SUFFOLK POLICY FOR FAMILY AND INFORMAL CARER ADMINISTRATION OF SUBCUTANEOUS MEDICATIONS AT THE END OF LIFE

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Version 1

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INTRODUCTION

Policies and guidance for carer and/or patient administration of subcutaneous medication in adult palliative care have been developed elsewhere within the United Kingdom.[1],[2],[3],[4],[5],[6] In Australia the benefits of this practice are reported as not only offering immediate symptom relief, but carers also valued the role and felt that it gave them a sense of empowerment, pride and achievement as opposed to feelings of hopelessness.[7] Studies have shown that with appropriate education and support, carers can confidently administer subcutaneous medication to relieve breakthrough symptoms, including providing the right medication for the particular symptom, documenting appropriately, and monitoring effectiveness.[8] In a 2017 survey by Dying Matters, six out of ten people said that they would feel comfortable giving a pain relief injection to someone who was dying and wanted to stay at home.[9]

This policy has been developed in response to a number of requests from patients and carers in the locality to be able to administer subcutaneous medication in a palliative care setting.

Carers have a significant role in symptom management and commonly administer or assist with the administration of oral medication, and subcutaneous medications such as insulin and low molecular weight heparin. In palliative care there are occasions when it may be helpful to train a patient or carer to give other subcutaneous medication including:

- Regular medication which cannot be taken orally due to issues with absorption or nausea or vomiting. Examples include short-term use to avoid the requirement of a syringe driver as a result of chemotherapy-induced nausea and vomiting, or longer term use in patients who are otherwise mobile and independent, where a syringe driver may be burdensome. Visiting times from a health care professional to maintain a syringe driver may not be convenient to the patient.
- Emergency medication for symptoms that may develop, particularly in the last days of life. National and local policy supports healthcare professionals to prescribe 'Just in Case' medication for use at the end of life. These include an opioid, sedative, antiemetic and anti-secretory and can be administered by injection as required.[10] Rapid access to this medication in the community is important to improve symptom management and can reduce unwanted or unnecessary admissions to hospital or hospice in the last days of life. Carers may express a wish to be trained to administer these medications, in the best interests of the patient, in order to provide timely access. This may be particularly relevant in more rural areas, where there is a longer wait for healthcare professionals to attend.

PURPOSE

This policy provides the guidance and associated documentation for healthcare professionals to support patients and carers in the safe administration of prescribed medication by the subcutaneous route. The guidance will:

- Facilitate effective symptom control and offer greater patient choice and informal carer involvement
- Improve patient/carer understanding of medication, their indications, actions and side effects
- Assist healthcare professionals in the training and assessment of patients and carers in a consistent and safe manner

This policy is accompanied by a "Subcutaneous Injections Booklet" (see appendices). This booklet contains all the documentation for processes needed by healthcare professionals and patients/carers:

- Summary title page, with patient demographics, relevant contact numbers, and references to a useful external website and an online training video (both produced by external agencies, but containing entirely relevant content)
- Information section for carers
- Eligibility screening process for healthcare professionals to screen carer(s)
- Written consent process for up to three carers to undertake training
- Training process for carer(s), explaining each step of the process in detail; the professional undertaking the training can sign to confirm the competency of the carer(s) at each stage
- Six administration charts, each for one medication, which are used for carers to document each time a medication is given

SCOPE

This policy relates specifically to patients/carers giving medication via a subcutaneous cannula. It works in conjunction with national and local policies on medicine storage and administration.

Implementing this practice for an individual patient/carer should be led by their needs and wishes and must not be imposed by healthcare professionals. It is not anticipated that this will be suitable for all patients/carers. It must be made clear that the patient/carer is able to stop the practice at any time or that a healthcare professional may recommend that patient/carer administration of subcutaneous medication is no longer appropriate.

DEFINITIONS

- The term 'carer' is a person who is either providing or intending to provide a substantial amount of unpaid care on a regular basis for someone who is disabled, ill or frail. Carers are usually family members, friends or neighbours and, in this policy, are not paid care workers.
- Generally, this policy will be used to train family and other informal carers (e.g. friends and neighbours), but there may be some instances in which a patient may be trained to give their own injections, such as anti-emetics or pain relief when the oral route is not available. On the whole, this policy wording will refer to carers, but may be taken to apply to the patient themselves, in relevant circumstances.
- 'Subcutaneous' injection refers to the bolus administration of medication into the tissue layer between the skin and muscle.
- 'Just in Case' medication refers to injectable medication to manage common symptoms that may occur in patients in the last days of life e.g. pain, breathlessness, agitation, nausea, vomiting, and secretions.

POLICY

ELIGIBILITY CRITERIA

In order to proceed with implementing the practice with a patient, members of the healthcare team must first screen the patient, carers and household for suitability. This process is documented in the Subcutaneous Injections Booklet, available in the appendices. Eligibility screening may be

undertaken by any competent healthcare professional (e.g. registered nurse working in community nursing team, acute trust or hospice, GP, hospice doctor). Eligibility criteria are:

- The patient is an adult, diagnosed with a terminal illness, who may experience symptoms requiring subcutaneous medication
- The patient is willing to have injections administered by their carer, OR
- The patient is unable to communicate their views due to lacking mental capacity, but there is no reason to think they would object; if there is a person with Power of Attorney for Health and Welfare, they have no objection
- The carer(s) are willing to administer subcutaneous medications and are assessed as having the physical and mental capacity to do so
- There is agreement from the multi-professional team (minimum GP and community or hospice nurse) that it is appropriate for the patient and/or carer to administer subcutaneous medication
- The patient and/or carer successfully completes the necessary training (in Subcutaneous Injections Booklet), is considered competent by a healthcare professional, and feels confident to administer subcutaneous medication

EXCLUSION CRITERIA AND CAUTIONS

- The patient or carer has been assessed and lacks the capability (physical or mental capacity) to give subcutaneous medications
- Young carers (i.e. those under 18) are not excluded from the policy, and those deemed capable may be offered training, but care must be taken to ensure that they are not put under any pressure whatsoever to take part. Their own needs as a young carer must be considered, for example, that it does not have a negative impact on their education, wellbeing or development. Consideration also needs to be given to the young carer's age, understanding, family circumstances, wishes and the view of their parents/guardian.
- The patient or carer has a known history of substance misuse, or there are concerns regarding this
- There are concerns relating to substance abuse involving other persons who may have access to the home environment
- There are safeguarding concerns in relation to the patient or relevant carers, e.g. concern that the carers may not administer the medication in the best interests of the patient
- If the patient or carer are known to test positive for a blood-borne virus such as HIV or Hepatitis B or C, because of increased risk in the event of a needle-stick injury occurring, further risk assessment should be undertaken

RISK MANAGEMENT

- Sensitive discussion with any carers involved in the administration of subcutaneous medication should take place. This should explore how the carer may feel about undertaking the task and the giving of medication to relieve symptoms when the patient is close to death. Specifically, there should be discussion about the possibility that a patient may die shortly after medication is administered, and how a carer may feel in this situation. Healthcare professionals should offer increased support when it is recognised that the

patient may be in the last days or hours of death and offer to take over full responsibility for administering all medication at this point if the carer would prefer this.

- The prescriber will need to consider the types and number of injections available for the patient or carer to give. It may be that not all of the prescribed subcutaneous medications are appropriate to be given by the patient or carer. Only those medications which the carer has been assessed to safely administer should be written up on the administration chart in the Subcutaneous Injections Booklet.
- Patients/carers must be provided with written information for each medication including the name, dose, interval before a repeat dose is permitted, maximum number of doses in 24 hours, indication, and common undesirable effects. This will all be documented on the administration charts in the "Subcutaneous Injections Booklet" – see procedure below.
- Patients/carers must keep a record of all injections given, on the correct medication page in the Subcutaneous Injections Booklet. This must include date, time, dose, name of person giving the injection, and relevant comments such as whether they were advised to give the injection by a healthcare professional, and whether it worked to ease symptoms.
- Patients/carers must be provided with a 24-hour contact telephone number for the community nursing team.
- The patient/carer can administer an agreed maximum number of prescribed injections in any 24-hour period. This will be documented in the Subcutaneous Injections Booklet. They will be encouraged to consult the GP/Out of Hours Doctor or community nursing team if frequent injections are required, to review their effectiveness, to ensure any background medication (e.g. in a syringe driver) is reviewed, and that the doses of the subcutaneous medication are appropriate.
- The community nursing team should ensure that adequate supplies of the medications for injection are available, on a regular basis.
- Patients and carers will be provided with a sharps bin and taught the correct technique for sharps disposal.
- In the Subcutaneous Injections Booklet, patients and carers will be provided with information advising them of the correct steps to be taken in case of needle stick injury: make it bleed, wash it, cover it and report it to the GP and registered nurse immediately to report, according to local incident reporting policy.
- Should any medication errors or incidents occur this should be communicated to those involved in the patient's care immediately, and reported and investigated in accordance with local incident reporting policy. The incident should be investigated as soon as possible and, where necessary, the administration of subcutaneous medication by the patient or carer will cease and any further injections will be given by healthcare professionals
- Missing drugs: if the stock balance checks reveal that medications are missing which can't be accounted for (despite careful repetition of the stock check):
    - suspend carer administration immediately, and hold discussion with the family. With the patient/family's permission, assist them to conduct a search of relevant areas of the household, where appropriate
    - It should be checked whether the carers are documenting every medication administration correctly. Relevant portions of the training should be repeated.
    - If this does not resolve the situation, or there is serious cause for concern at any point, patient/carer administration should be immediately suspended, pending resolution

    - The incident must be discussed with relevant members of the MDT (i.e. community nursing team, GP, hospice if applicable)
    - The incident must be reported in line with local incident reporting procedures
    - If the missing medications are controlled drugs (i.e. opioid, midazolam), in addition to local processes, the matter should be reported to the police officer for controlled drug inspection via any of the below methods:
        - 01473 613 888 ext. 2869, or 07979 178 664
        - robin.pivett@suffolk.pnn.police.uk (secure email if sent from nhs.net)
    - The CD inspection team does not operate out of hours, but will pick the case up on the next working day and investigate as appropriate to determine whether the CDs are classed as missing or stolen; they will liaise with the CD Accountable Officer
    - Sharing information with an external party such as the police is a decision on which it may be appropriate to see the advice of the relevant Caldicott Guardian – this should be discussed by the MDT handling the case.
- Regarding patients/carers who are also doctors, General Medical Council (GMC) guidance states 'wherever possible you should avoid providing medical care to anyone with whom you have a close personal relationship'.[11] Advice was sought from the GMC during the formulation of this policy, as to whether family members who are doctors, who wish to undertake giving subcutaneous injections under this policy, would need to seek GMC guidance before doing so. The GMC's full response may be found in the appendices to this policy. In summary, the GMC guidance acknowledges that there may be occasions when treating a loved one is the only feasible option, and it will be a matter of judgement as to whether the situation this policy makes provision for is considered one of these occasions. The response also states that the GMC guidance is not a rule book, and there may be times when doctors can justify deviating from GMC guidance. There is no regulatory requirement for a doctor to contact the GMC for advice prior to providing treatment to a family member. Should they wish to do so, however, the standard response time is up to 15 days, though it could be highlighted that a response was urgent.
- Regarding patients/carers who are also nurses, The Nursing and Midwifery Council (NMC) Code (2015) does not state anything which would prevent nurses from undertaking this training.[12]
- Family members who also happen to be healthcare professionals may be therefore treated as any other family carer undertaking this process; they should undergo the full competency training process and be offered the same support and supervision.

CONSENT

Where the patient has the capacity to consent to the carer administering subcutaneous medication, this will be sought. It is however recognised that a number of patients will not have the capacity to agree to this and so the procedure may be undertaken in the patient's best interest. This should be documented according to local Mental Capacity Policy using the appropriate documentation. Carers will also require the mental capacity to undertake this delegated task.

Written consent from the carer(s) being trained is obtained in the Subcutaneous Injections Booklet. It should be documented in the patient's healthcare record that this has taken place.

PROCEDURE FOR IMPLEMENTATION OF PROCESS

1. **Idea to use the carer subcutaneous injections process originates:** a patient with a diagnosis of a terminal illness, or their carer, expresses a wish to undertake the administration of subcutaneous medication to facilitate the management of symptoms. This request may originate with the patient/carer, or follow a suggestion from a healthcare professional that it would be suitable.
2. **Eligibility screening:** there must be a discussion with the multi-professional team caring for the patient (minimum GP and community nurse, who must be familiar with the policy), to ensure that the patient/carer meets the inclusion criteria. The local palliative care teams will also support the practice. Once this has been agreed, it may be discussed in more detail with the patient/carer.
3. **Explanation:** a description of the procedure is discussed in detail with the patient or carer so that they may better understand what is required of them. When appropriate, this should include exploration of how the carer may feel about giving medication to relieve symptoms if the patient is close to death. Specifically, there should be discussion about the possibility that a patient may, by coincidence rather than through causation, die shortly after administering medication, and how a carer may feel in this situation. The carer should be reassured that, when used as directed, subcutaneous injections will not hasten or cause death.
4. **Written consent:** if they wish to proceed, the carer(s) sign the written consent process in the Subcutaneous Injections Booklet. Up to three named carers may be trained.
5. **Drugs prescribed and dispensed**: if not already in place, just in case medications must be prescribed for the patient:
    a. Four key drugs to treat: pain and breathlessness (an opioid); anxiety/distress/agitation (midazolam); nausea/vomiting (an anti-emetic); respiratory secretions (an anti-secretory)
    b. The specific medications which the patient/carer may administer by subcutaneous injection must be agreed (this may not necessarily include all the prescribed subcutaneous medications)
    c. Medications for use by the carer are listed in the Subcutaneous Injections Booklet with one medication per page; these may be written out by the prescriber, or transcribed by an appropriately trained nurse from a prescription, providing it contains full and clear details
    d. Where a range of doses of a medication is prescribed, the prescriber should advise the patient/carer to administer a set dose within the range and to seek advice if this requires adjustment; this aims to reduce the burden on the patient/carer in decision-making
    e. The maximum number of doses which the carer may administer before seeking help, for each drug, must be agreed.
6. **Training:** the Subcutaneous Injections Booklet contains a training package, to be completed with the carer(s) by a registered nurse or doctor. Each point of competency is outlined and the carer is signed off as competent on each point, after discussion and observation with the training professional. This may be done in a single training session or across several.
7. **Practising with a real drug:** the trainer must either supervise the patient/carer administering a named medication, if it is clinically appropriate to do so during the training (e.g. if the patient is in pain at the time) or observe them flushing the line with 0.3ml water for

injection, or other simulated training, which may include drawing up a dose of medication and discarding it.

8. **Documentation:** training should ensure that the patient/carer is familiar with recording of medication administered (date, time, dose) on the administration charts in the Subcutaneous Injections Booklet.
9. **Sharps management**: patients/carers must be trained in the safe disposal of sharps and understand the management of needle stick injuries; this is listed as a competency in the training package.
10. **Errors:** patients/carers must be aware of the process to follow in the event of a medication error or incident; this is listed as a competency in the training package. All incidents must be reported and investigated in accordance with local incident reporting policy.
11. **Support:** the registered nurse must ensure that the patient/carer has 24-hour contact details for the community nursing team; this is documented on the title page.
12. **Carer recorded as competent:** the electronic healthcare record should be updated by the trainer to record that the patient/carer is trained to administer subcutaneous medication. It is recommended that this information is included on SystmOne as a 'high priority reminder' as part of the care plan. If the GP uses a different electronic clinical record (e.g. EMIS) then the trainer is responsible for informing the practice and recommending this information is recorded in the record.
13. **Follow up agreed:** the frequency of contact by nursing teams must be agreed with the patient/carer and recorded within the SystmOne record. The patient/carer should contact the community nursing team after each administration of subcutaneous medication, unless a visit from them is already planned within the next 24 hours.
14. **Ready to start:** patient/carer may now commence administration of subcutaneous injections
15. **Maintaining and monitoring drug and equipment supplies:** the community nursing team should ensure that adequate supplies of the medications for injection and necessary equipment (e.g. needles, syringes) are available, on a regular basis. The stock levels of subcutaneous medications held in a patient's home must be counted at every visit by the community nursing team (minimum weekly), and recorded on their stock balance charts.
16. **Management of cannula:** the community nursing team must visit regularly to check on the integrity of the subcutaneous cannula, and to change it periodically, as per local policy. Generally it is recommended that the cannula is changed weekly as a minimum, but this may need to be sooner, to maintain patency.
17. **Doses/medications amended:** further support should be offered to the patient/carer after any change of dose. Any additional training or supervision can be recorded in the booklet.
18. **Record storage:** the Subcutaneous Injections Booklet must be retained in the home of the patient with their paper-based community record. It is good practice to have a copy of this form scanned into the electronic healthcare record for the patient once the booklet is complete. This will usually be after the patient has died.
19. **Concerns arising:** if any concerns arise about the competency of the patient/carer to continue administering subcutaneous injections, they should be offered additional support, if appropriate. This may include repeating the training and competency assessment. If concerns remain despite additional support, this should be discussed urgently with relevant members of the MDT (e.g. GP, community nurse, palliative care team). Consider suspending or terminating patient/carer administration of subcutaneous injections.

ROLES AND RESPONSILBILITIES

Patient and carer administration of subcutaneous medication is supported by national policy, legislation and professional governing bodies:

- The General Medical Council (GMC) advises that 'when you delegate care you must be satisfied that the person to whom you delegate has the knowledge, skills and experience to provide the care involved'.[13]
- The Nursing and Midwifery Council (NMC) Code (2015) advises to 'only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions. Make sure that everyone you delegate tasks to is adequately supervised and supported, and confirm that the outcome of any task you have delegated to someone else meets the required standard.'[14]

The decision for patients or carers to administer subcutaneous medication should be made by a multi-professional team (minimum GP and community nurse).

The community nurse responsible for assessing and overseeing the patient's care is responsible for ensuring the procedure for patient/carer administration of subcutaneous medication is followed and is continuously reviewed and monitored. They should ensure the patient or carer administering the injection has been trained and is competent to do so using the step-by-step assessment procedure. Registered nurses will be responsible for maintaining and updating their own knowledge and practice in the administration of medication.

The frequency of contact by a community nurse must be agreed with the patient/carer and recorded on SystmOne. Visits should ensure that symptoms are controlled, injection sites remain healthy and should provide support to the patient and their carer. If medication doses are adjusted the nursing team will support the patient/carer with any additional training required. The nursing team will also be responsible for oversight of the storage and monitoring of the controlled drugs in the patient's home, to identify discrepancies between expected and actual stock levels, as soon after they occur as possible.

All members of the clinical team have a responsibility to act if concerns arise about the ongoing fitness of the patient/carer to administer subcutaneous injections.

CONSULTATION, APPROVAL AND RATIFICATION PROCESS

Appendix 1 details the stakeholder groups and individuals who have been consulted in the production of this policy.

DISSEMINATION AND IMPLEMENTATION

This policy will be implemented by West Suffolk CCG and Ipswich and East Suffolk CCG in Suffolk Community Healthcare nursing teams, community palliative care teams run by St Nicholas Hospice Care and St Elizabeth Hospice, and promoted to GPs. Existing meeting structures and communication channels will be used.

APPENDIX 1: STAKEHOLDER CONSULTATION AND APPROVAL

Listed individuals have been consulted on behalf of their organisation, and any feedback incorporated as appropriate.

Name	Role	Organisation
Sarah Mollart	Policy author, Consultant in Palliative Medicine	SNHC (St Nicholas Hospice Care)
Mary McGregor	Consultant in Palliative Medicine	SNHC and WSHFT
Gemma Lockyer	Community team manager	SNHC
Dawn Prigg	Clinical Operations Manager	SNHC
Shelley Lee	Community Matron	WSHFT (West Suffolk Hospital FT)
Amanda Keighley	Senior Matron for Community Services	WSHFT
Sharon Basson	Head of Nursing, Community and Integrated Services Division	WSHFT
James Heathcote	Deputy Medical Director for Primary Care	WSCCG (West Suffolk CCG)
Andrew Yager	GP, Governing Body WSCCG	WSCCG
Kate Vaughton	Chief Operating Officer	WSCCG
Linda Lord	Chief Pharmacist	WSCCG
Kelvin Bengtson	Consultant in Palliative Medicine	St Elizabeth Hospice
Alison Blaken	Consultant in Palliative Medicine	St Elizabeth Hospice
Cecily Wright	Consultant in Palliative Medicine	James Paget Hospital
Verity Jolly	Clinical Services Director	St Elizabeth Hospice
Rachel Shallis	IPU CNS	St Elizabeth Hospice
Rebecca Pulford	Associate Director of Nursing	ESNEFT (East Suffolk North Essex FT)
David Egan	GP Prescribing Lead	IESCCG (Ipswich & East Suffolk CCG)
Rifat Choudhury	Chief Pharmacist	IESCCG
Lisa Nobes	Director of Nursing and Clinical Quality	WSCCG and IESCCG
Sheila Smyth	Director of Community Care Services	Suffolk GP Federation
Martin Edwards	Chief Nurse	Suffolk GP Federation
Marilyn Harvey	Adult Safeguarding Lead	Suffolk Community Healthcare
Gill Jones	Community Development Manager	Healthwatch Suffolk

APPENDIX 2: GMC RESPONSE REGARDING FAMILY CARERS WHO ARE ALSO DOCTORS

Thank you for your enquiry about a policy and practice document you are developing on supporting willing family carers to give subcutaneous (SC) injections for symptom control at the end of life.

In your email, you explain that the suggested policy would be to allow certain family carers to extend their current abilities to administer oral symptom control medications and certain SC injections (e.g. insulin, heparin), to giving injections of opioids and others medications used at the end of life, for patients wishing to remain at home to die. You also suggest that where the willing family carer is a doctor, it might be unclear whether it would be appropriate for them to fulfil such a role and you ask us whether, in those cases, the doctor needs to contact the GMC beforehand (and if so, what the relevant contact details are and what the timeframes for a response would be).

Before I respond to your specific questions, I will briefly outline the relevant GMC ethical guidance and explain its role in decision making.

You correctly point out that paragraph 16 g) of Good Medical Practice states that, wherever possible, doctors must not provide clinical care to people they are in a close personal relationship with.

The rationale for this concerns the potential for loss of objectivity when doctors are involved in treating people with whom they have a close relationship. We also know that doctors may find themselves in circumstances where they come under pressure from someone close to provide inappropriate or unsafe treatment. Knowing that boundaries have been set by their regulator can be helpful in managing expectations and supporting doctors to respond appropriately to pressure.

However, we do not say absolutely that doctors must never treat family members. Firstly, you will note that the sentence starts with the preface 'wherever possible'. So, although it is generally inappropriate to provide clinical care to someone the doctor has a close personal relationship with, the guidance acknowledges that there may be times when this is the only feasible option. It may, however, be a matter of judgement as to what types of situation might fall under this.

Secondly, it is important to clarify that that our guidance is not a rule book and, as I pointed out above, although it is generally inappropriate for a doctor to provide treatment to someone they are in a close personal relationship with, there may be times when it is justifiable to deviate from this. Doctors, when applying the principles of our guidance to their practice or conduct, should exercise their professional judgement – and if they felt justified in departing from our guidance, they would need to record their reasons for this and be prepared to defend their decision, if necessary.

Therefore, careful consideration must be given to the risks and the alternatives available for meeting the patient's needs. The onus is on individual doctors to consider whether, in the particular circumstances which they face, they can justify a decision to provide treatment to their family member.

It is also relevant to point you in the direction of paragraphs 17 – 19 of our 'Good practice in prescribing and managing medicines and devices' guidance which provides additional detail on this topic. Although the scenario you describe is not a prescribing one, the same principles will apply (although, possibly, to a greater degree in a prescribing context).

Those paragraphs state that:

17 Wherever possible you must avoid prescribing for yourself or anyone with whom you have a close personal relationship.

18 Controlled medicines present particular dangers, occasionally associated with drug misuse, addiction and misconduct. You must not prescribe a controlled medicine for yourself or someone close to you unless:

- no other person with the legal right to prescribe is available to assess and prescribe without a delay which would put your, or the patient's, life or health at risk or cause unacceptable pain or distress, and
- the treatment is immediately necessary to:
    - save a life
    - avoid serious deterioration in health, or
    - alleviate otherwise uncontrollable pain or distress.

19 If you prescribe for yourself or someone close to you, you must:

- make a clear record at the same time or as soon as possible afterwards. The record should include your relationship to the patient (where relevant) and the reason it was necessary for you to prescribe.
- tell your own or the patient's general practitioner (and others treating you or the patient, where relevant) what medicines you have prescribed and any other information necessary for continuing care, unless (in the case of prescribing for somebody close to you) they object.

You will note that this guidance takes account of the particular risks in relation to controlled drugs.

A final point to raise about our guidance on this topic is that it will also apply to other types of care, such as administering oral medication. If my understanding is correct, some doctors may already be administering such care to family members at the end of their lives in their homes.

In terms of answering your specific questions, you ask whether it would be 'necessary' for doctors to contact us if they are considering administering the type of treatments covered under your new policy, in their role as a 'willing family carer'. Similarly, you also ask whether the advice in other similar policies (in other regions) to contact us is correct or appropriate.

From our point of view, there is no regulatory (or legal) requirement for a doctor to contact us in these circumstances. If doctors are comfortable that they are meeting our guidance or can justify any departure from it, this should not be necessary. However, if a doctor were in any way concerned or would like clarification on a particular matter, they would, of course, be welcome to contact us.

In terms of contact details, you are correct that it is: standards@gmc-uk.org. The standard response time could be up to 15 working days, although the doctor could, of course, highlight whether a response was urgent. Another option would be for the doctor to contact their defence organisation (if they are a member of one).

I hope this is helpful. If you have any more questions, please don't hesitate to get in touch.

Jessica Watkin, Policy Manager, General Medical Council, 25.1.2019

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