This formulary for pain and symptom management in adults is intended as a guide for prescribers in hospital and community.

Special care should be taken when prescribing strong opioids, particularly in opioid naïve patients, because of the risk of adverse effects. The dose and frequency should be carefully stated on the prescription. For further guidance see BNF.

Many drugs listed are unlicensed in their use or route and as such the clinician takes personal responsibility for prescribing.

If symptoms are not controlled, contact Specialist Palliative Care for advice. Advice should be sought early to avoid symptom crisis - see contact numbers, page 11.

When prescribing for Barnsley patients out of hours this formulary should be adhered to.

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<table>
<thead>
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<th>Pages</th>
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<tr>
<td>Management of Other Symptoms</td>
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<td>Useful Contacts</td>
<td>11</td>
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</tbody>
</table>
1. MANAGEMENT OF PAIN

Consider patient’s TOTAL PAIN
Physical + Psychological + Spiritual + Social

Assess pain using a pain assessment tool—professionals should use a tool with which they are familiar such as a verbal rating scale (VRS) or visual analogue scale (VAS)

WHO ANALGESIC LADDER

Step 3
Non Opioid (Paracetamol 1g qds)
+ Strong Opioid (see page 2)
+/- Adjuvants

If pain persists or increases

Step 2
Non Opioid (Paracetamol 1g qds)
+ Weak Opioid (Codeine Phosphate 30 to 60mg qds)
+/- Adjuvants

If pain persists or increases

Step 1
Non Opioid (Paracetamol 1g qds)
+/- Adjuvants

NB: Analgesia should be prescribed on a regular basis.
Co-prescribe laxatives at Steps 2 and 3 (see page 6)

Step 2:

<table>
<thead>
<tr>
<th>Step 2 opioid</th>
<th>Usual max oral dose</th>
<th>Approx 24-hr Oral Morphine equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine Phosphate</td>
<td>240mg</td>
<td>25mg</td>
</tr>
<tr>
<td>Tramadol</td>
<td>400mg</td>
<td>30 to 40mg</td>
</tr>
</tbody>
</table>
2.
Step 3: See information on page 5 about prescribing in renal and hepatic impairment

Titration:
Paracetamol AND Strong opioid to replace Step 2 weak opioid
Oral Morphine Solution 10mg/5ml: 2.5 to 5mg 4 hourly plus PRN
(Dose depends on previous opioid use - see conversion chart)

Co-prescribe laxatives (see page 5) plus anti-emetic, eg Haloperidol 500microgram to 1mg PRN

Maintenance:
Once pain stabilised on a regular 4 hourly Oral Morphine Solution, calculate total dose given over previous 24 hours (regular plus PRN) Administer in divided doses as twice daily Modified Release Morphine

Co-prescribe Oral Morphine Solution PRN of 1 to 4 hourly equivalent to approximately 1/6th total daily dose of Modified Release Morphine. Do not make changes to the PRN dose if this is effective for the patient, irrespective of the background dose.

ALTERNATIVE CHOICE/ROUTES
Oral:
Oxycodone available as:
Immediate Release Oxycodone solution 5mg/5ml or capsules and Modified Release Oxycodone

NB Oxycodone solution is also available as Concentrate 10mg/ml. Prescription of this in error has led to cases of respiratory arrest.

<table>
<thead>
<tr>
<th>CONVERTING FROM</th>
<th>TO</th>
<th>FACTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral Morphine</td>
<td>Oral Oxycodone</td>
<td>Divide by 2</td>
</tr>
<tr>
<td>Oral Morphine</td>
<td>Subcut Morphine</td>
<td>Divide by 2</td>
</tr>
<tr>
<td>Oral Oxycodone</td>
<td>Subcut Oxycodone</td>
<td>Divide by 2</td>
</tr>
</tbody>
</table>

NB Conversion varies widely between individual patients

Transdermal:
1. **Fentanyl**
Fentanyl patches (each patch over 72 hrs)
Fentanyl is a potent opioid - a 25microgram/hr patch is equivalent to up to 90mg/day Oral Morphine
Fentanyl is not suitable for unstable pain and should NOT be used as a 1st line strong opioid. It is more likely to cause respiratory depression than oral opioids.

Seek specialist advice if the Fentanyl dose exceeds 75microgram/hr
3.

When converting to Fentanyl from Modified Release Morphine 12 hourly:

Apply the first patch at the same time as taking the final dose of Modified Release Morphine

At end of life DO NOT REMOVE FENTANYL PATCH. Patients may require additional SC opioid via syringe driver: seek specialist advice.

Dose Conversion for Fentanyl

<table>
<thead>
<tr>
<th>Oral Morphine (mg/day)</th>
<th>Fentanyl patch (microgram/hr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 to 60</td>
<td>12</td>
</tr>
<tr>
<td>60 to 90</td>
<td>25</td>
</tr>
<tr>
<td>90 to 135</td>
<td>37</td>
</tr>
<tr>
<td>135 to 180</td>
<td>50</td>
</tr>
<tr>
<td>180 to 225</td>
<td>62</td>
</tr>
<tr>
<td>225 to 315</td>
<td>75</td>
</tr>
</tbody>
</table>

2. Buprenorphine

Buprenorphine can be considered to be virtually equipotent with Fentanyl. Buprenorphine may cause less Opioid Induced Hyperalgesia (OIH) than other opioids (see page 4)

It is available in two formulations: seven day patches of 5, 10 and 20microgram/h, and twice weekly patches of 35, 52.5 and 70microgram/h Buprenorphine is not suitable for unstable pain.

The weekly patch may be useful for patients in the community who have been using a weak opioid and are no longer able to swallow

Subcutaneous:
See section on syringe drivers on page 9

Alfentanil may be useful for patients with renal impairment (eGFR <30) for whom a patch is not suitable. Alfentanil has a short half-life so PRN doses may need to be given every 30 minutes

Methadone may also be used especially if toxicity is experienced with other opioids. This should be done in an inpatient setting (preferably hospice) – seek specialist advice

ADJUVANT ANALGESICS:

Adjuvant analgesics are recommended at all 3 steps of the analgesic ladder

Neuropathic pain (neuro-modulatory agents):

Amiriptyline 10mg nocte increasing to 75mg nocte (larger doses may be used by specialists). Caution in cardiac disease and patients aged over 75.

Gabapentin, Pregabalin or Duloxetine - see titration in BNF but caution in elderly and renal impairment

Clonazepam, Ketamine and other drugs may be used - seek specialist advice. Ketamine should not be used long term due to urinary tract toxicity.
4. Bone pain:
Consider neuro-modulatory agents as above
NSAIDs (e.g. Ibuprofen or Naproxen) +/- gastroprotection as per local guidelines, bisphosphonates and/or palliative radiotherapy may be helpful

Raised intracranial pressure:
Dexamethasone 8mg od (bd if severe symptoms) for 5 days titrating down according to symptoms/response. Discuss with Oncologist re radiotherapy. Consider gastroprotection; steroids alone do not significantly increase risk of GI bleed but do by around a factor of 4 when given with NSAIDs.
Initiate anticonvulsants after first seizure; Levetiracetam 250mg od starting dose is recommended - consider specialist neurological advice.

Hepatic distension syndrome (liver capsule pain):
First line: follow WHO analgesic ladder; usually responds well to opioids. If pain uncontrolled, consider Dexamethasone under specialist advice. Monitor closely for steroid induced side effects e.g. hyperglycaemia, proximal myopathy, and limit to a short course only (two weeks max).

SIDE EFFECTS ASSOCIATED WITH OPIOIDS
All patients on opioids will have small pupils; this alone does not indicate toxicity

Constipation:
Always co-prescribe a laxative (softener plus stimulant) - see page 6.

Sedative effect:
Expect a sedative effect for the first 2 to 3 days after starting opioids. If this persists consider seeking specialist advice. Patients may require an opioid switch, dose reduction or/and addition of an adjuvant. Specialists may initiate Methylphenidate to counteract sedation.

Nausea and vomiting:
Nausea and vomiting may occur for first 5-7 days (30% of patients). Consider co-prescription of PRN anti-emetics. Review regularly as anti-emetics may not be required long term.
Oral
eg Haloperidol 500microgram to 1mg PRN (maximum 2.5mg over 24 hours)

Respiratory effects:
Opioids reduce respiratory rate but increase tidal volume so minute ventilation is not significantly affected.
Significant respiratory depression is rare with chronic oral opioid administration. Reduced conscious level alone is not an indication to give naloxone. Think: is the patient dying?
Do not administer naloxone without seeking specialist advice.
Do not administer naloxone unless RR<8 AND Oxygen sats <92%
Naloxone use in palliative care:
Dilute a standard ampoule containing 400microgram to 10mL with 0.9% NaCl
Administer 0.5mL (20microgram) IV every 2 minutes until respiratory status satisfactory. Do not titrate against conscious level. Over-enthusiastic reversal can cause acute severe pain and make subsequent pain management challenging.

Confusion/delirium:
Exclude other possible causes before attributing to opioids. Seek advice.
5. **Opioid toxicity:**
This may occur if pain is poorly responsive to opioids, or if opioids and their metabolites are accumulating due to renal or hepatic impairment. Signs are:
- Increased drowsiness or/confusion
- Vivid dreams/hallucinations
- Muscle twitching/myoclonus
It may respond to a reduction in dose or frequency, or an opioid switch. Seek specialist advice.

Prothrombin Time (PT) is a better indicator of severe hepatic impairment than standard liver function tests. INR is only relevant if on warfarin.

<table>
<thead>
<tr>
<th>Opioid</th>
<th>Renal impairment</th>
<th>Hepatic impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Moderate</td>
<td>Severe*</td>
</tr>
<tr>
<td>Morphine</td>
<td>Reduce dose or switch</td>
<td>Avoid</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Reduce dose or switch</td>
<td>Avoid</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>Normal dose</td>
<td>Normal dose</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Normal dose</td>
<td>Normal dose</td>
</tr>
<tr>
<td>Methadone</td>
<td>Normal dose</td>
<td>Normal dose</td>
</tr>
<tr>
<td>Alfentanil</td>
<td>Normal dose</td>
<td>Normal dose</td>
</tr>
</tbody>
</table>

*Always seek specialist advice in cases of severe renal or hepatic impairment*

**Opioid induced hyperalgesia:**
Increasing pain associated with rapidly escalating opioid doses. Characterised by change in pattern of pain, becoming more diffuse and associated with hyperalgesia, allodynia and myoclonus. When severe may progress to delirium, fits, coma and death. **Seek Specialist Palliative Care advice**

Will require a reduction in background opioid. May need ketamine and/or a switch to methadone or buprenorphine

**Serotonin Syndrome:**
Palliative care patients may be prescribed multiple drugs affecting serotonin release, putting them at higher risk of serotonin syndrome. Drugs include SSRIs, SNRIs, TCAs, tramadol, fentanyl, methadone, metoclopramide and ondansetron.

It is characterised by autonomic disturbance (increased pulse, BP and temp), neuromuscular dysfunction (tremor, clonus and hyperreflexia) and altered mental state (anxiety and agitation). It may progress to coma and death. **Seek anaesthetic support: badly affected patients may need to be paralysed and ventilated**
6. PHARMACOLOGICAL MANAGEMENT OF COMMON SYMPTOMS

Please consider volume and palatability when prescribing laxatives for palliative care. Macrogols and Lactulose are often poorly tolerated; patients rarely have adequate additional fluid intake for these to be effective.

**Constipation:**
Consider cause and non-drug management
Perform rectal examination

Prevention and maintenance:
Prescribe softener plus stimulant, eg: Docusate 100mg caps and Senna. Titrate as needed.
Co-danthramer liquid 10ml od or Co-danthrusate capsules two od and titrate. These combined preparations are more expensive. Do not prescribe Dantron in patients with faecal incontinence due to the risk of skin irritation.

**Persistent constipation/impaction:**
Rectal: Suppositories:
- Bisacodyl 10 to 20mg od
- Glycerin 4gram, 1 to 2 od or
- Enemas: Sodium Citrate Micro-enema PRN
- Phosphate enema PRN
Oral: Macrogols (Laxido ®) up to 8 sachets daily have been used

**Colic:**
Consider cause (for example constipation)
Hyoscine butylbromide SC 20mg 1-2 hrly PRN or
Hyoscine butylbromide 60 to 120mg/24 hrs SC via syringe driver plus 20mg PRN 1-2 hrly

**Nausea and vomiting:**
Consider cause and non-drug management
Exclude bowel obstruction
Consider SC route early - convert to oral route once symptoms resolved

Haloperidol 500microgram to 1.5mg PRN, 2.5 to 5mg SC /24 hours
- good for metabolic causes
Cyclizine 50mg tds or 50 to 150mg/24 hrs in syringe driver
- do not co-prescribe Domperidone/Metoclopramide
- may worsen heart failure
Domperidone 10 to 20mg oral every 4-8 hours or 30mg -60mg PR every 6-8 hours; useful in gastric stasis
Metoclopramide 10 to 20mg tds oral or 30 to 100mg/24 hours via syringe driver
- useful for gastric stasis
- do not co-prescribe Cyclizine

NB recent guidelines about maximum dose and duration of metoclopramide are deemed not to apply to palliative care
Levomepromazine 6.25 to 12.5mg nocte orally
6.25mg PRN 4-6 hourly
6.25mg stat or 12.5 to 25mg SC via syringe driver
Use 2nd line - broad spectrum, more sedating, lower incidence of extrapyramidal side effects (EPSE)

Ondansetron is generally not useful in palliative care, apart from in chemotherapy, post-op and some cases of bowel obstruction. It causes constipation.
7. **Breathlessness:**
Consider cause and remember non drug management. A fan is as good as oxygen in palliative care patients who are breathless but not hypoxic. Avoid prescribing oxygen in patients who are not hypoxic (O₂ sat >92%).

Oral Immediate Release opioids titrated according to response using small doses e.g. morphine sulfate liquid 1 to 2.5mg PRN
Lorazepam tablet 500microgram oral or sublingual (maximum 2mg in 24 hours) if associated with anxiety

**Agitation/terminal restlessness:**
Consider reversible causes (for example hypercalcaemia, constipation, urinary retention) and non-drug management

If panic, anxiety and restlessness predominate – use benzodiazepine For altered sensorium with delirium, hallucinations, disorientation and disturbed sleep/wake cycle – use antipsychotic

Oral:
**Haloperidol** 500microgram to 1.5mg  4 hourly PRN
**Lorazepam** 500microgram sublingual PRN (maximum 2mg in 24 hours)

Buccal:
**Midazolam** can be used under specialist advice

Subcutaneous:
Haloperidol 2.5mg stat or 5-10mg/24 hours in a driver
Levomepromazine 12.5mg stat or 12.5-50mg/24 hours in syringe driver
Midazolam 2.5-5mg stat or 10mg -30mg/24 hours in syringe driver.
Higher doses of both drugs can be used under specialist advice.

Benzodiazepines may cause a paradoxical increase in agitation

**Oral thrush:**
Ensure good oral hygiene and denture care
Nystan ® 5mL qds (much cheaper than nystatin)
Miconazole gel 5 to10mL qds if end of life/unable to tolerate Nystan
Fluconazole 50mg od for 7 days

Please refer to local mouthcare guidelines

**Excessive respiratory secretions:**
Subcutaneous:
Hyoscine butylbromide 20mg stat or prn or 60mg to 120mg/24 hours via syringe driver

Transdermal:
Hyoscine hydrobromide patch 1mg/72 hours
Can cause confusion and drowsiness

Consider changing or stopping medicines if noisy secretions continue after 12 hours
HYPERCALCAEMIA

Symptoms may be non-specific e.g. drowsiness. Think: is the patient dying? If Ca>2.8mmol/l and symptomatic: admit to rehydrate if necessary and then Zoledronate 4mg IV. Seek advice if reduced GFR.

METASTATIC SPINAL CORD COMPRESSION (MSCC)

_Early detection is key._ Refer to NICE guidelines. Any patient with symptoms suggestive of spinal metastases and neurological symptoms such as radicular pain, limb weakness or difficulty walking needs referral **immediately.** Objective neurological examination may be normal. _Dexamethasone_ 8mg bd. Discuss with spinal surgeon on-call/oncologist.

SUPERIOR VENA CAVA OBSTRUCTION

_Dexamethasone_ 8mg bd may be used though evidence lacking. Discuss with oncologist/Interventional radiologist regarding stent, chemotherapy or radiotherapy as appropriate.

CATASTROPHIC TERMINAL HAEMORRHAGE

Sit patient up and give reassurance. If time, consider _Morphine_ 10mg IV/IM and _Midazolam_ 5mg to 20mg IV/IM.

---

**On call Acute Oncologist 7 days, 9am - 5pm: 07949 021449**

Out of hours via Sheffield Teaching Hospitals: 0114 271 1900

**PRE-EMPTE PREScribing AT THE END OF LIFE**

These are a guide for prescribing for patients **not** currently requiring opioids or antiemetics. For other patients, please seek advice. More information can be found in guidance associated with My Care Plan.

**Morphine sulfate** 10mg/mL injection 2.5 to 5mg sc hourly PRN
For pain or dyspnoea
Supply 10 x 1mL ampoules

**Midazolam** 10mg/2mL injection 2.5 to 5mg sc hourly PRN
For agitation, distress or dyspnoea
Supply 10 x 2mL ampoules

**Hyoscine butylbromide** 20mg/mL injection 20mg sc hourly PRN
For respiratory secretions or colic
Supply 10 x 1mL ampoules
Seek advice over 120mg/24 hours

**Haloperidol** 5mg/mL injection
500microgram to1.5mg sc 2 to 4 hourly PRN max 5mg/24 hours
For nausea or agitation/delirium
Supply 5 x 1mL vials
Seek advice over 5mg/24 hours

Also supply _water for injection_ 10 x 10mL vials
9. **SYRINGE DRIVER COMPATIBILITY:**
Compatibility information for mixing two drugs

Drugs listed below for use in a syringe driver should be diluted with water for injection. If more than two drugs are used, please seek specialist advice or see [www.pallcare.info](http://www.pallcare.info)

<table>
<thead>
<tr>
<th>DRUG</th>
<th>COMPATIBLE WITH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strong opioids, i.e.</td>
<td>Cyclizine</td>
</tr>
<tr>
<td>Morphine</td>
<td>Haloperidol</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Hyoscine butylbromide</td>
</tr>
<tr>
<td>For others, seek advice</td>
<td>Levomepromazine</td>
</tr>
<tr>
<td></td>
<td>Metoclopramide</td>
</tr>
<tr>
<td></td>
<td>Midazolam</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Cyclizine</td>
</tr>
<tr>
<td></td>
<td>Hyoscine butylbromide</td>
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<tr>
<td></td>
<td>Metoclopramide</td>
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<tr>
<td></td>
<td>Midazolam</td>
</tr>
<tr>
<td></td>
<td>Strong opioids</td>
</tr>
<tr>
<td>Hyoscine butylbromide</td>
<td>Haloperidol</td>
</tr>
<tr>
<td></td>
<td>Midazolam</td>
</tr>
<tr>
<td></td>
<td>Levomepromazine</td>
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<tr>
<td></td>
<td>Metoclopramide</td>
</tr>
<tr>
<td></td>
<td>Strong opioids</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>Cyclizine</td>
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<tr>
<td></td>
<td>Hyoscine butylbromide</td>
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<tr>
<td></td>
<td>Metoclopramine</td>
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<td></td>
<td>Midazolam</td>
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<tr>
<td></td>
<td>Strong opioids</td>
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<tr>
<td>Metoclopramide</td>
<td>Haloperidol</td>
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<td></td>
<td>Hyoscine butylbromide</td>
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<td></td>
<td>Midazolam</td>
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<tr>
<td></td>
<td>Levomepromazine</td>
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<td>Strong opioids</td>
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<tr>
<td>Midazolam</td>
<td>Cyclizine</td>
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<td></td>
<td>Hyoscine butylbromide</td>
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<td></td>
<td>Haloperidol</td>
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<td>Levomepromazine</td>
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<tr>
<td></td>
<td>Metoclopramine</td>
</tr>
<tr>
<td></td>
<td>Strong opioids</td>
</tr>
</tbody>
</table>

All combinations should be checked for signs of precipitation before and during administration.

The compatibility of some combinations listed is concentration dependent: **Cyclizine** in particular can cause any other drugs to precipitate at high concentrations.

Syringe drivers and sites must be checked 4-hourly for irritation; once skin is irritated absorption of drugs may be affected. This may be ameliorated by dexamethasone 0.5mg sc daily at the driver site.
## 10. CORE DRUG STOCKIST SCHEME

The following is a list of core palliative care drugs that a number of pharmacies across Barnsley have agreed to keep in stock. When medication is required urgently prescribers should therefore try to prescribe from within this list when possible at the set vial doses or tablet sizes. The drugs stocked will be reviewed necessary- please see the Barnsley CCG website for additions and amendments (address below).

<table>
<thead>
<tr>
<th>Drug</th>
<th>Formulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clonazepam</td>
<td>tablets 500 microgram</td>
</tr>
<tr>
<td>Cyclizine</td>
<td>injection 50mg/mL</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>injection 3.8mg/mL</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>tablets 2mg</td>
</tr>
<tr>
<td>Domperidone</td>
<td>suppositories 30mg</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>injection 5mg/mL</td>
</tr>
<tr>
<td>Hyoscine butylbromide</td>
<td>injection 20mg/mL</td>
</tr>
<tr>
<td>Hyoscine hydrobromide</td>
<td>patches 1mg</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>injection 25mg/mL</td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>tablets 25mg</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>tablets 1mg</td>
</tr>
<tr>
<td>Metoclopramide</td>
<td>10mg/2mL</td>
</tr>
<tr>
<td>Midazolam</td>
<td>injection 10mg/2mL</td>
</tr>
<tr>
<td>Morphine</td>
<td>injection 10mg/mL, 30mg/mL</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>injection 10mg/ml</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>liquid 5mg/5mL</td>
</tr>
<tr>
<td>Water for injection</td>
<td>10mL</td>
</tr>
</tbody>
</table>

Participating pharmacies can be found on the Barnsley CCG website:

barnsleyccg.nhs.uk/members-professionals/palliative-care.htm

Further information:

http://psnc.org.uk/barnsley-lpc/services-and-commissioning/barnsley-specialist-drugs-on-demand/

### KEY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>od</td>
<td>once a day</td>
</tr>
<tr>
<td>bd</td>
<td>twice a day</td>
</tr>
<tr>
<td>tds</td>
<td>three times a day</td>
</tr>
<tr>
<td>qds</td>
<td>four times a day</td>
</tr>
<tr>
<td>nocte</td>
<td>at night</td>
</tr>
<tr>
<td>PRN</td>
<td>as required</td>
</tr>
<tr>
<td>stat</td>
<td>immediately</td>
</tr>
<tr>
<td>hrly</td>
<td>hourly</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>SC</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>PR</td>
<td>per rectum</td>
</tr>
</tbody>
</table>
11. USEFUL CONTACTS

Community Macmillan Specialist Palliative Care Team:
Monday to Friday, 9.00am to 5.00pm
01226 644755
Saturday/Sunday/Bank Holidays, 9.00 am to 5.00 pm
01226 644575

Hospital Specialist Palliative Care Team:
Seven days a week, 9am to 5pm
01226 434921 or 01226 730000 Ext 4921
Ap phone 1674/ or 1675

Barnsley Hospice:
01226 244244
enquiries@barnsley-hospice.org

Palcall:
Advice line
Call to be made by senior practitioner
01226 244244 (nights, weekends and bank holidays)

Drug Information Centre:
Monday - Friday, 9.00 am - 5.00 pm
01226 432857 or 01226 730000 Ext 2857
Barnsley Hospital NHS Foundation Trust

Palliative Care Information Websites:
www.pallcare.info
www.palliativedrugs.com

CONTRIBUTORS
This formulary was produced by a multidisciplinary working party with representatives from primary and secondary care. The formulary will be reviewed and updated on a regular basis.

BIBLIOGRAPHY

BNF 70  September 2015 – March 2016  BMA RPSGB


Oxford Handbook of Palliative Care 2nd Edition

Oxford Handbook of Palliative Drugs 3rd Edition

