**Contingency plan for shortages of Just in Case Medication for Somerset**

This prescribing guidance has been agreed by representatives from Somerset Partnership, YDH, TST, St Margaret’s hospice and CCG and LPC. It has been developed in order to be able to respond quickly to any shortage of Somerset’s Just in Case medication.

The exact response will depend on the circumstances of the shortage. Where advance notice is provided, prescribers are advised to make changes as soon as reasonably possible in the event of a confirmed shortage. The information below summarises agreed principles.

When converting to other subcutaneous drugs, consideration will also need to be given to drug compatibility in the syringe driver and the total volume of infused drugs.

**Opioids:**

**Morphine sulphate shortage:**

* In the event of a shortage of morphine sulphate, then diamorphine should be used.
* Morphine 10mg injection is approximately equivalent to 7.5mg diamorphine.

**Diamorphine shortage:**

* In the event of a shortage of diamorphine then morphine sulphate should be used.
* Diamorphine 10mg injection is approximately equivalent to morphine 15mg.

Care is needed when switching from one opioid analgesic to another to ensure equipotent dosage and patients should be carefully monitored after any drug switch. Dose titration may be required.

Oral codeine, dihydrocodine and tramadol

$÷2$

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$$÷10$$

**Oral** Morphine

mg/day

Oral oxycodone

mg/day

x 2

x 10

$×$ 10

x 30

Subcutaneous alfentanil

mg/day

Alfentanil is AMBER in Traffic Lights. Seek advice from specialist Palliative Team

$÷4$

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x 2

x 3

x 4

Subcutaneous oxycodone

mg/day

$÷30$

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$÷3$

*Type equation here.*30

$÷2$

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Subcutaneous **morphine**

mg/day

Subcutaneous **diamorphine**

mg/day

**Midazolam shortage:**

* If midazolam is being used as a sedative, then levomepromazine can be administered instead. Levomepromazine 12.5mg doses are usually sedating.
* If midazolam is being used as an anticonvulsant, then levetiracetam (keppra) can be used in a syringe driver. Seek advice from the palliative care team regarding dosing. Leveciracetam orally is equipotent when given sc.
* For panic and anxiety, consider SL lorazepam 0.5mg up to qds

**Levomepromazine shortage:**

An alternative antiemetic can be chosen according to the cause of the patient’s nausea.

* **Cyclizine:** consider for central/ brain causes of nausea; 50mg tds, 150mg max in syringe pump ( will need alternative eg haloperidol for prn antiemetic). NB not compatible with buscopan in a syringe pump.
* **Metoclopramide:** consider for delayed gastric emptying; 10mg tds, 30mg in syringe pump
* **Haloperidol:** consider for toxins eg renal failure, drugs, hypercalcaemia; 1.5mg od sc, 1.5mg up to max 5mg in pump.

**Buscopan shortage:**

Glycopyrronium is the preferred alternative:

For treatment of respiratory tract secretions:

The principles of positioning in bed, and attention to fluid balance remain key first priorities in treating respiratory tract secretions.

* Start with glycopyrronium 200microgram SC stat
* Can be given 4 hourly PRN
* Continue with 600–1,200microgram/24h syringe pump

For treatment of bowel obstruction:

* Glycopyrronium 200 micrograms SC for colic PRN 4 hourly
* This can be used in a syringe pump 600 -1200 micrograms/24hr in syringe pump
* Consider octreotide 300 – 600 micrograms/24hr in syringe pump to reduce GI secretion