

National Core Community Palliative Care Medicines List

What is the National Core Community Palliative Care Medicines List?

The National Core Community Palliative Care Medicines List (the List) identifies four medicines for use by home-based palliative patients in the terminal phase who require urgent symptom relief. Most common terminal phase symptoms in uncomplicated palliative care patients can be optimally managed using medicines from the List.

The National Core Community Palliative Care Medicines List

MEDICINE		CLINICAL USES FOR THE TERMINAL PHASE
Clonazepam	2.5 mg/mL drops AND/OR 1 mg/mL injection	Seizure, anxiety, dyspnoea/distressing breathlessness, terminal restlessness/agitation
Haloperidol	5 mg/mL injection	Delirium, nausea/vomiting, terminal restlessness/agitation, refractory distress
Hyoscine butylbromide	20 mg/mL injection	Respiratory tract secretions/noisy breathing (prophylactic)
Morphine	10 mg/mL injection	Pain, dyspnoea/distressing breathlessness

Clinical context

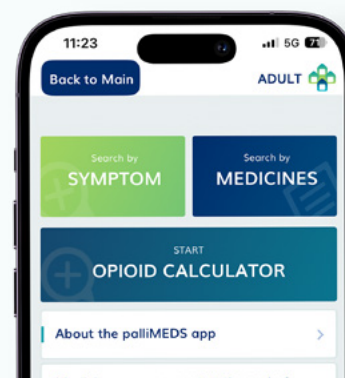
Most palliative care patients say they would like to be cared for, and to die, at home. However, palliative patients are inherently unstable; deterioration can occur at any time and distressing symptoms can suddenly emerge. Palliative patients need timely access to symptom control medicines to avoid unnecessary suffering and/or unwanted transfers to inpatient facilities.

Recommendations

- Prescribers caring for home-based palliative patients become familiar with prescribing and consider using the medicines in the List, where clinically appropriate.
- Community pharmacists stock the medicines in the List to allow rapid dispensing and timely and easy access for patients and list *Palliative medicine service* as part of their listed service offerings on Healthdirect.
- State/territory governments or local networks (e.g. Primary Health Networks, GP practices, community pharmacies):
 - Promote the List to their networks
 - Consider aligning state/territory or local core palliative medicines lists to the List to promote standardisation of best-practice care.

Education for prescribers

Prescribers can access prescribing information about the medicines on the List via the free **palliMEDS app**.



Why was the List developed?

In response to requests from key national stakeholders, in 2024 the Australian Government Department of Health and Aged Care supported caring@home to develop a core medicines list applicable across all Australian states and territories. The List is a vital tool that supports standardised, quality palliative care by improving access to medicines in the community.

How was the List developed?

In 2024, caring@home convened a national Working Party of clinicians (palliative medicine specialists, rural generalists, general practitioners, pharmacists, nurses) who developed version 1 of the List.

The Working Party reconvened in 2026 to review the List.

Working Party representative organisations

- ACT Health
- Agency for Clinical Innovation – End of Life and Palliative Care Network, New South Wales
- Australia New Zealand Society of Palliative Medicine (ANZSPM)
- Australian College of Nurse Practitioners (ACNP)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Commission on Safety and Quality in Health Care (ACSQHC)
- Department of Health, Tasmania
- Metro South Palliative Care Service, Metro South Health Queensland
- Northern Territory PHN (NTPHN)
- Palliative Care Australia (PCA)
- Pharmaceutical Society of Australia (PSA)
- SA Health
- Safer Care Victoria
- The Royal Australian College of General Practitioners (RACGP)
- Western Australia Country Health Service (WACHS)
- Western New South Wales Local Health District (LHD).

Working Party guiding principles

The Working Party followed two guiding principles to determine medicines to include in the List.

1. The List should be informed by the Palliative Care Therapeutic Guidelines, Therapeutic Goods Administration, and existing state/territory lists of core palliative care medicines.
2. Criteria when considering medicines to be included were:
 - Evaluation of evidence for management of symptoms common at end of life
 - Consideration of the cost of medicines, including the availability of PBS subsidies
 - If there is equivalent efficacy between two medicines consideration of both:
 - medicines that can address more than one frequently encountered symptom
 - most community friendly form of administration/transport/storage of medicine available.

More information

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