**KENT & MEDWAY PALLIATIVE CARE COMMUNITY PRESCRIPTION CHART**

**Date Started:**

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| **Patient Details** | | | |
| **Drug Sensitivities / Allergies** | Patient Name: | | |
| Print in Black Ink. Outline in **Red Ink.**  Specify previous reactions where known. | Address:  Date of Birth: NHS Number: | | |
| Source(s) of information: | Weight (kg): | Creatinine: | eGFR\*: |
| Recorded by: Date: | Date: | Date: | Date: |

\*Renal function impacts on opioid clearance; seek advice if eGFR <30mls/min

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| **Names of Health Professionals involved with patient care, including medical and non-medical prescribers:** | | | | | |
| **Full Name** | **Signature** | **Initials** | **Designation** | **Registration No.** | **Base** |
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| **General Practitioner** | **Additional support with medicines:** |
| GP Name: | Details, e.g. compliance box: |
| GP Practice: | Patient’s preferred Pharmacy: |
| Email Address: | Address: |
| Telephone Number: | Telephone Number: |

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| **Instructions: PRESCRIBERS** | | | **Instructions: NURSES or other HEALTHCARE STAFF** | | | |
| * **Prescribing must be individualised for the patient** * Write all entries in black ink. * Use approved names written in **BLOCK CAPITALS**. * Avoid abbreviations. Write ‘micrograms’ in full. Write ‘units’ in full. * Ensure you are familiar with the medicine and that the dose, frequency, route and duration are appropriate. * All parenteral medicines should be prescribed by the subcutaneous (SC) route as the first line. Intramuscular (IM) administration can be considered (If not contra-indicated). If the route changes, ensure this is documented on the chart and in the patient’s notes to avoid potential errors. * When prescribing PRN (when necessary) medication, please specify the **indication** and **MAX dose** required. * A start date must be written; otherwise, medicine will not be given. * The duration of therapy must be stated for a course of treatment. * Complete the Drug Sensitivities / Allergies section. * When changing to a lower or higher dose of a medicine or changing the frequency of dosing, “cross off” the entry and re-prescribe completely. **Add your initials and the date. Document reason.**   The existing entry must not be amended, nor should an additional entry for the same medicine be made, as this can lead to confusion about intention.   * Discontinue a medicine by crossing through it (top left to bottom right) and cancelling subsequent panels. Add your initials and the date. **Document reason**. | | | * For the charts to be legally valid, they **MUST** be signed by a prescriber, and this signature must be legible. Electronic/ typed signatures are accepted, provided they are paired with the prescriber’s registration number. (Provide specimen signatures and initials that you will use on prescription charts). * If more than one prescription chart is needed, ensure they are punched and tagged together. * Ensure that the Drug Sensitivities / Allergies section is complete.   Do NOT administer if this section is not filled in.   * Check every page methodically at every medicine administration. * Initial the appropriate box immediately after administration. * If a medicine is not administered, one of the omission codes must indicate the reason on the chart. Use the ‘Special Information’ section if further explanation is necessary. * It is the responsibility of every healthcare professional to ensure that staff on subsequent shifts have enough space to record medicine administration on the chart and that there are sufficient supplies of in-date medicines. | | | |
| **Guidance in Anticipatory Prescribing at the End of Life** | | | | |
| ***For detailed advice, refer to the Kent & Medway Symptom Control and Care of the Dying Patient: Palliative Care Guidelines.*** [*https://book.pallcare.info*](https://book.pallcare.info)***and***[*Scottish Palliative Care Guidelines | Right Decisions*](https://rightdecisions.scot.nhs.uk/scottish-palliative-care-guidelines/)  **Use caution and seek specialist advice for patients if** (this list is not exhaustive). For contact details, refer to the drug chart on the back page.   * Complex symptom control persists despite optimising treatment * Severe renal/hepatic impairment * Neurological disorders such as dementia, Parkinson’s, epilepsy, multiple sclerosis, motor neurone disease, etc. * Opioid use in impaired respiratory function   **General Guidance:**   * Prescribe proactively using the template as a guide. **Individualise prescribing following patient assessment.** * Remember to review all other medication (PRN and opioids). If the background analgesia is changed, then PRN requires review. Discontinue medicines as appropriate. * For people starting treatment who have not previously been given medicines for symptom management, start with the lowest effective dose and titrate as clinically indicated. * **Starting a syringe pump**: A syringe pump will take a number of hours to reach therapeutic levels. Therefore, it is good practice to give a ‘stat’ dose of necessary medicines when starting a syringe pump. **It is NOT necessary for a patient to have had a certain number of ‘stat’ doses before starting a syringe pump. A syringe pump is set up when the patient needs it.** * A range of doses can be prescribed to allow dosing flexibility; however, an excessively wide range is not acceptable. **A range starting at zero is not recommended.** A person setting up the syringe pump may decide to omit medicines following patient assessment. If a dose is omitted, use a relevant omission code (see page 6) and document the reason under ‘Special Information’. * **Calculating a ‘breakthrough dose:** The PRN dose must be reviewed when starting a syringe pump. The guidance PRN dose would be 1/6th of the total daily opioid dose. **Seek further advice if necessary.** * **Transdermal opioids:**  If setting up a syringe pump in a patient using transdermal patches, continue with the patch as usual and ‘top up’ the analgesic requirements with the infusion. Remember to include the opioid dose equivalent within the patch as well as the syringe pump when calculating the breakthrough dose of opioids. * The patient’s individualised treatment, including a review of prescribed medicines, should be reviewed according to local policy, individual patient circumstances, and the frequency of multidisciplinary meetings. **There is no legal requirement to revalidate the documentation at 28 days.**   **A review interval of no more than 6 months is recommended. If needed, please individualise the review interval for the patient.** | | | | |
| **Indication**\* | **Drug** | | **Syringe Pump dose over 24 hrs**  **(Continuous subcutaneous infusion CSCI)** | **PRN ‘breakthrough’ dose**  **(Subcutaneous injection)** |
| **Pain** | **Morphine Sulphate** Use with caution in renal impairment | | See conversion charts.  Caution: opioid naïve patients. | Divide the 24-hour dose by 6 to get  4 hourly doses.  Note: Alfentanil is not used PRN due to  its short half-life. |
| **Oxycodone** Use with caution in renal impairment | |
| **Alfentanil** is theOpioid of choice for severe renal impairment | |
| **Breathlessness** | **Opioid** Use with caution in renal impairment | |
| **Nausea and Vomiting**  *Consider:*   * *Clinical toxicity (e.g. drug-related) / metabolic or biochemical upset* * *Motility disorders* * *Intracranial disorders* * *GI irritation* * *Multifactorial/unknown/refractory* * *Higher centres*   *Many of the antiemetic drugs prolong the QT interval – check individual drugs before prescribing if concerned.*  *Please seek specialist advice in patients with Parkinson’s Disease.* | **Levomepromazine**  *Multifactorial/unknown/refractory, including higher centre.* | | Usual starting dose range  5 to 12.5 mg / 24hrs | 2.5 mg to 10 mg every 6 hours  (Total max 25mg in 24 hours  for nausea and vomiting) |
| **Cyclizine**  *Intracranial disorders.*  *Avoid in severe heart failure due to tachycardia.* | | Usual starting dose range  100 to 150 mg / 24hrs  Note: Use Water for Injection as a diluent | 50 mg every 8 hours  Total max dose 150mg in 24 hours  (including syringe pump) |
| **Metoclopramide**  *Motility disorders.*  *The prokinetic effect of metoclopramide will be lost if prescribed with an antimuscarinic drug such as cyclizine, levomepromazine or hyoscine butylbromide (Buscopan®).*  *Avoid long-term high-dose exposure.* | | Usual starting dose range  30 to 60 mg / 24hrs | 10 to 20 mg every 8 hours |
| **Haloperidol**  *Metabolic / toxicity / drug related.* | | Usual starting dose range  500 micrograms to 1.5 mg / 24hrs | 0.5 to 1.5mg every 4 hours |
| **Anxiety/Panic** | **Midazolam** | | 10 to 60 mg | 2.5 to 5 mg every 2 hours, increased to  10mg if necessary |
| **Agitation / Confusion / Terminal Restlessness** | **Levomepromazine** | | 25 to 100 mg  Higher doses on specialist advice only. | 12.5 mg to 25 mg every 4 hours |
| **Midazolam** | | 10 to 60 mg | 2.5 to 10 mg when necessary |
| **Convulsions** | **Midazolam** | | 20 to 30 mg | 5 to 10 mg. Repeat if necessary.  Max 20mg and then seek advice. |
| **Respiratory Secretions** | **Glycopyrronium** | | 600micrograms to 1.2 mg | 200 micrograms every 2 to 4 hours  Total max dose 1.2mg in 24 hours  (including syringe pump)  Higher doses on specialist advice only. |
| **Suggested quantities to supply. Please individualise quantities and strengths for the patient** | | | | |
| * **Morphine sulphate**   10 mg/1ml (10 x 1ml ampoules) or (30 mg/1ml if on larger doses)   * **Oxycodone**   10 mg/1ml (10 x 1ml ampoules) or 20 mg/2ml (10 x 2ml ampoules)   * **Alfentanil** NB Multiple strengths available. Caution advised.   Refer to important safety information in the BNF.   * **Glycopyrronium**   200 microgram/1ml (10 x 1ml amps) or  600 microgram/3ml (10 x 3ml amps) | | | * **Midazolam** 10 mg/2ml (10 x 2ml ampoules)   *NB Multiple strengths available, but 10 mg/2ml is preferred.*   * **Levomepromazine** 25 mg/1ml (10 x 1ml ampoules) * **Cyclizine** 50 mg/1ml (10 x 1ml ampoules) * **Haloperidol** 5 mg/1ml (10 x 1ml ampoules) * **Metoclopramide** 10 mg/2ml (10 x 2ml ampoules) * **Water for Injection** (10 x 10ml ampoules) * **Sodium Chloride 0.9%** (10 x 10ml ampoules) | |

**A Guide to Equivalent Doses for Opioids**

1. **The preferred option for the calculation of opioid conversions is to use the online converter or associated ‘app’:**

*PallCare Matters* [*http://book.pallcare.info*](http://book.pallcare.info)

1. **This chart provides approximate equivalent opioid doses and only forms part of a prescribing decision. Specialist advice should be sought if there are uncertainties about how to prescribe on an individual basis (for example, when higher doses are required, renal impairment, concerns about lack of response when titrating medicines).**

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| **Morphine** | | | | |  | **Oxycodone** | | | |  | **Diamorphine** | | **Alfentanil** |  | |
| **Oral** | | | **Parenteral** | |  | **Oral** | | **Parenteral** | |  | **Parenteral** | | **Parenteral** | **Transdermal\*\*** | |
| 24-hour total Morphine | Morphine modified release tabs/caps | Morphine solution  or  immediate  release tabs | Morphine by syringe  pump | Morphine prn SC |  | Oxycodone modified release tabs | Oxycodone  solution  or  immediate release  tabs/caps | Oxycodone by syringe  pump | Oxycodone prn SC |  | Diamorphine by syringe  pump | Diamorphine prn SC | Alfentanil  by syringe  pump | Fentanyl  patch | Buprenorphine patch |
| mg/24hrs | mg/12hrs | mg/4hrs | mg/24hrs | mg/prn |  | mg/12hrs | mg/4hrs | mg/24hrs | mg/prn |  | mg/24hrs | mg/prn | mg/24hours | micrograms/hr | micrograms/hr |
| 30 | 15 | 5 | 15 | 2.5 |  | 10 | 2.5 | 10 | 2.5 |  | 10 | 2.5 | 1 | 12 | 10 |
| 60 | 30 | 10 | 30 | 5 |  | 15 | 5 | 15 | 2.5 |  | 20 | 5 | 2 | 25 | 20 |
| 100 | 50 | 15 | 50 | 7.5 |  | 25 | 10 | 25 | 5 |  | 30 | 5 | 3 | 37 | 35 |
| 120 | 60 | 20 | 60 | 10 |  | 30 | 10 | 30 | 5 |  | 40 | 7.5 | 4 | 50 | 52.5 |
| 180 | 90 | 30 | 90 | 15 |  | 45 | 15 | 45 | 7.5 |  | 60 | 10 | 6 | 75 | 70 |
| 240 | 120 | 40 | 120 | 20 |  | 60 | 20 | 60 | 10 |  | 80 | 15 | 8 | 100 | 105 |
| 360 | 180 | 60 | 180 | 30 |  | 90 | 30 | 90 | 15 |  | 120 | 20 | 12 | 150 | 140 |
| 480 | 240 | 80 | 240 | 40 |  | 120 | 40 | 120 | 20 |  | 160 | 25 | 16 | 200 |  |
| 600 | 300 | 100 | 300 | 50 |  | 150 | 50 | 150 | 30\* |  | 200 | 35 | 20 | 250 |  |
| 800 | 400 | 130 | 400 |  |  | 200 | 70 | 200 | 35\* |  | 250 | 40 | 25 | 325 |  |
| 1000 | 500 | 160 |  |  |  | 250 | 80 | 250\* | 40\* |  | 300 | 50 | 30 | 400 |  |
| 1200 | 600 | 200 |  |  |  | 300 | 100 | 300\* | 50\* |  | 400 | 60 | 40 | 500 |  |

* + The conversions in this table are a pragmatic mix of the ‘traditional’ and ‘progressive’ methods used in the online converter tool. Dose conversions should be individualised.

They are likely to need to be adjusted according to the response. Consider a dose reduction of 25-50 % to allow for incomplete cross-tolerance.

* + Higher doses of morphine are too large a volume for SC injection.
  + \*Oxycodone injections beyond 20mg as a PRN dose and 200mg via a syringe pump are likely to require the oxycodone concentrated injection of 50mg/ml. It should be noted that this is expensive, and alternative opioids may be another option.
  + \*\*Use caution when calculating opioid equivalence for transdermal patches. Conversions to and from fentanyl and buprenorphine patches should be checked against the manufacturer’s guidance.
  + For any other opioids, e.g. codeine or tramadol, please refer to the online opioid converter.

Reference: <https://book.pallcare.info>

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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PALLIATIVE MEDICINES TO BE GIVEN AS REQUIRED – Prescribe pro-actively – Refer to page 2 for guidance** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for use  **PAIN / BREATHLESSNESS** | Drug  *\*Patients already on opioids should have individualised prescription* | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose range | Route  **SC** | Frequency | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maximum dose per 24 hours | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason for use  **NAUSEA AND/ OR**  **VOMITING** | Drug (see prescribing guidance) | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose range | Route  **SC** | Frequency | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maximum dose per 24 hours | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason for use  **ANXIETY / SEDATION/**  **AGITATION** | Drug  **MIDAZOLAM** | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose range  **2.5mg to 5mg** Increased to 10mg  if necessary | Route  **SC** | Frequency  **every 2 hours** | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maximum dose per 24 hours | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason for use  **RESPIRATOTY**  **SECRETIONS** | Drug  **GLYCOPYRRONIUM** | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose range  **200 micrograms** | Route  **SC** | Frequency  **every 2 hours** | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maximum dose per 24 hours  Total max 1.2mg in 24 hours  (including syringe pump) | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **PALLIATIVE MEDICINES TO BE GIVEN AS REQUIRED – Prescribe pro-actively – Refer to page 2 for guidance** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for use | Drug | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose range | Route | Frequency | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maximum dose per 24 hours | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason for use | Drug | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Maximum dose per 24 hours | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason for use | Drug | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose range | Route | Frequency | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maximum dose per 24 hours | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason for use | Drug | | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose range | Route | Frequency | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Maximum dose per 24 hours | | Start Date | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICINES TO BE GIVEN REGULARLY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **DRUG OMISSION CODING FOR PRESCRIPTION SHEET:** Please enter the code number and initials in the administration box | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Drug unavailable 2. Omitted (medical instruction) 3. Declined by patient 4. Unable to take  5. Instructions unclear or illegible 6. Not required 7. Other reason (please document under ‘Special Information’) | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | Time  Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Reason for use | Drug | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Dose | Route | | Frequency | | Start Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Signature & printed name | | | | | Stop Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Reason for use | Drug | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Signature & printed name | | | | | Stop Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **TRANSDERMAL PATCHES** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for use | Drug (**Brand Name**) | | | | | | **Day of**  **week** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dose | Route  **Transdermal** | Frequency  Check carefully | | Start Date | | **Date** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Further information e.g. day(s) of week to apply | | | | Stop Date | | **Time** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Application area | | | | | | **Dose** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature & printed name | | | | | | **Sign** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | | |
| **SYRINGE PUMP: Medicines to be administered over 24 hours by SC infusion** (If dose omitted, use relevant code and document under ‘Special Information) | | | | | | | | | | | | | | | | |
| Drugs | Dose range | Reason for use | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given |
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| **Water for Injection or**  Sodium Chloride 0.9%\* | **\*Delete as appropriate. Check compatibility using references.** | Diluent |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Special Instructions e.g. with respect to dosage changes:* | | Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Time set up |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Signature and printed name** | **Date** | Syringe pump checks completed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | | |
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| **Water for Injection or**  Sodium Chloride 0.9%\* | **\*Delete as appropriate. Check compatibility using references.** | Diluent |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| *Special Instructions e.g. with respect to dosage changes:* | | Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Signature and printed name** | **Date** | Syringe pump checks completed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | | |
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| Drugs | Dose range | Reason for use | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given |
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| *Special Instructions e.g. with respect to dosage changes:* | | Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | | |
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| Drugs | Dose range | Reason for use | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given | Dose given |
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| **Signature and printed name** | **Date** | Syringe pump checks completed |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | |
| **SYRINGE PUMP CHECKS** | | | | | | | | | | | | | | | |
| **Syringe Pump Make and Model**  Edition (if appropriate): | | | | | | | | | **Asset No:** | | | | **Service Date:** | | |
| Date  &  Time | Syringe  brand & size  recognised  correctly by pump? | Time remaining  (hh:mm) | Rate on display  (ml/hour) | Volume to be infused  VTBI  (ml) | Volume Infused  VI  (ml) | Is medication  being infused as expected? | Battery  percent  % | Site of giving set | Site Check | Are syringe & line contents clear? | Number of days since giving set inserted | Is an additive label attached to the syringe? | Keypad  locked?  (Yes/No) | Any further action required?  (Yes/No) | Signature &  Printed Name |
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| RUA – Right Upper Abdomen | | | | | | RUC – Right Upper Chest | | | | | RUT – Right Upper Thigh | | | | |
| LUA – Left Upper Abdomen | | | | | | LUC – Left Upper Chest | | | | | LUT – Left Upper Thigh | | | | |
| RLA – Right Lower Abdomen | | | | | | RS – Right Scapula Region | | | | | RD – Right Deltoid | | | | |
| LLA – Left Lower Abdomen | | | | | | LS – Left Scapula Region | | | | | LD – Left Deltoid | | | | |

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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | | | | | | | | | |
| **SYRINGE PUMP CHECKS** | | | | | | | | | | | | | | | |
| **Syringe Pump Make and Model**  Edition (if appropriate): | | | | | | | | | **Asset No:** | | | | **Service Date:** | | |
| Date  &  Time | Syringe  brand & size  recognised  correctly by pump? | Time remaining  (hh:mm) | Rate on display  (ml/hour) | Volume to be infused  VTBI  (ml) | Volume Infused  VI  (ml) | Is medication being infused as expected? | Battery  percent  % | Site of giving set | Site Check | Are syringe & line contents clear? | Number of days since giving set inserted | Is an additive label attached to the syringe? | Keypad  locked?  (Yes/No) | Any further action required?  (Yes/No) | Signature &  Printed Name |
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| RLA – Right Lower Abdomen | | | | | | RS – Right Scapula Region | | | | | RD – Right Deltoid | | | | |
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| Patient: NHS No: Date of Birth: Allergies: | | | | | | | |
| **MEDICINE RECORDS** | | | | | | | |
| **Name of Medicine** | |  | | **Formulation** |  | **Strength** |  |
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| **Date** | **Time** | **Quantity Received** | **Dose Administered** | **Quantity**  **wasted** | **Batch Number and Expiry Date** | **Balance** | **Signature &**  **Printed Name** | |
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| **Compliance Statement** | | | | | **Signature** | | **Date** | |
| The patient and/or relatives or carers have been advised on the safe disposal of unused controlled drugs via the community pharmacy | | | | |  | |  | |
| A plan is in place for the appropriate disposal of unused controlled drugs | | | | |  | |  | |

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| **MEDICINE RECORDS** | | | | | | | |
| **Name of Medicine** | |  | | **Formulation** |  | **Strength** |  |
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| **Date** | **Time** | **Quantity Received** | **Dose Administered** | **Quantity**  **wasted** | **Batch Number and Expiry Date** | **Balance** | **Signature &**  **Printed Name** |
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| A plan is in place for the appropriate disposal of unused controlled drugs | | | | |  | |  |

SPECIAL INFORMATION

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| Please use this page to record special information e.g. medicines supplied and omitted doses in the syringe pump.  Any clinical information should be written in the patient’s clinical record. | | | |
| **Date** | **Time** | **Information** | **Signature &**  **Printed Name** |
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| **Medication review** | | | | |
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| **Contacts** | |
| □ | **Other** |
| □ | **GP** |
| □ | **Darent Valley Hospital** Telephone: 01322 428100 |
| □ | **Darent Valley Hospital Palliative Care Team** Telephone: 01322 428293 |
| □ | **East Kent Local Referral Unit** Telephone: 0300 123 4415 |
| □ | **Ellenor Hospice** 0900hrs to 1700hrs Telephone: 01474 320007  (If called out of hours, there is an automated switchboard option to speak to night staff for advice) |
| □ | **HCRG Care Group Community Services (formerly Virgin Care)** Telephone: 0300 247 0400 |
| □ | **Heart of Kent Hospice** [THO.ClinicalAdminHoKH@nhs.net](mailto:THO.ClinicalAdminHoKH@nhs.net) Telephone: 01622 792200 |
| □ | **Hospice in the Weald** [hitw.hospice@nhs.net](mailto:hitw.hospice@nhs.net) Telephone: 01892 820500 |
| □ | **IC24 (Health Professional Line)** Telephone: 0300 5550104 |
| □ | **IC24 (Medical Support)** Telephone: 0300 0247111 |
| □ | **Kent & Canterbury Hospital** Telephone: 01227 766877 |
| □ | **Maidstone and Tunbridge Wells NHS Trust** Telephone: 01622 729000 |
| □ | **Medway Community Healthcare (MCH) Nurse Admin** 0830hrs to 1630hrs Monday to Friday Telephone: 0300 123 3444 |
| □ | **Medway Maritime Hospital** Telephone: 01634 830000 |
| □ | **Palliative Care Line MedOCC** Telephone: 01634 792098 |
| □ | **Pilgrims Hospices** [ph.pilgrimshospices@nhs.net](mailto:ph.pilgrimshospices@nhs.net) Telephone: 01233 504133 |
| □ | **Queen Elizabeth The Queen Mother Hospital** Telephone: 01843 225544 |
| □ | **West Kent Local Referral Unit** Telephone: 0300 123 1950 |
| □ | **William Harvey Hospital** Telephone: 01233 633331 |
| □ | **Wisdom Hospice** Telephone: 01634 830456 |
|  | **For further guidance, please refer to:** |