Policy for the use of a Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) Chart for subcutaneous and intramuscular medication in the community setting

This policy should be read in conjunction with the procedure on the use of the Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) Chart for subcutaneous and intramuscular medication in the community setting

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Contents

1 ‘At a glance’ summary/ key message of policy

Please use this policy alongside the Procedure document and the Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) chart for adults and children

Medicines governance is one of the areas for consideration recommended by the Royal Pharmaceutical Society (RPS) as part of their response to the Gosport Independent Panel, and which has informed this work. It is important to review and standardise policies and procedures for end of life prescribing, and the aim of this work is to standardise the Pan-London Symptom Control MAAR chart used across organisations and ensure there is a robust policy and procedure to standardise how the MAAR chart is used (https://www.rpharms.com/about-us/who-we-are/expert-advisors/hospital-expert-advisory-group/gosport-report#2). It does not include guidance on end of life symptom management but recommends referring to the Palliative Adult Network Guidelines (PANG) (https://book.pallcare.info), Association for Paediatric Palliative Medicine Master Formulary (https://www.appm.org.uk/guidelines-resources/appm-master-formulary/), or local symptom control / palliative care guidelines for local recommendations.

Patients likely to be in the last days / short weeks of life, those who are unable to swallow oral medications, and sometimes those with advanced life-threatening disease whose symptoms are uncontrolled with oral medications, may require medicines administered via the subcutaneous or intramuscular (I/M) route. The NICE Quality standard ‘Care of dying adults in the last days of life” [1] (March 2017) includes anticipatory prescribing, and outlines the rationale (to avoid a lapse in symptom control and distress for the person and those close to them), and need to prescribe drugs that are appropriate to the individualised anticipated needs of the dying person and to include written clinical indications, dosage and routes of administration, Overview | Care of dying adults in the last days of life | Quality standards | NICE. The NICE Guidance “End of Life Care for infants, children and young people with life-limiting conditions: planning and management” [2] (December 2016) refers to how to manage distressing symptoms, including pain, agitation, seizures and respiratory distress, click here

Sometimes these patients are cared for by a range of different NHS organisations and it is essential that the healthcare professionals looking after them have access to a standardised MAAR chart in order to ensure safe, effective and timely care.

This policy covers patients of all ages that have been risk assessed as requiring subcutaneous and/ or I/M medication. This includes regular medication via a continuous subcutaneous infusion (CSCI), when required medication and the anticipatory prescribing of these medicines.

The use of a standardised symptom control MAAR chart supports the safe administration of complex injectable regimens to overcome the risks of administering complex injectable regimens in the community, or other setting where in-house medication charts do not provide the necessary space and scope.

It sets out the minimum criteria for a MAAR chart required to ensure a consistent and standardised approach where patients choose to live and / or die in their preferred place of care, which is often their home, or the place they know as home.

It also aims to ensure all roles and responsibilities of staff using the MAAR chart are clear to support appropriate governance and ensure accountability is clear between the different parties involved. See Appendix 1 for Alliance Agreement Contract Template completed for London.

[1] https://www.nice.org.uk/guidance/qs144
[2] https://www.nice.org.uk/guidance/NG61/chapter/recommendations#approaching-the-end-of-life

All symptom control MAAR charts should be maintained as paper records in the home / community setting. Where these are completed electronically (as word documents or fillable forms), the prescriber should usually print them and sign with a physical signature, but in exceptional circumstances they can be completed electronically, as outlined in the procedure.

General progress notes regarding patient visits and interventions can be recorded on local paper or electronic patient records. However, any information relating to the care of the patient must also be documented in an agreed communication folder accessible to all staff involved in the provision of care in line with shared care arrangements.

NB: Whilst this document does not cover principles of anticipatory prescribing, it is expected that anticipatory medicines should always be available for patients approaching the last days of life in the home / community setting.

2 Assurance statement

The NHS Constitution safeguards the enduring principles and values of the NHS; it sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. Healthcare professionals employed within the NHS endeavour to provide a quality medicines management service maintaining high standards of care for all palliative patients and those in the last days or weeks of life.

3 Who should read this document?

For all healthcare professionals involved in care provision and medicines management for patients of all ages likely to be in the last days / short weeks of life, and sometimes those with advanced life-threatening disease whose symptoms are uncontrolled with oral medications, and who may need to receive subcutaneous medications

4 Aims and objectives

This policy aims to provide a consistent framework for care provision and in the management of subcutaneous and I/M medication within the home / community setting for patients who are likely to be in the last days / short weeks of life, or those with advanced life-threatening disease whose symptoms are uncontrolled with oral medication or who are unable to swallow oral medication.

The policy aims to minimise hazards to patients and ensures that healthcare professionals involved in administering medication do so effectively and safely.

The objectives of this policy are to:

- Ensure prescribing, administration and documentation complies with set standards and criteria to ensure it takes place in a clear and safe manner that is understood by all healthcare professionals involved in patient care.
- Avoid the distress caused to patients, carers and healthcare professionals through not having access to universal documentation and record keeping processes for medicines
- Reduce the risk of error caused by using multiple versions and formats of different paperwork and documentation that is unfamiliar to staff.

5 Explanation of terms and definitions

Medication Authorisation and Administration Record (MAAR): This is the collective term used for the authorisation and administration record form. These can exist as one combined document or as two separate documents depending on the circumstances in which they are being used.

Prescriber: The clinician authorised to initiate, prescribe and amend medication on the MAAR chart. (This can be a medical prescriber or a non-medical prescriber).

Regular medication: Medication given at regular intervals either on its own for a particular symptom or as a combination of medicines via a 24-hour CSCI for a range of symptoms.

As Required Dose (PRN): Doses which are given when required either alongside an existing 24-hour syringe pump infusion or alone to manage immediate symptoms

FP10 Prescription: Prescription form written to enable a community pharmacy to dispense / supply medication. It is here that the strength and dose of the drug is documented, and all healthcare professionals involved need to be aware of this information.

Continuous Subcutaneous infusion (CSCI): Requires the use of portable continuous infusion devices, such as syringe pumps, to give a continuous subcutaneous infusion, which can provide a good control of symptoms with little discomfort or inconvenience to the patient when the oral or other parenteral routes e.g. intramuscular or intravenous route are not possible

Syringe pump: Portable, battery-operated devices for delivering medications by continuous subcutaneous infusion (CSCI). They are used to allow continued drug delivery when the oral route is no longer feasible.

Anticipatory medicines: Anticipatory medications are prescribed for patients who are dying and in the terminal phase (unresponsive, with hours or days to live) and patients deteriorating and expected to soon be in the terminal phase. Medications prescribed are in anticipation of symptoms, designed to enable rapid relief at whatever time the patient develops distressing symptoms. Drugs prescribed in anticipation may include previous or current prescriptions, sometimes with a change in the route of administration, and newly prescribed drugs for anticipated new symptoms.

Crisis / Emergency medicines: There are some clinical emergencies that can occur in palliative and end of life care which can require urgent medical attention. They can be very distressing for patients and their families and friends, but some of this can be reduced by recognising which patients are at risk of developing these and making a plan in case it does happen. Medicines for emergencies in palliative care can include, massive haemorrhage, fits etc

6 Policy/Guideline/Protocol

This policy applies to patients that have been clinically assessed as requiring parenteral medicines where:

- oral medication is no longer able to control symptoms
- oral medication is no longer tolerated in the last hours, days or weeks of life
- the patient is unable to swallow oral medications (e.g. head and neck cancer)

This policy should be used in conjunction with the Procedure on the use of a Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) Chart for subcutaneous and intramuscular medication in the community setting

The MAAR chart is not a prescription and therefore cannot be used to obtain medicines. The MAAR chart is an authorisation from a prescriber that enables a qualified Health Care professional to administer medication to a patient. Wherever possible, the authorising clinician must print off and ‘wet’ sign the authorisation chart. The completed chart can then be scanned in and emailed to Community Nursing staff or handed to the patient / family / staff for use.

However, in exceptional circumstances, the authorising clinician can complete the chart electronically. Further details are outlined in the procedure.

This policy does not cover the use of topical preparations e.g. analgesic patches; however, there must be indication on the MAAR chart when a patch is in use.

6.1 Review of Medication on the MAAR Chart

(a) Review of Anticipatory Prescribing of Medication on the MAAR chart

The community healthcare team (Adult or Children's Community Nursing (CCN's) Team) and GP responsible for the patient should ensure the patient is reviewed regularly and as the patient's condition changes, from the date that the MAAR chart is written i.e. when the anticipatory medicines are prescribed on the MAAR chart. This is to ensure the medication is still clinically required & appropriate.

Prescribing on the MAAR chart should be clear and unambiguous. When multiple dugs are prescribed for administration via a syringe driver, their compatibility should be checked. If there are no local guidelines, Pharmacy/Medicines Information will be able to provide guidance on mixing drugs in a syringe driver. There is some information in the PANG guidelines (https://book.pallcare.info). This is a multi-disciplinary team responsibility, which includes the initiating prescriber, dispensing pharmacist, clinician clinically reviewing the chart, and the nurse involved in the administration of the syringe pump.

At the time a MAAR chart is required for the initiation of treatment, a clinical review must be undertaken by a GP, a member of the palliative care team or a senior community clinician.

There is currently no legal requirement for how long these charts are valid from the point they are written. A national group is reviewing this issue following Gosport and this document will be updated to reflect those outcomes and agreed best practice when available.

Currently it is considered best practice for the MAAR Chart to be reviewed regularly enough to meet the clinical requirements of the individual patient, balancing the risks of aiming to have medication available at the point of need for a given clinical scenario but to minimise the risk of these medications being used inappropriately in circumstances for which they were not intended. Be aware that local arrangements/governance requirements may vary so please check local relevant policies.

The anticipatory medications are prescribed when someone is thought to possibly be in their last days/weeks of life OR when they are unable to swallow and require administration via the subcutaneous route.

When deciding whether to administer medication as authorised on these charts please consider:

- Is the current situation consistent with the clinical scenario in which this MAAR chart was completed/intended? i.e. meant to be used when person is dying. For example, if the person is not dying and has fallen and broken hip, the MAAR chart is not valid.
- Has the patient's condition changed significantly from the intended circumstances leading to this authorisation - be aware that medication requirements can increase, decrease or stop.

If you are unsure whether administering medication as per this MAAR chart is appropriate, please seek further advice/assessment.

Any change following a review of a MAAR chart requires the change to be signed and dated by the prescriber undertaking the review. If a new chart is required, the prescriber should strike

through, sign and date the old MAAR chart, or give clear instruction to the clinician administering medication using the chart to do this. The old chart must be filed in the patient's notes to ensure it is taken out of use.

(b) Review of the in-use MAAR Chart (for regular and PRN medication)

Once medication has been initiated, the review of the MAAR chart should be in line with individual needs of the patient and changing clinical requirement.

It is anticipated that in these circumstances the patient is being reviewed on a very regular basis by the wider community team (GP, community nursing and possibly palliative care team).

Please note a Coroner's investigation will be required following a patient's death if the GP has not reviewed the patient 14 days prior to his/her death. Whilst the UK is responding to COVID-19, this requirement has been extended to 28 days as outlined in the Coronavirus Act 2020 here.

Where community nurses have almost filled all available administration sections of the "As required" MAAR chart, a clinical review should be undertaken, and a new MAAR chart prescribed.

NB: There may be more than one MAAR chart in use during an episode of care. All prescribing on the MAAR chart should be clear and unambiguous.

6.2 Medication storage and Stock Balance Chart:

- A Stock Balance Chart must be completed for each Controlled Drug (Schedule 2 and 3) that is kept in the patients' home (anticipatory CDs and 'in-use' CDs).
- A Stock Balance Chart can be completed for other (non-CD) medication to support timely ordering of medication.
- Refer to the Procedure document for use of the CD and non-CD Stock Balance Chart
- Refer also to local CD policy / procedure for further information regarding the management of CDs in community settings. Yellow card reporting can be found here https://yellowcard.mhra.gov.uk
  NPSA alerts can be accessed here: https://www.cas.mhra.gov.uk/Home.aspx

6.3 Risk Management

- Staff should be familiar with the process of risk assessment in line with local Trust Policy/procedure.
- All medication incidents and near misses should be reported via the local incident reporting system. In the event of an incident or adverse drug reaction, immediate care should be undertaken to minimise any harm to the patient. All relevant staff involved in the carer of the patient should be informed.
- Refer to local policy for reporting of missing medication or any other medication related incident.
- Any areas of concern should be shared with relevant colleagues to reduce the risk of the incident re-occurring.
- If there is an incident that is thought to be related specifically to the pan-London Symptom Control MAAR chart, procedure or policy, the incident should also be forwarded to england.london-scn@nhs.net
- In the case of an adverse drug reaction a Yellow Card should be completed and sent to the Medicines and Healthcare products Regulatory Agency (MHRA) -

https://yellowcard.mhra.gov.uk. Many medicines administered via the subcutaneous route in end of life care are off-label (i.e. not licensed to be administered via the subcutaneous route). However, the effective use of medicines via the subcutaneous route in this care setting is well documented and the prescriber should be conversant with such evidence and follow local policy on unlicensed medicines.

- All staff involved in the prescribing, administration, monitoring or provision of advice relating to opioids should be aware of the relevant national patient safety alerts, which can be accessed here https://www.cas.mhra.gov.uk/Home.aspx
- The most recent ones related to opioids are:
  - NPSA Safer Practice Notice 12 (May 2006)
  - NPSA Rapid Response Report (July 2008)
- Every healthcare professional involved in prescribing, dispensing and administering opioid medicines has a responsibility to check that the dose is safe for the individual patient

6.4 Transcribing of a MAAR Chart

Where local policies allow authorised healthcare professionals to undertake transcribing of a MAAR Chart, those policies should be adhered to in line with this policy.

6.5 Patient Information

Patients / carers should be provided with information explaining the purpose of the medicines prescribed and where they can get further information and support. See patient leaflet in appendix 2

6.6 Administration of "As required" medication via injection by family member / carer

This should only take place where local policies are in place. The policy should include the following:

- A risk assessment must be completed
- The family member / carer must be trained and be assessed as competent
- The family member / carer must be shown how to make a record of administration on the form to ensure all doses administered are documented
- The family member / carer must contact the community nursing team involved immediately so that a visit can be arranged as soon as possible to check and re-assess patient.

6.7 Disposal of Unwanted Medication

Local policy/procedures should be followed for the disposal of unwanted medication from a patient's home. See Procedure document for further information

7 External references and supporting documents

- Human Medicines Regulations 2012
  http://www.legislation.gov.uk/uksi/2012/1916/contents/made
- The Misuse of Drugs Act 1971 and regulations 1975
- Professional Guidance on the safe and secure handling of medicines, Royal Pharmaceutical Society (RPS). December 2018

- The Misuse of Drugs Regulations 2001
- The Safer Management of Controlled Drugs Department of Health, 2006
- Controlled Drugs (Supervision of management and use) Regulations Department of Health 2013
- NICE guideline, Controlled drugs: safe use and management (NICE medicines practice guideline NG46), 2016
- National Patient Safety Agency (NPSA): Reducing Dosing Errors with Opioid Medicines, Rapid Response Report NPSA/2008/RRR05
- Improving the Quality of Care in the Last days of Life: A Practical Guide to Getting Medications Right NHS London Clinical Networks, Steven Wanklyn
- NICE Care of Dying Adults in the last days of life, QS144 (March 2017)
- NICE Guideline for Care of the Dying Adult NG31(2015)
- NICE Guidance End of life care for infants, children and young people with life-limiting conditions: planning and management NG61 (2016)
- One Chance to Get It Right: Five Priorities of Care – Leadership Alliance for the Care of Dying People (2014)
- NICE guideline, End of life care for Adults: Service Delivery NG142 (2019)
- Department of Health End of Life Care Strategy, (2008)
- Gold Standards Framework, Control of Symptoms and Care in the Dying Phase http://www.goldstandardsframework.org.uk/
- Improving Supportive and Palliative Care for Adults with Cancer - NICE guidance (2004)
- Department of Health Guidance, Securing Proper Access to Medicines in the out-of-hours period (2004)
- Palliative care for adults: strong opioids for pain relief. Clinical guideline [CG140] Published date: May 2012 Last updated: August 2016
- The Royal Pharmaceutical Society (RPS), Areas for action following the report of the Gosport Independent Panel, https://www.rpharms.com/about-us/who-we-are/expert-advisors/hospital-expert-advisory-group/gosport-report
- Mental Capacity Act 2005 and amendments 2017,
- http://www.legislation.gov.uk/ukpga/2005/9/contents
- http://www.legislation.gov.uk/ukpga/2019/18/enacted
- https://www.mariecurie.org.uk/professionals/palliative-care-knowledge-zone/recognising-emergencies/recognising-emergencies#common (accessed on 31.12.19)
- Opioid thermometer

8 Roles and responsibilities

Chief Executive

The Chief Executive has accountability for ensuring the provision of high quality, safe and effective services and has overall responsibility and is accountable for ensuring that there is a managed environment which minimises the risk to patients, visitors, staff, contractors and all who use the premises for any purpose.

Chief Nurse

The Chief Nurse is accountable to the Executive board and has overall responsibility for the strategic direction of transcribing including ensuring policies comply with all legal, statutory and good practice guidance requirements.

Directors

All directors (including managing, clinical, service, operational, assistant operational) and general managers are responsible for the implementation of this policy into practice within their service areas and taking appropriate action should any breach of this policy arise.

Chief Pharmacist

The Chief Pharmacist is responsible for ensuring the pharmacy team provide advice and guidance on all elements of medicines management relating to this policy.

Senior Managers

All Senior managers have a delegated responsibility for ensuring that this policy is known to all staff and that its requirements are followed by all staff within their directorate/division/department.

Operational Leads

Are responsible for:

- Bringing to the attention of their staff the publication of this document.
- Providing evidence that the document has been cascaded within their team or department.
- Ensuring this document is effectively implemented.
- Ensuring that staff have the knowledge and skills to implement the policy and provide training where gaps are identified.

Qualified Staff

All qualified staff have shared governance and responsibility for the safe and effective use of the MAAR charts.

9 Equality statement

The policy reflects that all parts of the community has equality of access to services and that everyone receives a high standard of service as a service user, a carer or employee. This policy anticipates and encompasses commitment to prevent discrimination on any illegal or inappropriate basis and recognise and respond to the needs of individuals based on good communication and best practice.

10 Consent

Follow local consent policies.

Valid consent to treatment is central in all forms of healthcare.

“Consent” is a patient’s agreement for a healthcare professional to provide care. Patients may indicate consent non-verbally, orally or in writing. For the consent to be valid, the patient must: -

- be competent to take the particular decision
- have received sufficient information to take it
- not be acting under duress.

If there is any indication that the patient may lack mental capacity to consent, a mental capacity assessment must be carried out. Please refer to local Assessment of mental capacity policy for adults and young people.

A capacity assessment should be undertaken where appropriate, in line with local policies for Capacity, Consent and Best Interests Assessment for Health & Social Care Interventions.

11 Implementation process

Staff will be made aware of any new approved policies/procedures/guidelines via local organisational communication processes.

All senior managers/heads of service/team leaders need to ensure new policies and procedures are placed on team meeting agendas for discussion. There is an expectation that the team leader will develop local systems to ensure their staff are instructed to read all relevant policies and to identify any outstanding training deficits

12 Monitoring/review of policy

Please see compliance table at appendix 4.

This policy will be reviewed every 2 years, by a Pan-London Symptom Control MAAR chart steering group, convened by the London Clinical Network, Medical Directorate

13 Training & Competency

Staff should be trained in the use of this policy in accordance with local training and education and competency processes. Healthcare staff should also identify any training needs they have in relation to this policy.

Staff should seek further advice from their clinical manager if there are any aspects of the policy that are not clear.

All healthcare staff have the responsibility to check that the intended dose for the medication is safe for the individual patient.

14 Initial Screening Equality Impact Assessment Form

15 Appendices

(All sections of form to be completed by author in conjunction with Equality and Diversity team prior to consultation)			
Directorate/Department		St Joseph's Hospice	
Name of Policy/Service/Function		Policy for the use of a Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) Chart for sul	
New or Existing Policy/Service/Function?			
Name and role of Person completing the EQIA		J Naismith	
Date of Assessment		14/08/20	
		Yes/No	**What/Where is the Evidence to suggest this?**
1	**Does the Policy/Service/Function effect one group less or more favourably than another on the basis of:**		
	• Race, Ethnic origins (including, gypsies and travellers) and Nationality	No	
	• Gender (males and females)	No	
	• Age	No	
	• Religion, Belief or Culture	No	
	• Disability – mental, physical disability and Learning difficulties	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Married/or in civil partnership	No	
	• Pregnant/maternity leave	No	
	• Transgender reassignment	No	
2	**Is there any evidence that some groups are affected differently? Is the impact of the policy/Guideline likely to be negative?**	No	
3	**Is there a need for additional consultation e.g. with external organisations, service Users and carers, or other voluntary sector groups?**	No	
4	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
5	**Can we reduce the impact by taking different actions?**	No	

Assessor's Name: J Naismith **Date:** 14/8/20

Name of Director: Tony Mclean

6 **This section to be agreed and signed by the Equality and Diversity Manager in agreement with the Equality and Diversity Team**

Recommendation

Full Equality Impact Assessment required: NO ☑ YES ☐

Assessment authorised by:

Name: Janet Simkins **Date** 14/8/20

Appendix 1: Alliance Agreement

Appendix 2: Patient Information Leaflet

Appendix 3: Approval Form

Appendix 4: Monitoring and Audit Compliance Form

15.1 Appendix 1 – Alliance Agreement

Shared Prescribing and Administration Agreement for the Pan-London Symptom Control MAAR Chart

The NHS Long term 10-year plan[1] is to support people in the community and for more people to have patient centred care which enables them to die in the place of their choice. This can only be delivered by organisations working collaboratively. This proposal sets out a new inter-organisational agreement which is key in supporting deliver of this new way of working.

The four aims for best patient care in relation to the medicines access;

- To have timely access to anticipatory parenteral medications for symptom control at home – best for the patient
- To have confidence that everything is in place when it is needed (the prescription, the authorisation and administration chart, the medicines and the care plan)
- For staff to be supported to do what is clinically right and understanding their role and responsibilities
- For organisations to govern and share the risk.

The current system is that patient's drugs may be administered by staff in one organisation but prescribed by GPs or Doctors in another organisation. This system sometimes leads to confusion as to who is responsible for what and which paperwork should be used. This has the potential to be unsafe and be suboptimal and put staff and organisations are risk.

This proposal sets out to reduce this risk of confusion of responsibilities and establish a framework for good collaborative practice.

The medical responsibilities and accountability of prescribing and administering anticipatory parenteral medicines for symptom control, lies across the boundaries of more than one organisation that cares for that patient when the dying wish of the patient is to be at their home.

The purpose of this shared prescribing and administration agreement is;

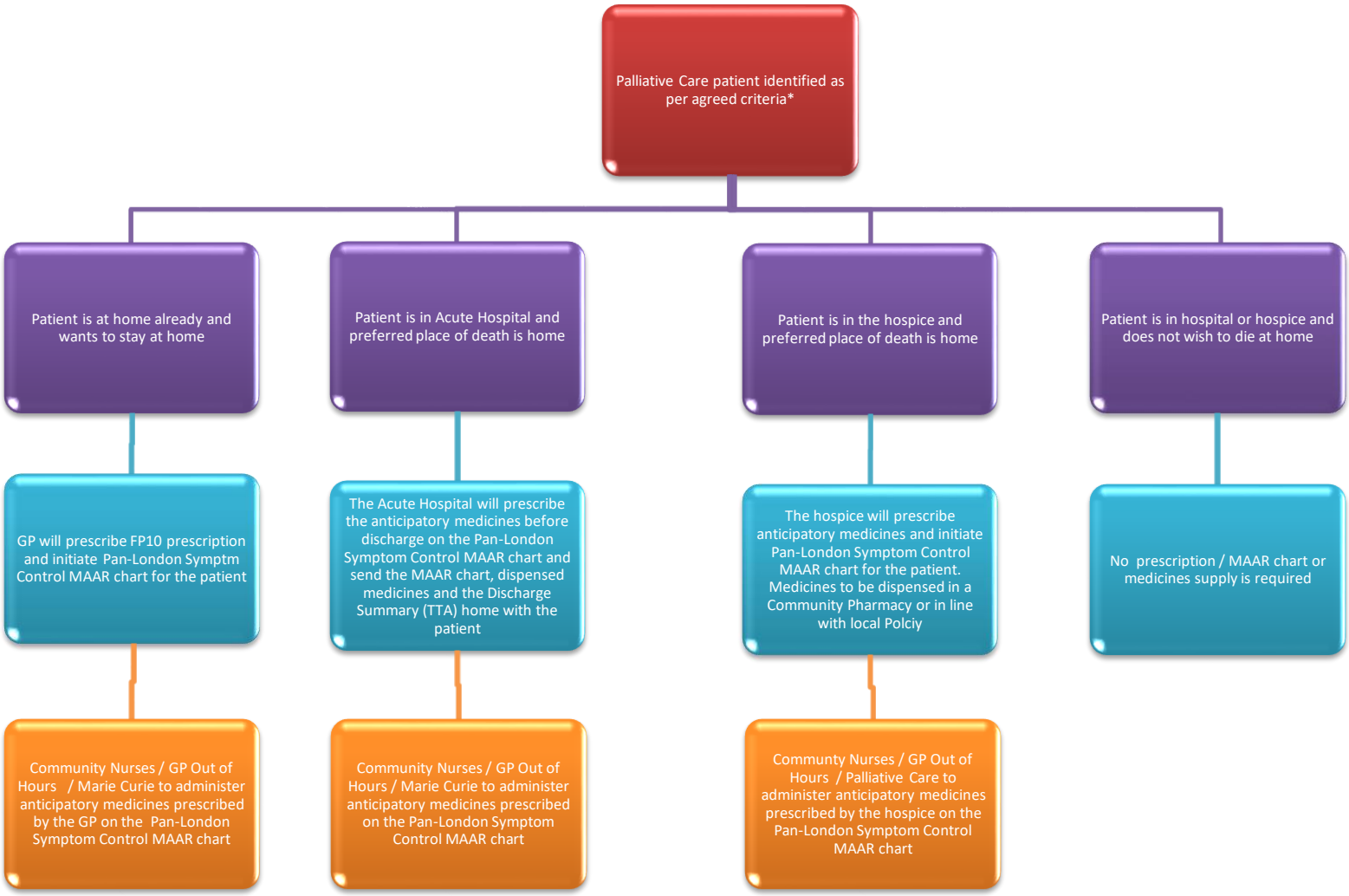
- to outline the responsibility for members of staff in the provider organisations to ensure seamless best care and share the risks that become apparent when one organisation may prescribe on behalf of a different organisation who will administer the medicines.
- to create an over-arching agreement which sets out how the participating organisations will work together in a collaborative and integrated way in order to facilitate a palliative care patient to a have good symptom control and where appropriate, a comfortable death in the place of their choosing.
- If members of staff practice in the way described, the organisations will share the risk and support their practice.

This agreement should prompt organisations to clarify the responsibilities of each healthcare professional and minimise delay to the patient receiving timely care and administration of their medicines in a safe manner at home.

This agreement is based around the Pan-London Symptom Control Medicines Administration and Authorisation Record (MAAR) chart. This MAAR chart is designed to be used within the patient's home only. It will not be used within the Acute Hospital setting or within a hospice setting. It may be signed by staff in the hospice or hospital as well as GPs and Doctors working out of hours and administered by Community Clinicians employed by any of the organisations in London detailed below:

- Acute and Community NHS Trusts
- NHS and independent Hospices, including community-based Marie Curie services
- Adult and Children's Community Nursing services
- NHS111 Out of Hours providers
- London Ambulance Service
- CCGs
- GPs

The Palliative Care* Patient Medicines Pathway



*Palliative Care patient = patient who requires subcutaneous medications to achieve symptom control or who is expected to die within days or weeks

Key activity for patients registered with a GP ***For all activities below, where there is a Care Plan in place (eg. CMC), please update accordingly	Responsibility of:
Palliative Care patient identified as per agreed criteria	All providers
Plan made if patient significantly deteriorates / changes their mind, whether to die at home or to go back to the acute hospital for care	Patient, All providers
Patient is discharged from Acute Hospital. Hospital prescribers to prescribe Discharge Summary (TTA), Pan-London Symptom Control MAAR chart and supply medicines (7-14 days' supply) to take home at the point of discharge. Hospital discharge records sent to the GP within 24 hours.	Hospital Prescribers
Ward Pharmacist to validate Discharge Summary (TTA) in usual way and to check Pan-London Symptom Control MAAR chart and medicines appropriately supplied	Hospital Pharmacist
Patient is discharged home from a Hospice. Hospice prescribers to prescribe an FP10 prescription for take home medicines, prescribe a Pan-London Symptom Control MAAR chart at the point of discharge.	Hospice Prescribers
FP10 prescription medicines obtained	Family / Carers / Adult or Children's Community Nurse/ Community Pharmacy
Initiating the Pan-London Symptom Control MAAR chart and prescribing an FP10 prescription for anticipatory medicines when the patient is at home	GP
Adult or Children's Community Nurse referral containing all relevant information to continue care at home (with support of GP, Marie Curie, Palliative Care teams etc). Pan-London Symptom Control MAAR chart sent to the patient's home or emailed to the Community Nurses at the time of referral.	GP (if patient at home) / hospice or Acute Hospital (if inpatient)
Adult or Children's Community Nurse team administers the anticipatory medicines at an appropriate initiation point following a care plan for the patient, based on the prescribing and completion of the Pan-London Symptom Control MAAR chart written by a prescriber from a separate NHS organisation or GP. It is the responsibility of the individual Nurse to be competent and fully trained in the management of Palliative Care patients and at administering the medicines prescribed for anticipatory care.	Adult or Children's Community Nurse
At the time a Pan-London Symptom Control MAAR chart is required for the initiation of treatment, please ensure a clinical review of the patient and the MAAR chart is undertaken with a GP/member of the palliative care team/senior community clinician, and that all drugs and doses are clinically appropriate and safe to administer	Adult or Children's Community Nurse / Palliative Care team / Hospice / SPA /London Ambulance Service
Reviewing the patient regularly and as the patient's condition changes NB: please note a Coroner's investigation will be required following a patient's death if the GP has not reviewed the patient 2 weeks prior [3] [4] Whilst the UK is responding to COVID-	GP / OOH Doctor / Hospice / SPA / Adult or Children's Community Nurse

[3] Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales (Sept 2018)

19, this requirement has been extended to 28 days as outlined in the Coronavirus Act 2020	
Electronic Pan-London Symptom Control MAAR chart to be made readily accessible to be printed off by all organisations signing this agreement.	Community Services / GPs
Re-writing the Pan-London Symptom Control MAAR chart in a timely manner / when all administration spaces have been used	GP on request of the Adult or Children's Community Nurse
Training on how to prescribe the Pan-London Symptom Control MAAR chart and how to administer medicines from it	All providers

Discharging the Acute **Hospital patient** back into the community / patient's home with Adult or Children's Community Nurse support:

- Should ideally occur within core hours (Monday to Friday 9 - 5pm). Outside of these hours the Adult or Children's Community Nursing / Out of Hours GPs / Palliative Care teams will need to be involved
- Contact details are stated on the Acute Hospital Discharge Summary (TTA) for the following:
    - Acute Hospital Doctor from the Discharging team (person who writes the Discharge Summary and Pan-London Symptom Control MAAR chart)
    - Team Specialty contact number
    - Community Specialist Palliative Care team
    - Medicines Information and Pharmacy contact numbers both within and outside working hours.

Initiating the Pan-London Symptom Control MAAR chart in the Community

- The GP must be able to access Pan-London Symptom Control MAAR chart
    - Any Adult or Children's Community Nurse should ensure Pan-London Symptom Control chart is clinically valid, and medications are available and still in date. Any nurse/ who needs advice to make this judgement will seek this from their Senior Nursing colleagues / GP / Hospice / SPA or OOH Doctor
    - Once medication has been initiated, review of the Pan-London Symptom Control MAAR chart is dependent on the needs of the individual patient and the frequency of review should be in line with changing clinical requirements.
    - The Pan-London Symptom Control MAAR chart lasts for 16 prn doses of the same medicine, or 12 days of the subcutaneous syringe driver and will need to be re-written in a timely manner before it administration spaces run out.
    - At the time a Pan-London Symptom Control MAAR chart is required for the initiation of treatment, please ensure a clinical review of the patient and the MAAR chart is undertaken. The Community Nurse may request a review from a Senior Nursing colleague, GP or a member of the Palliative Care team.

What to do if an **error** in prescribing or dispensing is discovered:

[4] What to do when someone dies gov.uk website https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner

Each provider should report the error through their own internal reporting system and notify the relevant other organisations / providers immediately of the error so it can be rectified. Internal investigations will be carried out by the reporting provider and results need to be shared across organisations at a local level (for example within Community Nursing team meetings / Pharmacy team meetings) to prevent it happening in the future.

References:

1. https://www.longtermplan.nhs.uk/
2. https://www.nice.org.uk/guidance/NG61/chapter/recommendations#approaching-the-end-of-life
3. Guidance for doctors completing Medical Certificates of Cause of Death in England and Wales Sept 2018 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/757010/guidance-for-doctors-completing-medical-certificates-of-cause-of-death.pdf. (Accessed 15.08.19)
4. What to do when someone dies gov.uk website https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner. (Accessed 15.08.19)

15.2 Appendix 2 – Patient Information Leaflet – Pan-London Symptom Control Medication and Administration Record

Anticipatory medicines

An information sheet for patients and their friends and family caring for them

What are 'anticipatory' medicines?

These are a small supply of medicines for you to keep at home just in case you need them. Your doctor or nurse will arrange a supply of these medicines for you. The medicines will come with paper forms that contain information to enable your doctor or nurse to give them to you if they are needed and your usual medicine is not working as well as it has done.

Who will give these medicines?

You cannot give yourself these medicines, and nor can a friend or family member (in exceptional circumstances we may train a family member, but this is rare). They can only be given by your doctor or nurse. A nursing folder will be provided which should be kept with the medication and will include some forms that the nurses will use to record what they have given. This is to make sure your treatment is effective and safe.

What are the benefits of having a supply of anticipatory medicines?

You may not need any of these medicines right now, but they have been prescribed for you because your doctor or nurse think that they may be needed at some point in the coming weeks or days. Sometimes it can be difficult to get these medicines in time, especially at night or at weekends so it is helpful to have them ready in your home just in case. They are usually injections and include medication for:

- pain
- nausea and/or sickness
- breathlessness or reducing secretions in the throat or chest that may cause noisy breathing
- anxiety or restlessness

The medicines that you are given will be tailored to your needs and will depend on your condition. Your doctor or nurse will explain this to you. You may not need all or any of the medications that are prescribed.

Are there any side effects with these medicines?

All medicines can have side effects and it can take a few days to adjust to any new medicines. The possible side effects with these medicines will vary depending on your condition and other medicines you may be taking, but may include drowsiness, feeling of sickness, a dry mouth and constipation. If you need any of these medicines your doctor or nurse will discuss the possible side effects with you and look at ways to help prevent them. Always include a friend or family member in this discussion if it helps you.

How are these medications given?

If you can take medicines by mouth and you want to continue this, it may be possible to offer some of these medicines as tablets or liquids instead of an injection. Your doctor or nurse can discuss this with you. Always include a friend or family member in this discussion if it helps you.

I am taking other medicines what happens to these?

It can be helpful to see if any of your other medicines can be stopped without causing a problem, especially if you are finding it difficult to take things by mouth. It may be important to continue with some medicines either by mouth, by patch or by injection. Others may need to be adjusted according to how you are (for example, medicines for epilepsy, diabetes or heart rhythm should be checked with your doctor). Your doctor or nurse will discuss this with you first. Always include a friend or family member in this discussion if it helps you.

How do I store these medicines?

As with any medicine follow these important safety steps:

• Store in the original box and at room temperature

• Store in a safe, secure place, out of the sight and reach of children

• Do tell at least one close family member or friend where these medicines are stored so they can be found when needed

• Do not share your medicines with anyone else, they have been prescribed only for you

• Take care of the paper forms that come with these medicines as your nurse or doctor will need this information to give the medicines to you

What if I need more medicines?

Your nurse will arrange to get a prescription from your doctor for more supplies. It is best to do this before supplies run out. If you notice supplies are running low, please let your nurse know as this will be helpful. The nurses are unable to collect medication from the community pharmacy. A friend or family member will need to be available to collect the medication or the community pharmacy may be able to deliver to you at home.

If you are admitted to hospital or another care setting, the medicines can go with you as they have been prescribed for you and it is useful for others to know what you have been prescribed and have available for use.

What happens to these medicines if they are no longer needed?

They should to be taken back to your local community pharmacy. Try and do this as soon as possible. It does not have to be the same community pharmacy that the medicines were from originally. The nurses are unable to return medication to the community pharmacy. A friend or family member will need to do this on your behalf.

Any questions?

If you have any questions about your anticipatory medicines, please talk to your GP, specialist palliative care nurse, your community nurse or other health care professional.

15.3 Appendix 3 – Approval Form

Approval Form (polices for regulation need to go to EMT all others to SLT)					
EMT ☐ SLT ☐ APPROVAL SHEET					
Policy title:	Policy for the use of a Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) Chart for subcutaneous and intramuscular medication in the community setting				
Author:	Pan London				
Lead Executive Director approval					
Meeting	**Date of meeting**	**Chair name and title**	**Signature of Lead Director/ EMT Chair**	**Approved? Y / N**	**Reason for non-approval**
EMT ☐ SLT ☐	13/7/20	Dr M Moran	Dr M Moran	Y	

15.4 Appendix 4 – Monitoring and Auditing Compliance with Policy

Monitoring table

Policy lead	**Element(s) to be monitored**	**How will you ensure that the policy is being implemented** For example via an internal or external audit, KPIs, surveys or any other evidence?	**How often will you monitor that the policy is being implemented** For example will the KPIs be looked at annually/quarterly	**Reporting arrangements** (Which committee or group will the monitoring of the policy be reported to?)	**Results of monitoring?**
	Incidents				
	Audit the MAAR chart against the policy/procedure for compliance				

Explanatory notes

1. **Policy lead** Who is the overarching lead for monitoring the policy's implementation?
2. **Element to be monitored** which bits of the policy will you be monitoring to ensure they are implemented or is it the entire thing?
3. **How will you ensure that the policy is being implemented?** For example, will you audit that it is being implemented, will you question staff or service users, use KPIs or if there any other method you will use to ensure it is being implemented.
4. **How often will you monitor that the policy is being implemented?** How often will you check to see if the policy is being implemented e.g. annually, six monthly, quarterly?
5. **Reporting arrangements** Where will you report the results of **3.** Which committee or working group or whatever will you be informing as to progress of the policy being implemented.
6. **Results of Monitoring:** Please summarize any results of the policy monitoring.