The Queen Elizabeth Hospital NHS King's Lynn NHS Foundation Trust | THE NORFOLK HOSPICE TAPPING HOUSE | Norfolk Community Health and Care NHS Trust | Norfolk and Norwich University Hospitals NHS NHS Foundation Trust

CHART STARTED:	DDMMYYYY
Chart……..of…….……	

Syringe driver and variable as required drug prescription and administration record

Patients and carers: if you require further support/ additional medicines, please contact..... *(insert number for single point of contact)*

SURNAME	FIRST NAME	NHS NO.

ADDRESS	DATE OF BIRTH
Postcode:	d d m m y y y y
	KNOWN SENSITIVITIES/ ALLERGIES
	INCLUDE NATURE OF REACTION:
GP/CONSULTANT	
OTHER THINGS YOU MAY NEED TO KNOW ABOUT THE PATIENT'S MEDICINES	
Eg other important medicines; patches, oral analgesia, previous syringe driver doses, etc	Signed: Date:

Advice for health and social care professionals and patients, family and carers
Contact number: 0330 158 8011:
option 1: Advice for Health and Social Care Professionals
option 2: Advice for patients, family and carers
NHS Ipswich Regional Medicines Information Service: 01473 704431 (healthcare care professionals for technical queries on medicines e.g. compatibility)

Prescribing

1. Use BLOCK LETTERS and approved units.
2. All entries must be signed and annotated with the name of prescriber in block letters
3. Ensure all required information has been completed and **diluent** is prescribed.
4. Chart **must** be reviewed regularly, by a prescriber, to ensure medicines remain clinically appropriate
5. To discontinue a drug or change the dose, strike through this row. **Date and initial**, then re-write the prescription in the row below
6. When this chart is full, all prescriptions should be cancelled and current treatment re-written on a new chart.

Medicines Administration

1. Check entries in EVERY section to avoid omissions.
2. Check doses are appropriate and compatibility of mixes.
3. Check expiry dates and visual check of medicines
4. RECORD each dose by initialling the appropriate box and stating the amount given.
5. Record any non-administration in the patient's record
6. Order further supplies in good time, especially for weekends and bank holidays

For NNUH/QEH pharmacy use
Clinical check and date: ……
Syringe driver ID: ……

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Stock Control	Patient's name: DOB: NHS No.:	See front page for details of the palliative care advice line and medicines information service

Drug name , strength and form …………………					Drug name, strength and form ……………………………				
Date	**Time**	**Dose given**	**Stock level**	**Signature**	**Date**	**Time**	**Dose given**	**Stock level**	**Signature**

Drug name , strength and form …………………					Drug name, strength and form ……………………………				
Date	**Time**	**Dose given**	**Stock level**	**Signature**	**Date**	**Time**	**Dose given**	**Stock level**	**Signature**

Symptom control assessment for patients with a syringe driver	Patient's name: DOB: NHS No.:

Pump check: At each visit / following pump reload, check: time / vol remaining, line clear, pump lock on and battery level (must be at least 35%) ⟶

Date / Time	Site	Pain	N&V	Restlessness	Secretions	Signature	Pump check (sign)	Vol / rate

Guidance on symptoms scoring and action to take				
Site Check	**Pain score**	**Nausea / vomiting**	**Restlessness**	**Retained secretions / noisy breathing**
0: satisfactory	0: No pain	0: No N&V	0: No restlessness	0: Satisfactory
1: pink	1: Slight Pain	1: Nauseated	1: Slight restlessness	1: Slightly noisy
2: inflamed	2: Mild Pain	2: Occasional vomit	2: Agitated	2: Mild noise
3: hardened	3: Moderate Pain	3: Regular vomiting	3: Very Agitated	3: Moderate noise
Change site if score 2 or 3	4: Severe Pain	4: Continuous vomiting		4: Very noisy

- Consider giving a prn dose of prescribed medication if score 1 or above for any symptom.
- Review dose of medication(s) via CSCI according to prn usage for the previous 24 hours.
- Review effectiveness of medication if at upper dose limit and no improvement in symptom(s). May need change of drug.
- If a new symptom develops, and needs 2 or more prn subcutaneous doses of medication in 24 hours, consider adding the new drug to CSCI. Check with prescriber for compatibilities.
- Record the symptoms assessment on SystemOne.

Continuous subcutaneous infusion (CSCI) chart All doses to be given s/c via driver over 24hrs and continued until review	Patient's name: DOB: NHS No.:	*Health professionals:* *Need advice?* *See front page for details of the palliative care advice line and medicines information service*

A	Drug and Diluent	B Indication	C Circle/Delete as appropriate	D Start dose	E Max Dose	F Increase In increments of	Dose	Date Time Signature	Dose	Date Time Signature
Start date	*1 Diamorphine*	*Pain*	*Needed / ~~*Only start if reqrd~~	*5mg*	*10mg*	*2.5mg*				
	2 Midazolam EXAMPLE	*Restlessness*	*Needed / ~~*Only start if reqrd~~	*5mg*	*10mg*	*2.5mg*				
Prescriber's name &Signature	*3 Hyoscine butyl bromide*	*Secretions*	*Needed / ~~*Only start if reqrd~~	*60mg*	*120mg*	*20mg*	EXAMPLE			
	4 Haloperidol	Nausea and vomiting	~~*Needed /~~ *Only start if reqrd	*2.5mg*	*5mg*	*2.5mg*				
Rate: over 24 hours	Diluent: G									
Start date	1		*Needed / *Only start if reqrd							
	2		*Needed / *Only start if reqrd							
Prescriber's name &Signature	3		*Needed / *Only start if reqrd							
	4		*Needed / *Only start if reqrd							
Rate: over 24 hours	Diluent:									
Start date	1		*Needed / *Only start if reqrd							
	2		*Needed / *Only start if reqrd							
Prescriber's name &Signature	3		*Needed / *Only start if reqrd							
	4		*Needed / *Only start if reqrd							
Rate: over 24 hours	Diluent:									
Start date	1		*Needed / *Only start if reqrd							
	2		*Needed / *Only start if reqrd							
Prescriber's name &Signature	3		*Needed / *Only start if reqrd							
	4		*Needed / *Only start if reqrd							
Rate: over 24 hours	Diluent:									
Start date	1		*Needed / *Only start if reqrd							
	2		*Needed / *Only start if reqrd							
Prescriber's name &Signature	3		*Needed / *Only start if reqrd							
	4		*Needed / *Only start if reqrd							
Rate: over 24 hours	Diluent:									

Continued from previous section	Patient's name: DOB: NHS No.:

DOSE	DATE, TIME AND SIGNATURE	DOSE	DATE, TIME AND SIGNATURE	DOSE	DATE, TIME AND SIGNATURE	DOSE	DATE, TIME AND SIGNATURE	DOSE	DATE, TIME AND SIGNATURE	CONTINUE ON NEXT LINE IF NO CHANGE TO THE PRESCRIPTION (CROSS OUT PRESCRIPTION SECTION AND WRITE " AS ABOVE")
A Ensure that all drugs to be combined in the same syringe driver are written in the same section of the chart, not as separate signed entries. The CSCI chart allows for up to four drugs to be prescribed and administered in one syringe driver. If medicines are given over 2 syringe drivers, each driver should be prescribed on a separate chart and the chart are annotated on top of the 1st page as 1 of 2 and 2 of 2. **B** The indication for each drug can be specified in the 'indication' column. **C** The need for initiation of certain drugs or delay until required can be highlighted by the prescriber by circling or deleting 'needed' or 'only start if required' as appropriate. This allows flexibility in terms of drugs being prescribed but not necessary administered until required without delay in the prescribing and supply. **D** Ensure appropriate starting dose is prescribed in accordance with patient's current medication and PRN doses. Starting does **should not be written as 0mg**. Consider writing doses for controlled drugs in both words and figures for clarity. **E** Ensure appropriate maximum dose is prescribed.					**F** Dose increments should typically not be more than 30-50% of total daily dose. **G** Ensure the diluent and volume is specified. Check compatibility of mixing the and the most appropriate diluent prior to prescribing using the syringe driver book or https://www.palliativedrugs.com/ ✓ Diamorphine is the usual preferred first line opioid for analgesia at end of life for opioid naïve patients. Oxycodone is the preferred second line opioid. **Please seek guidance in renal impairment.** Morphine is a valid alternative if diamorphine is unavailable. ✓ **No verbal amendments** to controlled drug prescriptions are acceptable. The prescriber must re-write and sign the chart. ✓ Bear in mind **other opioids** the patient may be taking that are not prescribed on syringe driver chart e.g. patches ✓ Each prescription row on the chart has **space for 7 days of administration**. ✓ Ensure at least 3 days' supply is prescribed on maximum specified dose					

Anticipatory, breakthrough and when required medication	Patient's name: DOB: NHS No.:	

1. Drug (approved name)	Route	**Date/ Time**									
Dose	Min interval / max in 24hrs	**Dose**									
Indication & other Instructions											
Prescriber's name & Signature	Date	**Given By**									
2. Drug (approved name)	Route	**Date/ Time**									
Dose	Min interval / max in 24hrs	**Dose**									
Indication & other Instructions											
Prescriber's name & Signature	Date	**Given By**									
3. Drug (approved name)	Route	**Date/ Time**									
Dose	Min interval / max in 24hrs	**Dose**									
Indication & other Instructions											
Prescriber's name & Signature	Date	**Given By**									
4. Drug (approved name)	Route	**Date/ Time**									
Dose	Min interval / max in 24hrs	**Dose**									
Indication & other Instructions											
Prescriber's name & Signature	Date	**Given By**									
5. Drug (approved name)	Route	**Date/ Time**									
Dose	Min interval / max in 24hrs	**Dose**									
Indication & other Instructions											
Prescriber's name & Signature	Date	**Given By**									
6. Drug (approved name)	Route	**Date/ Time**									
Dose	Min interval / max in 24hrs	**Dose**									
Indication & other Instructions											
Prescriber's name & Signature	Date	**Given By**									

Continued from previous section	Patient's name: DOB: NHS No.:	*Health professionals:* *Need advice?* See front page for details of the palliative care advice line and medicines information service.

Date/ Time																		
Dose																		
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Subcutaneous fluids and CD bag record sheet	Patient's name: DOB: NHS No.:	*Health professionals:* *Need advice?* See front page for details of the palliative care advice line and medicines information service

Subcutaneous Fluids						
Date	**Fluid**	**Volume**	**Rate / to be given over**	**Prescriber Signature**	**Nurse Signature**	**Time given**

Date	**Time**	**Opening serial number**	**Closing serial number**	**Signature**	**Print name**