Macmillan Rural Palliative Care Pharmacist Practitioner Project

Resource Toolkit
Resource Toolkit

To access any of the hard-copy resources listed below, please contact the Project Lead Mrs Alison MacRobbie via: alison.macrobbie@nhs.net or 01463 706829.

- Sunny Sessions Care Home Training- Session 1.1 What is Palliative Care?
- Session 1.1 Solutions
- Sunny Sessions Care Home Training- Session 1.2 What is End of Life Care?
- Session 1.2 Solutions
- Sunny Sessions Care Home Training- Session 2 Addressing Pain in Elderly Patients
- Session 2 Solutions
- Session 2 Participant Tools
- CD Mouse mats and Mugs Templates
- Macmillan Rural Palliative Care Pharmacist Practitioner Key and Associated Roles and Responsibilities
- Ask 3 Card and Medicines Information Support Card Templates
Sunny Sessions Care Home Training - Session 1.1 What is Palliative Care?

**What is Palliative Care?**

- For people with cancer only
- Treatment is always stopped
- Takes place only in hospitals
- Improves quality of life for people who are ill and their families
- Team approach
- Assessment and treatment of pain and other distressing symptoms, physical, psychosocial and spiritual
- Does not prolong or hasten death
- Only the person who is ill can benefit from palliative care
- For all people with a life limiting condition, including cancer (and their families)
- People with dementia would not be appropriate for palliative care
- From diagnosis
- For the last few hours or days of life only

**Discussion points:**

For people with cancer only:

Palliative care has been historically associated with the latter stages of cancer. However, it is now widely accepted that palliative care should be for people with a wide range of non-malignant conditions, including dementia, heart failure, renal failure, motor neuron disease, chronic obstructive pulmonary disease (COPD), etc.

Improves quality of life for people who are ill and their families:

Palliative care offers a support system, addressing the needs of the person who is ill and family members. By addressing these needs, it is hoped that the person who is ill will remain mentally and physically active as possible for as long as possible. Providing bereavement counselling etc can also help family members cope and adjust to the situation.

Team approach:

Palliative care works best when a team approach is used. Doctors, nurses, pharmacists, chaplains, social workers, Occupational Therapists (OT), physiotherapists etc all have a role to play. Excellent communication networks between health professionals, supporting staff and the ill person and their families is essential.
Does not prolong or hasten death:
The goals of palliative care are to ease pain and other symptoms e.g. breathlessness, depression and to provide support to the ill person and their families.

For all people with a life limiting condition, including cancer (and their families):
Palliative care provides a holistic approach to improve quality of life for both the person who is ill and their families. Any person with a life limiting condition, be it cancer or dementia for example and their families should have access to palliative care services.

From diagnosis:
Traditionally thought of from the last few days of life, but by providing palliative care from diagnosis (or a life limiting condition), can help to control symptoms and plan ahead for future treatments. People who are ill, and their families can build up good relationships with members of the palliative care team, when the person is 'well'. When the person's condition deteriorates, they and their families will already have good support systems in place to allow a 'good death'.

For the last few hours or days of life only:
See above.

Treatment is always stopped:
Palliative care does not mean that treatment is stopped. For some people this may be a consideration and appropriate, but in general appropriate treatment will continue to manage distressing symptoms such as pain or breathlessness and to maintain or improve quality of life.

Takes place only in hospices:
Palliative care can take place in any setting: persons own home, a relative's home, a care home, hospital or hospice.

Assessment and treatment of pain and other distressing symptoms, physical, psychosocial and spiritual:
This is the main role and definition of palliative care.

People with dementia would not be appropriate for palliative care:
Quite the opposite! People with dementia (and their relatives) should be part of palliative care. Dementia is a long term condition where the person needs appropriate symptom relief, support and planning for the future.
Sunny Sessions Care Home Training - Session 1.1 “What is Palliative Care?” Solutions

What is Palliative Care?

Match the following phrases to what palliative care is and what palliative care is not.

- For people with cancer only (N)
- Treatment is always stopped (N)
- Takes place only in hospices (N)
- Improves quality of life for people who are ill and their families (Y)
- Team approach (Y)
- Assessment and treatment of pain and other distressing symptoms, physical, psychosocial and spiritual (Y)
- Does not prolong or hasten death (Y)
- Only the person who is ill can benefit from palliative care (N)
- For all people with a life limiting condition, including cancer (and their families) (Y)
- People with dementia would not be appropriate for palliative care (N)
- From diagnosis (Y)
- For the last few hours or days of life only (N)

Solution

(Over, Down, Direction)
CANCER (10, 12, SE)
PARAPLEGIA (19, 10, W)
RESPIRATORY FAILURE (1, 20, R)
HEART FAILURE (3, 12, N)
DEMENTIA (1, 17, E)
MOTOR NEURON DISEASE (12, 15, S)

Resources: Highland Palliative Care Pathway:
Sunny Sessions Care Home Training - Session 1.2 What is End of Life Care?

Outcomes:
- What needs to be considered for anticipatory planning for end of life care
- Recognise problems that may be related to medicines
- Know what action to take

End of Life

What do you need to think about?
(Tell in the sunflower petals)

Assessment:
- When a person's condition deteriorates, an assessment is required to identify whether there is a reversible cause for the deterioration. A reversible cause could be:
  - Dehydration (very hot weather, not able to help themselves to fluid, worried about getting to the toilet and not drinking, some medicines make you very dry)
  - Infection (consider urine infection especially if incontinent or has a catheter or chest infection if has been bed bound)
  - Delirium (may be caused or made worse by medicines or infection or other disease)
  - Opioid toxicity (hallucinations, twitching, plucking, restlessness, excess sleepiness)
  - Sudden kidney damage (known as acute kidney injury, this can affect how the body gets rid of medicines or toxins, can be caused by some drugs or infection)
  - Steroid withdrawal (also smoking or nicotine withdrawal, alcohol withdrawal)
  - Hypercalcaemia (high levels of calcium in the blood)

Treatment Goals:
- If a reversible cause for deterioration is found then appropriate treatment can begin. The person should be regularly reviewed and assessed for further signs of change whether better or especially if getting worse.
- If no reversible cause can be found, it may be decided that the person is entering the end stage of life and actively dying. The goals of treatment may now have changed. Planning ahead becomes even more important. Although there is no longer a cure, there should still be care to maintain quality of life. This is often referred to as comfort care and involves:
  - Eye and mouth care
  - Pressure mattress and skin care, repositioning for comfort
  - Bladder and bowel care
  - A comforting presence

DNACPR:
There may also be a “ceiling of care” agreed. For example, symptom control for pain would be available but if the person developed pneumonia (chest infection) they would not be admitted to hospital.
Sunny Sessions
For Care Homes
Session 1a

What is End of Life Care?

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) status should be reviewed and ensure that appropriate communications and documentation have taken place. DNACPR only means that a heart will not be re-started if it stops. All other comfort care measures will still be provided.

Medication:
Medication should be reviewed and any medication not appropriate in line with the agreed goals of care should be stopped. Sometimes stopping medicines suddenly causes a withdrawal reaction. Look out for patients who become more agitated or restless or other changes in symptoms and alert senior staff.

If the medicine is considered essential, the way that it is given (route of administration) may need to be reviewed and changed. If the person is having difficulty swallowing tablets, then a liquid version of the medicine may be needed or possibly giving the medicine by injection under the skin (subcutaneously). If the medicines are needed on a frequent basis then a syringe pump may be needed.

Anticipating symptoms and getting medicines in place ‘just in case’ they are needed is very important. The types of medicines you will need for the different symptoms that may occur are:
- opioid e.g. morphine, diamorphine, oxycodone – for pain relief or possibly to relieve breathlessness
- midazolam – this is a sedative and reduces anxiety but can also be used to treat seizures or fits
- hyoscine butylbromide – this medication reduces secretions and also treats colic pain
- levo-remifentanil – treats restless agitation and delirium, nausea and vomiting

Fluids and Food:
Support the person to take food and drinks as long as they are able to (with assistance) and want to.

As death nears, there is little or no appetite for food, and people are usually awake enough to swallow safely. We know that near the end of life the body cannot use nutrients in food, and people do not become stronger or live longer when more calories are provided. If there is no interest in food, then there is a benefit to the patient in feeding the issue. In fact, this may result in increased nausea or a bloated sensation. If restricted by the patient and it is safe to do so, small amounts of favourite foods can be provided.

Intake of fluids also decreases. People nearing death become dehydrated, meaning their body has less water than it would when healthy. This is a normal part of the natural dying process. This is not the same thing as being thirsty, which relates more to the person’s experience of dehydration. A dying person would have to be awake enough to experience a sense of thirst, and this is usually related to a sensation of dry mouth relieved by giving mouth care. In a comfort-focused approach to care, fluids are not generally provided by a drip unless there are specific reasons (sometimes to heath confusion, to diminish medication side effects).

Communication:
Palliative care does not begin at the end of life. It should start at some point soon after diagnosis of a life-limiting condition.
It is important to document in care plans and continually review treatment goals as the person’s condition changes.
Discuss the care plan with the person (if possible) and family members to keep them informed and prepare them for what to expect.
Communicate with other members of the care team to ensure everyone has the most up-to-date information.

Capacity:
If a person can no longer communicate their wishes on Adults with Capacity forms is required for whichever activities they can no longer participate in decision making about. This could include medicines administration.
Sunny Sessions Care Home Training - Session 1.2 What is End of Life Care? Solutions

Sunny Sessions
For Care Homes
Session 1a

End of Life

WHAT DO YOU NEED TO THINK ABOUT?
(FILL IN THE SUNFLOWER PETALS)

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Sunny Sessions
For Care Homes
Session 1a

Solutions

What is End of Life Care?

3. This can be a cause of deterioration (9)

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<th>2</th>
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<th>6</th>
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Sunny Sessions Care Home Training Session 2- Assessing Pain in Elderly Patients

Outcomes:
- Recognising the presence of pain
- Having the tools to identify pain
- Knowing what action to take

Observations related to pain

<table>
<thead>
<tr>
<th>Amount of Pain</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Observations</td>
<td>0</td>
<td>(1-3)</td>
<td>(4-6)</td>
<td>(7-10)</td>
</tr>
</tbody>
</table>

- Smiling
- Grimacing
- Striking out
- Chatty
- Rigid
- Reassured by voice or touch
- Grunting

- Fidgeting
- Cheerful
- Tense
- Inconsolable
- Sighing
- Frowning
- Fists clenched

- Noisy laboured breathing
- Relaxed
- Distressed pacing
- Altered sleep
- Sad
- Normal breathing

Assessing Pain in Elderly Residents

- Pain is under-diagnosed and under-treated in older people.
- UK statistics show pain or discomfort reported by about half of over 65 years, and a bit more than half (58%) of men and women aged over 75 years.
- Institutionalised elderly people (e.g., care home residents) give results between 45-83% of residents (i.e., 4 out of 5 people) reporting at least one current pain problem.
- Pain is subjective, a personal experience. It has several factors:
  - Sensory—Intensity, location, character
  - Affective—emotional component, how pain is perceived
  - Impact—effect of pain on residents’ ability to function and interact

- Assessment:
  - The responsibility of every member of staff
  - Takes place in two parts—direct enquiry and observation
  - More difficult when there is cognitive impairment and communication barriers

- Asking Questions:
  - Who?—patient/resident, carers, relatives
  - Sensory aids for good communication?—enough light, glasses, hearing aids, large diagrams
  - The most appropriate form of questions—verbal, diagrams, charts, observation
Sunny Sessions
For Care Homes
Session 2

What should you ask? (Fill in sunflower petals above)

a) Where is it?, what’s it like?, what makes it worse?, what makes it better? (sore, hurting, aching, constant, heat, cold)
b) How long has it been present?
c) How does it affect what you do each day? (daily activities)
d) How does it affect how you get on with other people? (relationships)
e) How does the pain make you feel?
f) How severe?
g) Goal setting - what do you want to happen?

Challenges in managing pain in the elderly.
a) Residents don’t/ can’t complain about pain
b) It is expected in the elderly
c) Compliance issues e.g. swallowing problems, opioid fear
d) Are resident in pain or is there another cause? e.g. fever, anxiety, sadness, boredom, interaction with other residents
e) Effects of polypharmacy – more drugs = more side effect

Scenario

Mr B (aged 91 years old) was admitted to the home 3 weeks ago. He is very hard of hearing and short-sighted. He has mild dementia. He is visited 3 times a week by his wife who lives quite a distance away.

The first week, he was quite agitated and unsettled. He referred to the home as a "hotel" and had problems orientating himself to his room. Over the last week he has become less mobile and quiet. He is eating less.

Q1. What may be bothering this resident?
   How would you go about gathering information to assess him?

Q2. What actions might you take?

Q3. What follow-up actions would you take?

What should you do?

Check routinely
Bring to the attention of trained staff/manager if necessary
Try non-medications if suitable depending on pain assessment
and these have worked before e.g. heat or cold, position change, reassuring presence and chat, breathing techniques etc.
If prescribed - give medicine
If action is taken - check to see whether the action/ intervention has had any effect
   Leave enough time for an action to have an effect, usually about 20 minutes.

A few days later you notice Mr. B seems to be wanting to go to the toilet frequently and appears in discomfort, often spending some time in the toilet groaning and holding his stomach.

Q4. What might be bothering this resident?
   How might you go about gathering information to assess him?

Q5. What actions might you take?

Q6. What follow-up actions would you take?
Conclusions

Staff training and proper evaluation can impact staffing time.
However, if pain is discovered, addressed, and relieved, increased life-style can be greatly enhanced and their ability to self-care improved, saving staff time in these areas.

Pain can be caused by many different things as you have seen in the scenario.

Tools

- Pain body map
- Examples of pain scales — numeric, verbal descriptor, verbal numeric & pain thermometer
- PAINAD — pain assessment in advanced dementia scale (and descriptions)
Sunny Sessions Care Home Training - Session 2 Assessing Pain Solutions

Observations related to pain

<table>
<thead>
<tr>
<th>Amount of pain</th>
<th>None</th>
<th>Mild (1-3)</th>
<th>Moderate (4-6)</th>
<th>Severe (7-10)</th>
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<tbody>
<tr>
<td>Observations</td>
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<tr>
<td>Smiling</td>
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<td>Fidgeting</td>
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<td>Altered sleep</td>
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<tr>
<td>Rigid</td>
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<td>Rested</td>
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<tr>
<td>Cheerful</td>
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<tr>
<td>Scared</td>
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<td>Normal</td>
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<td>Breathing</td>
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<td>Normal</td>
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<td>Grinacing</td>
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<td>Grunting</td>
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<tr>
<td>Noisy breathing</td>
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</table>

Scenario - Answers

Mr B (age 91 years old) was admitted to the home 3 weeks ago. He is very hard of hearing and short-sighted. He has mild dementia. He visited 3 times a week by his wife who lives quite a distance away.

The first week, he was quite agitated and unsettled. He referred to the home as a ‘hotel’ and had problems orientating himself in his room. Over the last week he has become less mobile and quiet. He is eating less.

Q1. What might be bothering this resident?
   How would you go about gathering information to assess him?
   A1. He has badly fitting dentures which are causing discomfort and his inability to eat, which is leading to lethargy (see observations, questions diagram)

Q2. What actions might you take?
   A2. Oral gel, mouthwash, encourage to visit a dentist to correct ill-fitting denture. Pain relief

Q3. What follow-up actions would you take?
   A3. Check that the situation has improved. Mr B is more able to communicate, is eating more comfortably.

A few days later you notice Mr. B. seems to be wanting to go to the toilet frequently and appears in discomfort, often spending some time in the toilet groaning and holding his stomach.

Q4. What might be bothering this resident?
   How might you go about gathering information to assess?
   A4. He has become constipated due to the increase in fluid intake after his denture problem was resolved. Lack of movement has contributed as he used to go out for regular short walks with his wife at home. The care home is at a warmer temperature than he is used to and he is not drinking as much fluid as previously because he doesn’t like the taste of the water in the home. (Observations, questioning, diagrams, will)

Q5. What actions might you take?
   A5. How constipated is this resident? What is normal for him? – consider fruit juice (increases fluid intake, may have a laxative action), increase exercise, add fibre to his diet, request laxatives, request medicines review

Q6. What follow-up actions would you take?
   A6. Regular observation to see if interventions have been acted on and are effective.
Sunny Sessions Care Home Training - Session 2 Participant Tools

Body Pain Indicator Chart

Date: ___________________________ Doctor: ___________________________
Patient's Name: ___________________________ Ref #: ___________________________
Date of Birth: ___________ Age: ______ Gender: Male ☐ Female ☐
Insurance Details: ___________________________

Use a pencil or pen to indicate the body areas where you are experiencing pain or discomfort.

Front

Back

www.FreePrintableMedicalForms.com
Pain Assessment in Advanced Dementia Scale (PAINAD)

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. Definitions of each item are provided on the following page. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during caregiving, after the administration of pain medication).

<table>
<thead>
<tr>
<th>Behavior</th>
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<th>Score</th>
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</thead>
<tbody>
<tr>
<td>Breathing</td>
<td>Normal</td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing</td>
<td></td>
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<tr>
<td>Independent of vocalization</td>
<td></td>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation</td>
<td></td>
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<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan</td>
<td>Repeated troubled calling out</td>
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<td></td>
<td>Low-level speech with a negative or</td>
<td>Loud moaning or groaning</td>
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<td></td>
<td></td>
<td>disapproving quality</td>
<td>Crying</td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or</td>
<td>Sad</td>
<td>Rigid</td>
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<tr>
<td></td>
<td>inexpressive</td>
<td>Frightened</td>
<td>Fists clenched</td>
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<tr>
<td></td>
<td></td>
<td>Frown</td>
<td>Knees pulled up</td>
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<tr>
<td>Body language</td>
<td>Relaxed</td>
<td>Tense</td>
<td>Pulling or pushing away</td>
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<td></td>
<td></td>
<td>Distressed pacing</td>
<td>Striking out</td>
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<td>Fidgeting</td>
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<tr>
<td>Consolability</td>
<td>No need to</td>
<td>Distracted or reassured by voice or</td>
<td>Unable to console, distract, or reasure</td>
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<td>console</td>
<td>touch</td>
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TOTAL SCORE

Scoring:
The total score ranges from 0-10 points. A possible interpretation of the scores is: 1-3=mild pain; 4-6=moderate pain; 7-10=severe pain. These ranges are based on a standard 0-10 scale of pain, but have not been substantiated in the literature for this tool.

Source:

PAINAD Item Definitions
(Warden et al., 2003)

Breathing
1. Normal breathing is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. Occasional labored breathing is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. Short period of hyperventilation is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. Noisy labored breathing is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. Long period of hyperventilation is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. Cheyne-Stokes respirations are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization
1. None is characterized by speech or vocalization that has a neutral or pleasant quality.
2. Occasional moan or groan is characterized by mournful or mumbling sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. Low level speech with a negative or disapproving quality is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. Repeated troubled calling out is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. Loud moaning or groaning is characterized by mournful or mumbling sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. Crying is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.
Facial Expression
1. **Smiling or inexpressive.** Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. **Sad** is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. **Frightened** is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. **Frown** is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. **Facial grimacing** is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language
1. **Relaxed** is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. **Tense** is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. **Distressed pacing** is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. **Fidgeting** is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. **Rigid** is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. **Fists clenched** is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. **Knees pulled up** is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. **Pulling or pushing away** is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. **Striking out** is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability
1. **No need to console** is characterized by a sense of well-being. The person appears content.
2. **Distracted or reassured by voice or touch** is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. **Unable to console, distract, or reassure** is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.
### Guidance for writing controlled drug prescriptions in Palliative Care

**Form GP10**

**Name**

**Address**

**Age if under 12 yrs**

**Post Code**

*The address of the patient. In some cases a patient will not have an address. In such cases "no fixed abode (NFA)" would be allowed.*

**No of Days Treatment**

**CH No**

**Pharmacy Stamp**

**Dispensing Endorsements**

**The dose** must be on the prescription and cannot be expressed as "to be given by subcutaneous injection as directed". However a dosage expressed as “10mg to be given by subcutaneous injection as directed” would be allowed. (Contact your palliative care pharmacist for advice regarding dose ranges)

**The form** of the medicine must always be on the prescription expressed as ampoules, tablets, capsules, patches, oral solution etc

**Midazolam Inj 5mg/ml 2ml ampoules**

**Label:** 10mg to be injected subcutaneously as directed

**Send 10 (ten) ampoules**

**The strength** only needs to be on the prescription if the medicine is available in more than one strength

**The total quantity** must be written in the number of dosage units e.g. ampoules, tablets, millilitres etc in words and figures

It must be signed by the prescriber.

It must be dated. Supply the medicine(s) within 28 days of date specified (including owings).

**Signature of Prescriber**

**Date**

**HI234-5**

*The address of the prescriber must be within the UK.*

*There must be particulars to indicate the type of prescriber*

Please read notes overleaf and complete relevant parts BEFORE going to a pharmacy.

**Prescription serial No**

123456789

**Template No**
**Conversion Chart**

This is advice on conversion factors and dose equivalents. It is not a guideline on using opioids. If converting in the opposite direction multiply rather than divide.

*When changing to a different opioid it is usual to reduce the final opioid dose by one third; vigilance and provision for opioid toxicity and breakthrough pain is advised at this time. Contact Palliative care team for advice.*

- **ORAL MORPHINE**
  - mg/24hrs
  - Divide by 2

- **SUBCUTANEOUS MORPHINE**
  - mg/24hrs
  - Divide by 2

- **SUBCUTANEOUS DIAMORPHINE**
  - mg/24hrs
  - Divide by 3

- **SUBCUTANEOUS DIAMORPHINE**
  - Equivalent

- **FENTANYL PATCH**
  - microgram/hr
  - Divide by 10th

- **SUBCUTANEOUS ALFENTANIL**
  - mg/24hrs

- **ORAL OXYCODONE**
  - mg/24hrs
  - Divide by 2

- **SUBCUTANEOUS OXYPHEDRINE**
  - mg/24hrs

**Breakthrough pain:**
- For same opioid & route divide 24 hour opioid dose by 6
- For Fentanyl: divide patch strength (microgram) by 5 to get breakthrough diamorphine dose (mg)
<table>
<thead>
<tr>
<th>Function</th>
<th>Task / Population / Community Pharmacy coverage</th>
<th>Human Resource Needed/Contract Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Macmillan Rural Palliative Care Pharmacist Practitioner (MRPP) Role</td>
<td>Provide a specialist palliative care service to diverse local community and Multi-professional team (MPT)</td>
<td>Scottish community pharmacy contract</td>
</tr>
<tr>
<td></td>
<td>Contribute to increased awareness of pharmacy palliative care services within the Operational unit/CHP.</td>
<td>Full payment from health board/funding body</td>
</tr>
<tr>
<td></td>
<td>Participate in, and contribute to, developing research activities.</td>
<td>Full payment from health board/funding body</td>
</tr>
<tr>
<td></td>
<td>Identify, analyse and contribute to solutions for issues in accessing medicines.</td>
<td>Access to relevant IT/telephony/networks</td>
</tr>
<tr>
<td></td>
<td>Guide establishment and evaluate systems to ensure MPT and patients/carers can access urgently required medicines.</td>
<td>Access to space for administration time</td>
</tr>
<tr>
<td></td>
<td>Negotiate with MPT in identifying patients eligible for Palliative Care Register and facilitate appropriate communication to community pharmacy health care provider.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Establish communication between healthcare settings to provide continuity of pharmaceutical patient care on patient admission/discharge.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Support signposting to, liaison with and referral of care provision to meet identified patient needs.</td>
<td></td>
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<tr>
<td></td>
<td>Establish, deliver and lead on pharmaceutical palliative care education and training to MPT.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adhere to and encourage best practice prescribing for symptom control and palliative care clinical guidance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Manage complex information searching/synthesis/analysis of advice where evidence may be lacking, and maintain and update information relating to medicines in multiple systems to ensure current advice is accessible.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improve the availability of information on unlicensed medicines for healthcare professionals and appropriate information for patients/carers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Improve awareness in primary care of the risks of serious medication incidents.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consider strategies/practices to minimise medicines wastage whilst maintaining best possible symptom management and advanced care planning.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitate self-audit of practice relating to palliative care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop and support access to palliative care pharmaceutical guidance in appropriate formats for MPT and patients/carers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contribute to the identification and quantification of potential future resources.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enable an increased contribution from community pharmacists to deliver the operational unit or CHP objectives for palliative patients and contribute to development of the operational unit or CHP palliative care strategic direction.</td>
<td></td>
</tr>
</tbody>
</table>
Ensure prompt identification and training of new pharmacists joining the community pharmacy palliative care network.

| General Community Pharmacist Role | Provide general Community Pharmacy service. | Scottish community pharmacy contract  
Develop and maintain specialism.  
Deliver pharmaceutical education and training to MPT.  
Support signposting to, liaison with and referral of care provision to meet identified patient needs.  
Implement and maintain systems for provision medicines information to MPT, patients and carers.  
Support patients and carers in medicines understanding and confidence in safe use.  
Implement and maintain systems to ensure MPT and patients / carers can access urgently required medicines.  
Implement systems for communication and contribution to MPT, and attend gold standards frameworks meetings to ensure anticipatory care planning and continuity of care provision.  
Implement systems for providing appropriate medicines information at admission and accessing medicines and treatment information on discharge from care settings.  
Participate in self-audit of service provision.  
Liaise with other community pharmacy service providers to enable sharing of practice across the health board. |
| Leadership and Coordination with Management / Administrative Functions | Liaise with area specialist palliative care pharmacist/Macmillan Specialist Palliative Care Pharmacist to enable sharing of practice across the health board.  
Liaise nationally with Macmillan Pharmacist Facilitators and Scottish Palliative Care Pharmacists Association members.  
Lead in peer review and provide information about and access to local pharmaceutical palliative care education and training.  
Assist practitioners in negotiating systems to obtain relevant support in palliative pharmaceutical care service provision.  
Signpost to relevant materials for use in practice and supports local implementation.  
Negotiate service provision through local contractors committee, provides service specification, leads and encourages initiative development.  
Monitor service provision and budgets.  
Promote pharmaceutical involvement as part of MPT in palliative care service development and delivery.  
Conduct relevant administrative tasks (minute taking, sending emails, updating action Plan etc.). | Clinical leader/management Administrative support
Ask 3 Card and Medicines Information Support Card Templates

Ask 3

Each time you talk to your pharmacist, doctor or nurse about medicines, ask these questions

1. What does this medicine do?
2. What do I need to do?
3. Why is it important for me to do this?

Medicines Support Needs Information

If admitted to hospital, please share this card with the staff looking after you.

(please tick)

☐ I have my medicines provided in a blister pack (MDS/Dosette box) from my community pharmacist
☐ I have a chart provided from my pharmacy to help me with my Medicines
☐ I have care at home support with my medicines (level 3/managed support)
☐ I have other support needs with my medicines (please state)

To hospital staff: please contact my community pharmacist (details over) to advise of hospital admission/discharge to assist medicines reconciliation and for continuity of medicines related needs.

Patient name...........................................  CHI.................................  Date..........................