitioners should document all medications administered on the medication chart. A carer may use a medicines diary to record medications they have administered.



[National medication chart examples](#)

To estimate medication dosages and frequency, the principle of 'minimal effective dose' should be used. Consider the following:

### For people already on regular background opioids:

- Dosage for oral breakthrough should be around 1/10<sup>th</sup> to 1/6<sup>th</sup> of the total background opioid dose over the previous 24-hours. Then,
- Convert this dose to its injectable subcutaneous equivalent, according to conversion chart. This dose within 1/10<sup>th</sup> to 1/6<sup>th</sup> range of the total background opioid dose over the previous 24 hours.



[Opioid Conversion Ratios Guide to Palliative Care Practice Guideline](#)

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**For people with symptoms responsive to opioids but who are not on regular background opioids, the recommended starting dose will vary.**

- It is reasonable to consider providing a dose range (for example 2.5 to 5 mg) to allow visiting healthcare practitioners to respond to the clinical situation.
- Consider frailty and comorbidities. In general, prescribe a low starting dose and adjust promptly according to response<sup>1</sup>.
- Dose frequency is generally determined by the estimated time required to observe response (for example hourly as required).
- Although theoretically there is no maximum allowed dosage over 24 hours for many of these medications, it is recommended to have instructions for carers to alert healthcare practitioners before administering more than two doses for reasons outlined in the Review section.
- The Six Rights of Safe Medication Administration should be applied by healthcare practitioners administering anticipatory medication.



### Appendix 3: Six Rights of Safe Medication Administration

## SAFESCRIP<sup>T</sup>

It is now mandatory to check SafeScript prior to writing or dispensing a prescription for a high-risk medicine. This follows worldwide best practice, as mandatory systems adopted in other countries have shown to provide greater reduction in harms from high-risk prescription medicines.

There will be exceptions in some circumstances, including when treating patients in hospitals, prisons, police gaols, aged care and palliative care.



# Provide

The next step is to provide the person, their carer and the care team with the resources and equipment to use anticipatory medicines.

## CARER SUPPORT



Provide the person and carer with support resources:

- Telephone support numbers
- Community support provider details
- Care escalation information/action plans

Provide an action plan if appropriate.



### Appendix 4: Action plan examples

For carers and healthcare practitioners, distressing symptoms at end of life and the need to administer these high burden medications can have significant psychological effects. Adequate support should be available throughout the process.

## PRESCRIPTIONS, ORDERS AND SUPPLIES

### Anticipatory medicines pack contents

Example anticipatory medicine packs for carers are available from



[caring@home project](mailto:caring@home.project) or [Shannon's Bridge](#)

The coordinating care team is responsible for supporting the carer to have the prescriptions, orders and supplies arranged, for example, prior to discharge from an inpatient facility, or by the patient's designated community palliative care provider. The local pharmacy should be contacted at least 24 hours prior to discharge or transfer of care to ensure that the medications are in stock and ready to be dispensed.

**Table 4: Anticipatory medicines pack contents**

#### At a minimum, pack should include:

- |  |                            |
|--|----------------------------|
| • Any dispensed medications                                  | • Labels for medications   |
| • Prescriptions (take to pharmacy ASAP)                      | • Sharps container         |
| • Information for the carer including 24-hour contact number | • Syringes                 |
| • Medicines diary  | • Blunt drawing up needles |
|  | • Cannulas                 |
|  | • Saline                   |
|  | • Alcohol wipes            |
|  | • Band aids                |
|  | • Micropore tape           |

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## PREPARING AND ADMINISTERING MEDICINES

In supporting the preparation and administration of injectable anticipatory medications, the healthcare practitioner should consider the following:

- **Local policy** – consult the policies of the specific health service on preparing and administering medicines.
- **Duty of care** – healthcare practitioners have a duty of care to act reasonably to protect the person (and others who may be harmed by their actions). They should exercise their **clinical judgement** in each case.
- **The role of the carer** – carers can play a role in preparing and administering medication, if they are willing and able to do so.
  - Speak with the carer to understand what they feel comfortable with.
  - Provide verbal and written resources to help them prepare and /or administer medicines.
  - Caring@home Project package for carers includes resources on training carers to label a syringe, open an ampoule and draw up medicines.
- **Differences between ‘patient’s own medication’ and ‘stock medication’**– Clinicians should consider these differences when preparing and administering anticipatory medications.
  - **Patient’s own medication** are prescribed by a medical or nurse practitioner and dispensed to a specific person<sup>18</sup>. This includes Schedule 8 poisons (labelled ‘Controlled Drug’) and Schedule 4 poisons (labelled ‘Prescription Only Medicine’).
  - **Stock medication** has not been individually supplied by prescription for a specific patient (for example, by a pharmacist on prescription). Stock medication refers to medications held by a service that holds a Health Services Permit to lawfully possess Schedule 4 and Schedule 8 poisons that have not been dispensed to a specific person<sup>18</sup>.

For non-specialist healthcare practitioners or services, it is suggested that advice is sought from the specialist palliative care service available in their area.



### Table 5: Patient’s own medication and stock medication

- **The Drugs, Poisons and Controlled Substances Regulation Act 2017** enables a person assisting in the care of another person to possess and administer (or help administer) the person’s own medicines.
  - The medicines must be ‘patient’s own medication’ (i.e. dispensed by a pharmacist, medical practitioner or nurse practitioner, and labelled appropriately) and administered according to the instructions on the label. This applies to both Schedule 4 and Schedule 8 medicines.
  - This does not include any **imprest** stock that was intended to be administered by a nurse according to an administration chart.
  - The carer should administer the medication in accordance with the directions on the label from the pharmacy. If they are not clear, then they should contact the pharmacist or prescriber.
  - A carer cannot administer the medicines differently to the exact directions on the label. They cannot decide to increase or decrease a dose.

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## STORAGE

Injectable medications should be stored according to the directions on the label. This may be at room temperature, or in a refrigerator in an appropriate container to decrease risk of microbial contamination. Each syringe must be labelled using a colour-coded label and marked in accordance with national standards<sup>13</sup>.

## DISPOSAL

Legislation requires that any obsolete, expired or unused medications must be disposed of and destroyed after the person has died<sup>18</sup>. It is the responsibility of the carer to ensure the disposal of the medications and sharps container. Discussion about disposal of medication needs to occur at the same time as prescribing.

**Unused medications must be returned to the nearest pharmacy for appropriate disposal. Local councils will assist with the disposal of sharps containers.**

## DOCUMENTATION

A record must be kept of 'prescription only' stock medication that is administered by a nurse or medical practitioner in the person's medication order<sup>18</sup>. Carers can document administered medication on the medication chart and/or in the medicines diary.



For stock medications that are Schedule 8 poisons, a separate record (for example, a drug register or administration book) must also be kept by a nurse or medical practitioner.

**Table 5: Patient's own medication and stock medication**

	Patient's own medication	Stock medication
<b>Where are the medications supplied from?</b>		
Dispensed by prescription from a pharmacy	✓	x
From an imprest system	x	✓
<b>Where are the medications stored?</b>		
In private residence	✓	x
In a residential aged care facility	✓	✓ Only if it holds Health Service Permit
Disability group homes	✓	x
<b>Who can prepare and administer the medications?</b>		
Registered nurse	✓	✓
Endorsed enrolled nurse	✓	✓
Medical practitioner	✓	✓
Nurse practitioner	✓	✓
Carers	✓	x
<b>What is the role of the health professional?</b>		
Prepare an injection using dispensed medication(s) in accordance with instructions on the label or an order authorised by a medical practitioner or nurse practitioner	✓	✓
Administer an injection using dispensed medication(s) in accordance with instructions on the label or an order authorised by a medical practitioner or nurse practitioner	✓	✓
Support a person to take or administer their medication(s) and/or assist a carer to administer medication(s)	✓	x
Provide an action plan if appropriate	✓	✓

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# Review

## ASSESSMENT AND REASSESSMENT

All people prescribed anticipatory medicines should be assessed prior to prescribing. Once anticipatory medicines are in place, people should be reassessed regularly for new and ongoing care needs.

It is important to consider the limitations of anticipatory medicines.

**New, worsening or unresponsive symptoms** may signal a change in underlying disease or an additional problem directly or indirectly related to the underlying disease. Additional interventions, including non-pharmacological, may be required, for example:

- Treating urinary tract infections with antibiotics for comfort, or excluding urinary retention and inserting a urinary catheter if required.
- Considering more serious complications of the person's disease that may require escalation and possible admission depending on the person's goals of care and wishes (for example malignant spinal cord compression, bowel obstruction).

For non-specialist healthcare practitioners and services, seek advice from the local specialist palliative care service, rural regional palliative care consultancy service or statewide 24-hour end of life and palliative care advice service [name to be advised shortly] if there is concern that symptoms are not responding to the prescribed anticipatory medicines.

### **Urgent assessment and intervention are required when:**

- distressing symptoms are refractory to initial management (for example lack of acceptable clinical response after two doses of medications)
- there are unacceptable adverse effects from medications (for example worsening of agitation or delirium from opioids)
- there are excessive breakthrough requirements. Implementing or adjusting the background regimen (for example continuous subcutaneous infusions) will achieve better symptom management and reduce carer burden.

**Access to urgent and appropriate medical or nursing support, such as a [local specialist palliative care service](#) or [rural palliative care consultancy services](#) or general practitioner, should be available for people and carers at their preferred place of care.**

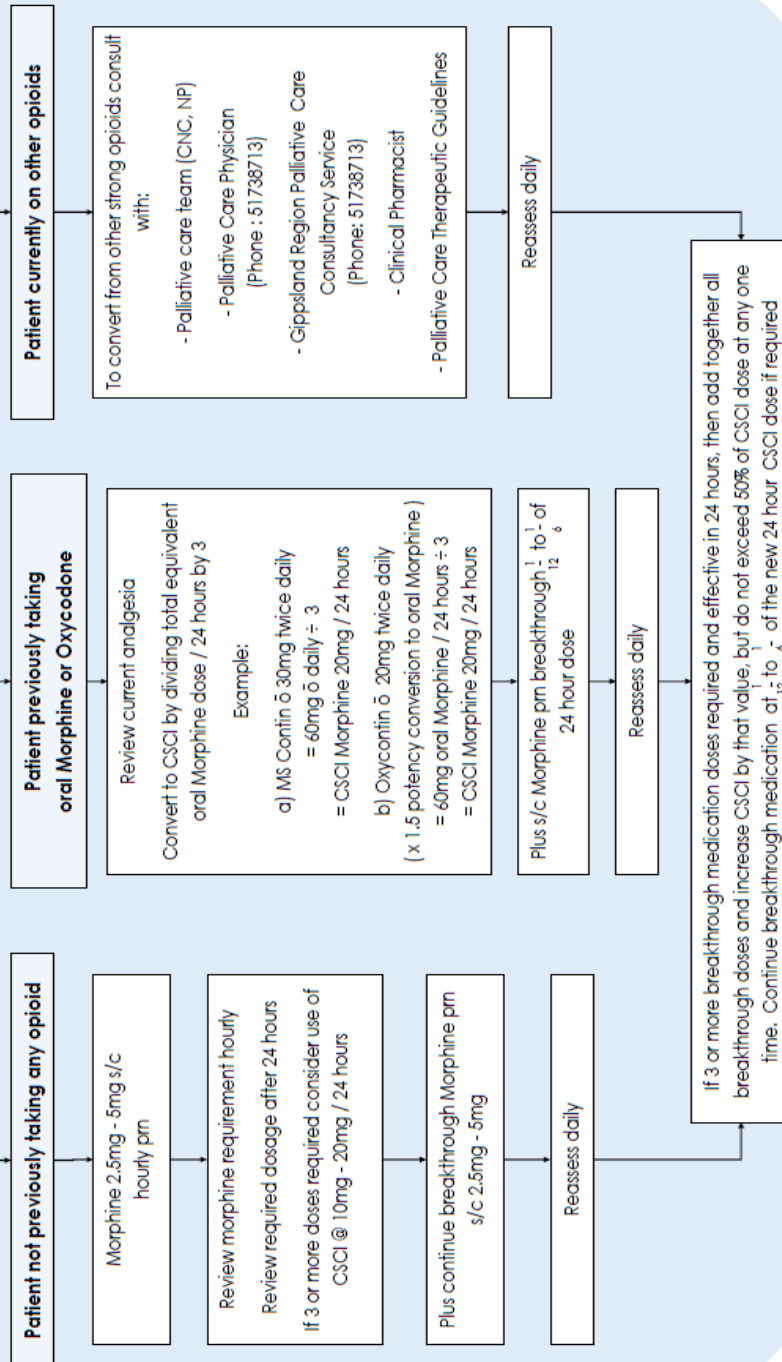
# Appendix 1: Symptom control algorithms



Example of Symptom Control Algorithm, Gippsland Region Palliative Care Consortium<sup>19</sup>

## CARE PLAN FOR THE DYING PERSON SYMPTOM CONTROL ALGORITHMS

### PAIN



### NOTES

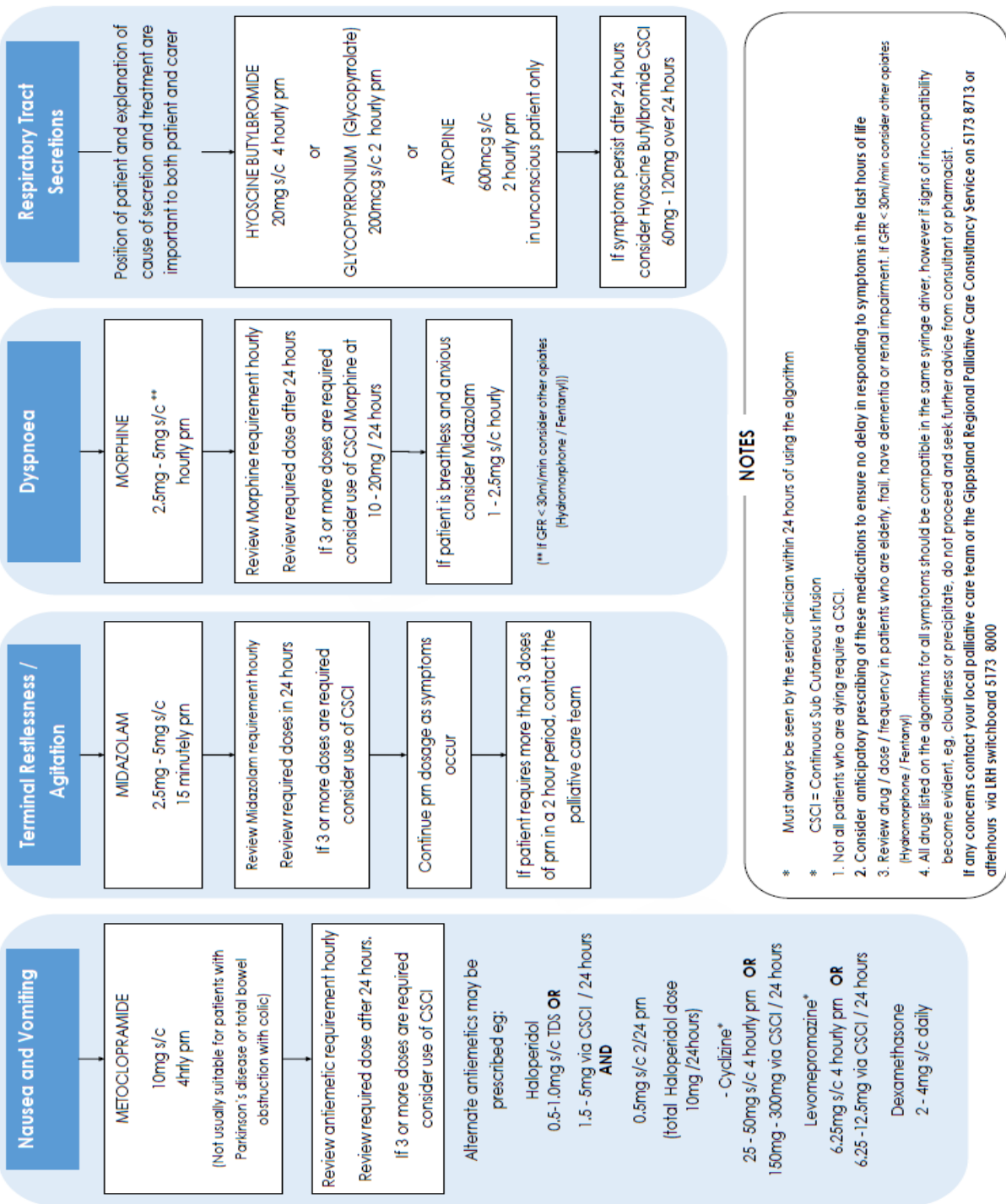
\* Must always be seen by the senior unit clinician within 24 hours of using the algorithm

1. Not all patients who are dying require a CSCI. Consider anticipatory prescribing of these medications to ensure no delay in responding to symptoms in the last hours of life
2. Use a validated pain assessment tool to ensure consistent assessment of patient's pain
3. Review drug / dose / frequency in patients who are elderly, frail, have dementia or renal impairment
4. In severe renal impairment morphine metabolites may accumulate and are associated with increased risk of side effects and narcosis. Consider using other opioids eg. Fentanyl or Hydromorphone
5. If patient has morphine allergy consider Hydromorphone 0.5mg—1mg s/c hourly prn
6. If using opiates for management of dyspnoea this should be taken into account when titrating opiates for pain
7. All drugs listed on the algorithms for all symptoms should be compatible in the same syringe driver, however if signs of incompatibility become evident, eg. cloudiness or precipitate, do not proceed and seek further advice from consultant or pharmacist.
8. If any concerns contact your local palliative care team or the Gippsland Regional Palliative Care Consultancy Service on 5173 8713 or afterhours via LRH switchboard 5173 8000

\* CSCI = Continuous Subcutaneous Infusion

GRPCC CPDP Medication Guidelines Algorithm September 2020 v2.

## CARE PLAN FOR THE DYING PERSON SYMPTOM CONTROL ALGORITHMS



## Appendix 2: Drugs commonly used as anticipatory medicines

The table below outlines drugs commonly used for anticipatory prescribing. The contents of this table has been sourced from palliMEDS.



**For all drugs** the starting dose range is provided in the table below, however may need to be titrated depending on individual patient requirements.

**For all opioids** the starting dose range is provided for an opioid naive patient.

**For patients on regular opioids**, the prn dose may need to be adjusted to remain congruent with existing 24/24 opioid dose.

For additional or second-line medications, please consult a specialist palliative care physician.

Drug	Palliative care indication	Strength available and PBS qty or pack size		Doses for anticipatory prescribing	PBS Indication and restriction
Clonazepam	Anxiety	1 mg/1 ml	5 amps	0.2 to 0.5 mg SL or SC, 2-hourly prn	PBS – Epilepsy
	Dyspnoea	2.5 mg/ml liquid (1 drop = 0.1 mg)	10 ml x 2	If symptoms are ongoing, or more than 3 doses are required in a 24 hour period, refer to palliMEDS for regular prescribing  Multifocal myoclonus: 0.5 to 1 mg PO, SC or SL, once or twice daily  Seizure: 1 mg IV, SC or SL, every 10 mins prn	PBS Palliative Care Authority  Myoclonus – prophylaxis or prevention and receiving palliative care
	Hiccups				
	Myoclonus				
	Restless legs syndrome				
	Seizures				
Fentanyl	Pain	100 microg/2 ml	5 amps	For people not regularly taking opioids, when morphine is contraindicated or not clinically appropriate.	NON-PBS (PRIVATE prescription)
	Breathlessness (Caution: high potency opioid)			25 to 50 mcg SC, 2-hourly prn  If symptoms are ongoing, or more than 3 doses are required in a 24 hour period, refer to palliMEDS for regular prescribing	
Hydromorphone (Dilauid)	Pain	2 mg/ml amps	5 amps	For people not regularly taking opioids, when morphine is contraindicated or not clinically appropriate	PBS
	(Caution: high potency opioid)	10 mg/ml amps		0.5 to 1 mg SC, 2-hourly prn  If symptoms are ongoing, or more than 3 doses are required in a 24 hour period, refer to palliMEDS for regular prescribing	



Drug	Palliative care indication	Strength available and PBS qty or pack size		Doses for anticipatory prescribing	PBS Indication and restriction
<b>Hyoscine-n-butyl bromide (Buscopan<sup>®</sup>)</b>	Bladder pain Bowel obstruction Noisy breathing/secretions Pain associated with smooth muscle spasm	20 mg/ml ampoule	30 amps	20 mg SC, 2-hourly prn  Usual total maximum dose is 120 mg in 24 hours  If the person has responded to anticipatory prescribing, refer to palliMEDS for regular prescribing	<a href="#">PBS Palliative Care – Streamline Authority no: 6207</a>  For use in patients receiving palliative care
<b>Metoclopramide</b>	Nausea and vomiting Gastric stasis Early satiety	10 mg/2 ml amp	10 amps <a href="#">40 amps</a>	10 mg SC, 8-hourly prn  Maximum recommended dose for adult is 30 mg per day (however, in the last days of life, doses above this amount becomes less of a concern)  If symptoms are ongoing, or more than 3 doses are required in a 24 hour period, refer to palliMEDS for regular prescribing	PBS  <a href="#">PBS Palliative Care – streamline authority no: 6084</a>  Nausea or Gastric stasis
<b>Midazolam</b>	Agitation Airways obstruction Delirium Dyspnoea Acute severe haemorrhage Myoclonus Seizures	5 mg/ ml amp 15 mg/3 ml amp 50 mg/10 ml amp 5 mg/5 ml amp (**generally not used in palliative care)	5 amps	2.5 mg SC, 1-hourly prn  Usual total maximum dose is 60 mg in 24 hours  If symptoms are ongoing, or more than 3 doses are required in a 24 hour period, refer to palliMEDS for regular prescribing	<a href="#">NON-PBS (PRIVATE prescription)</a>
<b>Morphine Sulfate</b> <b>Morphine Hydrochloride</b>	Pain Dyspnoea Cough	10 mg/ml, 15 mg/ml, 30 mg/ml, 10 mg/ml, 20 mg/2 ml, 50 mg/5 ml	5 amps	Dyspnoea: 1 to 2.5 mg SC, 1-hourly prn  Pain: 2.5 to 5 mg SC, 1 hourly prn  If symptoms are ongoing, or more than 3 doses are required in a 24 hour period, and the person is not regularly taking opioids, refer to palliMEDS for regular prescribing	PBS

# Appendix 3: Six Rights of Safe Medication Administration







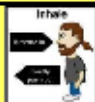








<b>RIGHT PATIENT</b> Medication has been prescribed for the correct patient and correct clinical indication	Check the name on the medication order is the same as the patient At least three approved patient identifiers are required each time medication administration occurs For patients deemed incompetent in the community, three patient identifiers should be confirmed with the patients' medical treatment decision maker (MTDM) or next appropriate person (for example carer if MTDM is not available)
<b>RIGHT MEDICATION</b> Correct dispensed medication	Check medication prescription by approved prescriber Does the medication label match the prescribed order? Check expiry date Be vigilant with look-alike and sound-alike medications Check for <b>allergies</b>
<b>RIGHT DOSE</b> Correct dose of medication is written	Does the dosage and strength match the prescribed order? If necessary, calculate the dose and check this calculation is correct with another nurse or medical professional
<b>RIGHT TIME</b> Medication administered at required time	Does the administration time match the prescribed order? Before administering a prn medication, ensure specified time interval has passed between doses For community patients, ensure patient/carers/family have received appropriate education regarding administration of medication
<b>RIGHT ROUTE</b> It is recorded the route to give the medication	Does the route of administration match the prescription? Confirm that the patient can take or receive the medication by the prescribed route Prior to crushing, check the 'Australian Don't Rush to Crush Handbook'  Examples of routes of administration and approved abbreviations <ul style="list-style-type: none"> <li>• Oral (PO)</li> <li>• Intramuscular (IM)</li> <li>• Intravenous (IV)</li> <li>• Subcutaneous (subcut)</li> <li>• Sublingual (subling)</li> <li>• Topical (topical)</li> <li>• Per Rectum (PR)</li> </ul> Contact specialist palliative care if route of administration differs to evidence-based practice as some medications are used 'off label'
<b>RIGHT DOCUMENTATION</b> The medication diary is completed after every dose	Document administration or sign medication order <b>after</b> administering the prescribed medication Review patient after administration for effect and document If medication was omitted, document the reason why in text or using an approved abbreviation

# Appendix 4: Action plan examples

Loddon Mallee Palliative Care Service Symptom Management Plan for Breathlessness

## Patient's Breathlessness Action Plan

UR: .....

Everyday Management		
Syringe Driver with Morphine and Midazolam	Changed daily by nursing staff	
Hand held fan, ceiling fan and/or desk fan circulating to give the sensation of increased air flow		 
<b>When increased work of breathing/shortness of breath occurs</b>		
1. Where possible, sit up straight and remain calm. Family please speak in a soft voice when giving instructions		Helps to open up airway
2. Make sure you have your fan on and let it blow in your face, like the one provided in hospital		Gives the sensation of increased air blowing on your face
3. Take slow deep breaths In through your nose, out through your mouth, if responsive and able to do this	 	
4. Give Ordine 2mg/ml, 1-2mls when feeling short of breath <b>IF ABLE TO SWALLOW</b>		Dose is 2-4mg when needed
5. Lorazepam 0.5mg If shortness of breath is making you feel anxious then place half a tablet under your tongue. Can be repeated every 4 hours		Place the Lorazepam under your tongue and let it dissolve
6. After 30 minutes, if breathing is not improved then repeat Ordine 1-2mls. If after another 30 minutes breathing has not improved, take another 1ml		 
7. If breathing does not improve after this you can use a subcutaneous injection (under the skin) of the above medications to help you feel less short of breath. See the box to your right for details →	<b>Morphine 10mg/1ml</b> Give ¼- ½ a ml as an injection every 30mins to 1 hour as needed	<b>Midazolam 5mg/1ml; Give ½ - 1 ml as an injection every 30mins to 1 hour as needed</b>
8. If breathing is still not better, call your palliative care nurse on		 
<b>Prior to Bathing and Toileting please follow these steps:</b>		
1. Give Oral Ordine 1-2mls or Subcutaneous Morphine ¼ to ½, 30 minutes prior to any activities- this allows it time to work <b>BEFORE</b> a wash or toileting take 1-2mls (if needed) <b>AFTER</b> a wash or toileting if breathing does not settle after 5 minutes take a further 1-2mls		
2. <b>ALWAYS</b> use your aids to help you- bed mechanics as the Occupational therapist has shown you <b>Hospital Bed, Slide Sheets, tilting the bed and safe manual handling practices</b>		
<b>*HAVE YOU OPENED YOUR BOWELS??</b> Use Coloxyl with Senna OR Movicol		
<b>Follow the directions above if shortness of breath does not settle down</b>		

Symptom Management Plan devised by Loddon Mallee Palliative Care Service NP 28/02/2018

## ACTION PLAN

Action plan for: (use a separate action plan for each symptom)

- |   |   |
|---|---|
| <input type="checkbox"/> Pain                         | <input type="checkbox"/> Agitation/delirium |
| <input type="checkbox"/> Respiratory tract secretions | <input type="checkbox"/> Breathlessness     |
| <input type="checkbox"/> Nausea/vomiting              | <input type="checkbox"/> Other              |

Name

Address

DOB

UR number

You have been prescribed:

Drug name

Dose

and

and

and

<b>Give</b>		And	
<b>and if this does not work</b>			
<b>Wait</b>		minutes/ hours, and then	
<b>Give</b>		And	
<b>and if this does not work</b>			
<b>Wait</b>		minutes/ hours, and then	
<b>Give</b>		And	
<b>and if this does not work</b>			
<b>Contact</b>			
<b>or if not available call 000 and state the person is a palliative patient.</b>			

Please note: If the plan works, it can be repeated every \_\_\_\_\_ hours where symptoms return. It should not be used more than \_\_\_\_\_ times in 24 hours. If the symptoms remain despite using the plan, contact the number above.

Note: the purpose of this document is to provide advice for symptom management only, using medications that have already been prescribed to you or your relative by your or their doctor or nurse practitioner. **This document contains suggestions for how to manage your or your relatives' symptoms. It is not a prescription for medications.**

For complete medication information including side effects, refer to the information that has been provided by your prescribing doctor, nurse practitioner, pharmacist or hospital. This plan does not replace this information.

#### FOR AMBULANCE VICTORIA PARAMEDICS

Ambulance Victoria paramedics should support the patient or carer in following the established care plan in the first instance. If this is not successful contact the palliative care service and treat the patient as per AV Clinical Practice Guideline A0712 Palliative care.

This approach is endorsed by the AV Medical Advisory Committee.

#### Completed by

#### Signed

Designation

Date

#### Authorised person available for signature

Signed

Name

(Prescribing specialist/GP/NP)

Date

Time

#### Authorised person not available for signature

Signed

Name

(Prescribing specialist/GP/NP)

Date

Time

#### Follow up confirmation of verbal order

Verbal order confirmed by

(Prescribing specialist/GP/NP)

Signed

---

## Appendix 5: Example letter

Dear <Doctor>

Re: <Name, DOB, Address>

After our recent assessment of <Name>, we are writing to ask for your help in prescribing medications that may be required for distressing symptoms when the oral route is no longer possible. We have made some guideline recommendations to you about drug, dosage and quantity needed (see over).

The most common preventable reason for an unplanned and unwanted hospital transfer is lack of access to necessary medications. Our aim is to anticipate potential symptoms and have medications available in the home in case needed.

We have reviewed the following:

- Access to after-hours pharmacy
- Preferences for future medical care
- Preferences for place of death
- Concerns about misuse or diversion
- Understanding about who will give the medication
- Common symptoms that may arise include pain, breathlessness, anxiety, restlessness/agitation and noisy/gurgly breathing in the terminal phase.

Commonly prescribed medications and doses can be found at <Link>

Please contact us if you are aware of any issues that may guide prescribing for <Name>.

If you have any concerns, please contact us.

We appreciate your assistance to support <Name> to remain in his/her preferred place of care.

Kind regards

<Signature>

<Name>

<Role/Title>

# Appendix 6: Caring@home resources



Resources can be downloaded from the [caring@home website](#)

## Community service providers

Guidelines for the handling of palliative care medicines in community services	These guidelines can be used by community service providers to inform the development of detailed protocols and procedures tailored to the requirements of individual services.
Example policies and procedures	These documents may be used by community service providers to develop and/or review relevant documentation within their own organisation's policy and procedure framework.

## Healthcare professionals

Online education modules	The online education aims to educate nurses about how to train carers to manage breakthrough symptoms safely using subcutaneous medicines.
palliMEDS	This app familiarises primary care prescribers and community pharmacists with eight palliative care medicines used for management of terminal symptoms.
Palliative care symptom management medicines for Australians living in the community	A consensus-based list of medicines suitable for use in the community for the management of terminal symptoms.

## Carers

A practical handbook for carers: <i>Helping to manage breakthrough symptoms safely using subcutaneous medicines</i>	The handbook provides written and pictorial material with all the information a carer needs to help manage breakthrough symptoms safely using subcutaneous medicines.
Writing a label, opening an ampoule and drawing up medicine: <i>A step-by-step guide</i>	This illustrated guide explains how to label a syringe correctly, open an ampoule and draw up medicine using a step-by-step approach.
Giving medicine using a subcutaneous cannula: <i>A step-by-step guide</i>	This illustrated guide explains how to give medicine through a subcutaneous cannula using a step-by-step approach.
Medicines diary	The medicines diary is for carers to record all the subcutaneous medicines that are given.
Colour-coded labelling system	The colour-coded labelling system acts as an extra safety check to ensure the correct medicine is given for each breakthrough symptom. It includes sticky labels for syringes and the symptoms and medicines: <i>Colour-coded fridge chart</i> .
A practice demonstration kit	The demonstration kit is used to practise giving medicines through a subcutaneous cannula.
Short training videos	The videos show how to give subcutaneous medicines.

# Glossary

Term	Definition
<b>Administer</b>	To personally introduce a medication to a person's body (or personally observe its introduction) <sup>20</sup> .
<b>Anticipatory medication</b>	Injectable or sublingual medication prescribed to manage symptoms in a person with a life limiting illness who are unable to swallow, absorb or tolerate oral medications, to manage symptoms in the home with the goal of preventing avoidable admission to a healthcare facility.
<b>Anticipatory prescribing</b>	<p>Anticipatory prescribing can be defined as the proactive prescribing of medicines that are commonly required to control symptoms in palliative care. These medications may be used to control symptoms at any time, including the last days of life.</p> <p>Anticipatory prescribing is based on the premise that although each person is different, many symptoms and changes can be predicted, and management measures can be put in place in advance.</p>
<b>Breakthrough symptoms</b>	Even with regular medicines, sometimes symptoms can unexpectedly get worse. When this occurs, it is called a breakthrough symptom and may require an extra dose of medicine <sup>13</sup> .
<b>Catastrophic events</b>	Uncommon but extremely distressing events for people, families and attending clinical staff. They are acute events that are terminal within seconds to minutes. Examples include massive haemorrhage and acute airway obstruction.
<b>Carer</b>	<p>A carer (usually a family member or friend) is someone who provides care to a person (usually at home). The carer may or may not live with the person, and the carer may be aged or have their own health issues<sup>12</sup>.</p> <p>The carer provides personal care, support and assistance to another person who has a disability, medical condition or mental illness, or who is frail and aged<sup>13</sup>.</p>
<b>caring@home</b>	<p>A national project funded by the Australian Government which aims to improve the quality of palliative care service delivery across Australia by developing resources that support people to be cared for, and die at home, if this is their choice.</p> <p><a href="https://www.caringathomeproject.com.au">https://www.caringathomeproject.com.au</a></p>
<b>Dispense</b>	A commonly used term that is <b>not interchangeable</b> with 'supply'. For example, a pharmacist might dispense a prescription with the intention of supplying the medication but the supply might not occur until a later time. To avoid misunderstandings, the terms 'administer' and 'supply' are used in legislation <sup>20</sup> .
<b>End of life</b>	Two areas of definition exist. One is the period of time a person lives with an advanced progressive illness. The other refers to the end stage of weeks or days prior to death <sup>12</sup> .
<b>Endorsed enrolled nurse</b>	An enrolled nurse is a person with appropriate educational preparation and competence for practice, who is registered with the Australian Health Practitioner Regulation Agency (AHPRA) to practise nursing in Australia. Endorsed enrolled nurses can administer medicines if they have completed medication administration education.



Term	Definition
<b>Incident symptoms</b>	Symptoms occurring as a direct consequence of movement or activity. If movement can be predicted, medication can be administered pre-emptively to mitigate or prevent symptoms arising <sup>21</sup> .
<b>Life limiting illness</b>	A person with a life limiting illness may die prematurely. This term is often used for people living with a chronic condition that may seem life threatening but can continue for many years or even decades <sup>12</sup> . For the purpose of this guideline, chronic conditions which may have life threatening exacerbations are included in this definition.
<b>Life threatening illness</b>	A person with life limiting illness who is likely to die prematurely. Often used when referring to children or adults who have an illness with a poor prognosis and their life span may be considered shortened <sup>12</sup> .
<b>Nurse practitioner</b>	A nurse practitioner is a registered nurse educated to a master's degree level. The role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to, the direct referral of patients to other healthcare professionals, prescribing medications and ordering diagnostic investigations. The qualification requirement is a Masters of Nurse Practitioner <sup>23</sup> .
<b>Opioid naive</b>	Patients who are not chronically receiving opioid analgesics on a daily basis <sup>26</sup> .
<b>Opioid tolerant</b>	Patients who are chronically receiving opioid analgesics on a daily basis, who are taking, for one week or longer, at least <sup>26</sup> : <ul style="list-style-type: none"> <li>• 60 mg oral morphine/day</li> <li>• 25 µg transdermal fentanyl/hour</li> <li>• 30 mg oral oxycodone/day</li> <li>• 8 mg oral hydromorphone/day</li> <li>• 25 mg oral oxymorphone/day, or</li> <li>• An equianalgesic dose of any other opioid.</li> </ul>
<b>Palliative approach</b>	The palliative approach is based on the tenets of palliative care. It aims to improve the quality of life for individuals with life limiting illness and their families through early identification, assessment and management of pain and other physical, psychological, social, cultural and spiritual needs. The palliative approach tailors care to the needs and priorities of the individuals and their families <sup>12</sup> .
<b>Palliative care</b>	Palliative care is defined as care that improves the quality of life of people and their families facing the problems associated with lifethreatening or life limiting illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems – physical, psychosocial and spiritual <sup>12</sup> .
<b>Prescribe</b>	A term that commonly relates to the action of a practitioner who authorises treatment that may be carried out by another person. The 2017 Regulations describe this action in accordance with the three different mechanisms by which the treatment may be authorised; namely <b>'issuing a prescription'</b> , <b>'writing a chart instruction'</b> and <b>'authorising administration'</b> <sup>20</sup> .

Term	Definition
<b>Prescriber</b>	A health professional authorised to write prescriptions and medication orders and give directions (verbal or written) about administration and supply of prescription-only medicines.
<b>Prescription only</b>	Medicines prescribed by a medical or nurse practitioner and is dispensed to a specific person. Includes Schedule 8 poisons (labelled 'Controlled Drug') and Schedule 4 poisons (labelled 'Prescription Only Medicine').
<b>Registered nurse</b>	A nurse with appropriate educational preparation and competence for practice, who is registered with the Australian Health Practitioner Regulation Agency (AHPRA) to practise nursing in Australia <sup>13</sup> .
<b>Sharps container</b>	A container used for disposing of needles and syringes that are generally classified as 'sharps' in state and territory waste management legislation.
<b>Schedule 4 poisons</b>	Schedule 4 poisons (labelled 'Prescription Only Medicine') include most other medicines for which prescriptions are required – for example, local anaesthetics, antibiotics, strong analgesics (such as Panadeine Forte®) – and that are not classified as Schedule 8 poisons. Whereas most benzodiazepines are Schedule 4 poisons; flunitrazepam and alprazolam are classified as Schedule 8 poisons.
<b>Schedule 8 poisons</b>	Schedule 8 poisons (labelled 'Controlled Drug') are medicines with strict legislative controls, including opioid analgesics – for example, pethidine, fentanyl, morphine (MS-Contin®, Kapanol®), oxycodone (OxyContin®, Endone®), methadone (Physeptone®) and buprenorphine. Two benzodiazepines (flunitrazepam and alprazolam) are also classified as Schedule 8 poisons and ketamine is a Schedule 8 poison, which some nurse practitioners may be authorised to prescribe.
<b>Stock medication</b>	Medicine that has not been individually supplied by prescription for a specific patient (for example, by a pharmacist on prescription).
<b>Subcutaneous cannula</b>	A thin plastic tube that is inserted under the person's skin by a healthcare professional or appropriately trained carer <sup>13</sup> to aid the appropriate administration of subcutaneous medications.
<b>Subcutaneous medicine</b>	Medicine injected under the skin <sup>13</sup> .
<b>Supply</b>	To provide a medication to be administered at a later time <sup>20</sup> .
<b>Unused medications</b>	Medicines no longer required or remaining after the person's death. Includes all the person's medication.

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