[1] Primary Care Unit, Department of Public Health and Primary Care, University of Cambridge, UK

[2] Nottingham Centre for the Advancement of Research into Supportive, Palliative, and End of Life Care, School of Health Sciences, University of Nottingham, UK

[3] Mountbatten Hospice and St Mary's Hospice, Isle of Wight, UK

bb527@cam.ac.uk

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Is end-of-life anticipatory prescribing always enough?

End-of-life anticipatory prescribing can give patients timely access to symptom relieving drugs in their last days and hours, but improved review, provision, and personalisation of medication is needed, write Ben Bowers and colleagues

Ben Bowers, [1,2] Paul Howard, [3] Bella Madden, [1] Kristian Pollock, [2] Stephen Barclay[1]

Dying in pain or distress is a cause of considerable concern for patients, their loved ones, and clinicians.[1-4] Helping patients to die in comfort is an essential goal of end-of-life care. During out-of-hours periods, which make up the majority of time, sourcing medical assessments, prescriptions, and drugs from pharmacies can be challenging and at times is not possible.[3,4] Consequently, anticipatory prescribing of injectable drugs ahead of possible need is recommended good practice internationally to optimise timely symptom control in the community and prevent crisis hospital admissions.[5,6] Anticipatory prescribing is a well established, clinician-led solution to overcome difficulties in rapidly accessing drugs in the community. But this solution is not always put in place and additional options are required.

Injectable anticipatory drugs are typically prescribed as needed for five common and distressing symptoms: pain, breathlessness, nausea and vomiting, agitation, and noisy respiratory tract secretions.[7] The drugs, including opioids and sedatives; equipment; and signed administration authorisation charts are kept in the patient's home or care home where they are available for visiting nurses, doctors, paramedics, or trained family carers. Not all dying patients need these drugs: between 40% and 54% of anticipatory prescriptions go unused.[8,9] After the patient's death, families are expected to return unused drugs to a pharmacy for secure disposal.

The widespread practice of anticipatory prescribing and its underpinning policy is based on clinicians' perceptions that the intervention offers reassurance to all involved and provides effective, timely symptom relief.[2,3,10] There is still inadequate evidence to draw conclusions about the appropriate use, clinical effectiveness, and safety of anticipatory prescriptions.[4,6,10-12]

Injectable anticipatory drugs are commonly prescribed weeks or even months before death, including on discharge from hospital, often with limited review of their continued appropriateness.[7,9] The timing of such prescriptions is challenging given the prognostic uncertainty for patients with non-cancer conditions such as dementia, ischaemic heart disease, and multimorbidity in old age,[9] where illness trajectories may be unpredictable and the dying phase is protracted.[13,14]

Anticipatory drugs can be helpful when the patient, family, and clinicians agree on when to use them and their clinical appropriateness is regularly reviewed.[2,8,9,12] Their storage in the home or care home for lengthy periods may, however, have unintended consequences. Their presence can simultaneously be comforting and an unwelcome "momento mori," reminding patients and their families of impending death.[4,7,9,12,15] Patients and their families may worry that the drugs could cause over-sedation and even hasten death.[4,12] Their presence may be interpreted by visiting clinicians who are unfamiliar with the patient as a signal that care should focus on last-days-of-life care, even when this may not yet be the case.[8,15] Putting in place injectable anticipatory medications is not always acceptable for patients and their families, or appropriate where there are concerns about possible drug misuse or diversion.[3,6]

There are always going to be patients whose death is not anticipated or whose goals remain recovery focused until the last hours of life. It is important to ensure rapid and tailored access to last-days-of-life symptom control drugs in the community in these situations, when anticipatory prescribing is not possible or may have been overlooked.

We propose four parallel context and resource-dependent options to be considered by clinical teams, service commissioners, and policymakers.

Firstly, that some community pharmacies are adequately resourced to supply end-of-life drugs out of hours, ideally at all hours. Secondly, that emergency paramedics carry end-of-life drug stocks that they can administer to dying patients, ideally following remote senior clinician consultation and authorisation. Thirdly, that community healthcare services and nursing homes hold a stock of end-of-life drugs that can be dispensed and delivered rapidly following a prescription. Fourthly, that changes are made to pharmaceutical regulations to permit end-of-life drugs prescribed for one care home resident to be repurposed for another resident, following a medical assessment and individualised prescription, as was permitted temporarily during the initial phase of the covid-19 pandemic in England and widely welcomed.[16] These last two approaches would require changes in legislation and appropriate safeguards in many countries.

These proposed options will need careful piloting and robust evaluation of their clinical effectiveness, safety, and unintended consequences, and consideration of patients' and families' views and experiences of care. They may considerably reduce drug wastage. There is a pressing need to facilitate ready access to end-of-life care drugs in the

community. These and other innovative and complementary options have real potential to avoid preventable suffering in the final days and hours of life.

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