DRAFT

Palliative Care Subcutaneous Medication Administration Policy

The purpose of this policy is to standardize how subcutaneous medications will be administered for patients who are on the on the Acute Palliative Care Unit (G12NW).

The process for administering medications through the subcutaneous site needs to be streamlined so that the workflow from physician to pharmacy to nurse to patient is transparent.

This policy will be reviewed at regular intervals to check for its effectiveness, and to report outcomes.

Caveats

1. Oral is the preferred route of drug administration.
2. Intravenous is the preferred route of administration if oral is not available → Nausea, vomiting, dysphagia, mucositis, aspiration, or altered mental status, etc.
3. Subcutaneous will be used for:
    a. Patients who require parenteral medications (not tolerant of oral: nausea and vomiting, esophageal obstruction, bowel obstruction, severe mucositis, oral lesion) AND
    b. In whom IV access is no longer feasible
    c. Trial prior to discharge home with subcutaneous medications
4. For patients who are going to be discharged to home or to home hospice with subcutaneous medications:
    a. Switch to SQ will start 24-48 hours prior to planned discharge
    b. Outpatient pharmacy will provide medications to assist in the transition

Inpatient Flow

1. Physician will make the assessment to use the subcutaneous route. Please see Table 1 for the medications available.
2. Practitioner will order a subcutaneous line.
3. Nurse, physician, clinical nurse specialist, or advance nurse practitioner may place the subcutaneous line.
4. Using the standard Alaris pump, fluid will be injected via continuous subcutaneous infusion (CSQI) into the patient at a range of 5 to 50 ml/hr.
5. For all of the medications available from the manufacturer as prefilled syringes, the pharmacy will dispense the syringe.
6. For all other medications, the pharmacy will dispense piggybacks.
7. For inpatient narcotic orders, only three bags will be dispensed at a time.

(SIDE BAR: Another patient cannot use narcotic orders, once the narcotics have been dispensed. They must be destroyed, and the pharmacy that

covers G12NW is having to destroy anywhere from 50-100 bags PER MONTH.)

8. The nurse will give these medications as follows:
    a. Prefilled syringes- SQ push, followed by a saline flush.
9. Piggybacks: Hook into the SQ catheter via Y-site.

Table 1: Medications Available for Subcutaneous Administration		
Drug	**Starting SQ Dose**	**Range or Maximum SQ Dose**
Atropine		
Chlorpromazine	12.5-25 mg Q4-6H	100 – 200 mg Q4H Maximum dose: 1000 mg daily
Dexamethasone	2-4 mg BID	Usual Range: 4-16 mg/day Max: 50 mg/day
Fentanyl	Opioid-exposed conversion ratio: Morphine 10 mg ~ Fentanyl 100-200 mcg Opioid-naïve: Choose another agent first	Dose may be titrated up or down as tolerated for efficacy. Similar to continuous intravenous dosing for any pure opioid, the maximum dose is determined by patient need and tolerability
Haloperidol	0.5-5 mg Q4-6H around the clock **or** 0.5-5 mg Q1H PRN	Agitation: Max 100 mg/24 hours Antiemetic: Max 10 mg/24 hours
Hydromorphone	Opioid exposed: 2.5-5: 1 ratio from PO to subq Opioid-naïve: 0.5 to 1 mg every 2 to 3 hours PRN	Dose may be titrated up or down as tolerated for efficacy. Similar to continuous intravenous dosing for any pure opioid, the maximum dose is determined by patient need and tolerability. May need to lower dose in renal dysfunction.
Lorazepam	0.5 to 1 mg SQ every 4 hours Max: 10 mg/day in divided doses	In order to minimize pain at the injection site and to reduce risk of precipitation of drug in the syringe, the 2 mg/ml lorazepam solution should be diluted with NS or D5W to 1 mg/ml
Methadone	Opioid exposed: Convert to methadone based on Table 2 Opioid-naïve: Choose another agent first	Dose may be titrated up or down as tolerated for efficacy. Similar to continuous intravenous dosing for any pure opioid, the maximum dose is determined by patient need and tolerability. No renal or hepatic dosage adjustments needed.
Metoclopramide	10 mg AC and HS or 10 mg Q6H	Maximum dose studied via continuous subcutaneous infusion is 240 mg/day
Midazolam	Should be administered through the conscious sedation protocol **only**	
Morphine	5-20 mg SC Q4-6 hours. Interval may be shortened, PRN	Dose may be titrated up or down as tolerated for efficacy. Similar to continuous intravenous dosing for any pure opioid, the maximum dose is determined by patient need and tolerability
Octreotide	Usual dose: 300-600 mcg/day CSQI over 24 hours or given as bolus injections TID	Can be infused in NS, sterile water, or D5W AE: Dry mouth and flatulence Clinical experience with doses over 750 mcg/day is limited

Phenobarbital	Usual: 200-600 mg over 24 hours Bolus: 50 and 200 mg	Infuse with sterile water, NS Use: Antiepileptic (prophylaxis or treatment) **Not stable with most drugs, separate line**
Ranitidine	150 mg once or twice daily	Maximum is 300 mg daily

Table 2: Morphine to Methadone Conversion Ratios	
Oral Morphine Equivalent Dose (mg)	Morphine: Methadone
< 30	2:1
30-99	4:1
100-299	8:1
300-499	12:1
500-999	15:1
> 1000	20:1
Methadone should be dosed every 8 hours Rescue dose is 10-15% of total daily dose	