PALLIATIVE CARE SYRINGE PUMP CHART

LOCATION (circle): **Hospital / Community**	**URN:**
WARD / CARE HOME:	**SURNAME:**
CONSULTANT / GP:	**FIRST NAMES:**
NO. OF SYRINGE PUMPS: ..... **OF**	**ADDRESS:** ADDRESSOGRAPH
WEIGHT (kg):	**DATE OF BIRTH:**

Refer to the Palliative care: Syringe pump policy for further information on set-up & drug compatibility

SET-UP

1. **Generally use Water for Injections as the diluent**
2. **On some occasions Sodium Chloride 0.9% should be used as the diluent**
3. **Use the diluent to make the total volume up to 17mL (in a 20mL syringe) or 22mL (in a 30mL syringe)**
4. **Use BD Plastipak luer lock syringes**

SYRINGE PUMP DRUG COMPATIBILITY

Use drug compatibility charts in the policy for stability information when mixing TWO or THREE drugs

If prescribing FOUR DRUGS in a single syringe pump or for combinations not included in the policy contact the Specialist Palliative Care Team (tel. 876555) or Hospital Pharmacy (tel. 442628) for advice

PRESCRIPTION

DATE & TIME	TOTAL VOLUME		MEDICINE ADDED TO SYRINGE PUMP (draw a line through unused rows)	
			APPROVED DRUG NAME	DOSE
/ / :	17mL or 22mL (circle)			
DILUENT	ROUTE	DURATION		
	SC	24 HOURS		

PRESCRIBER'S SIGNATURE		**REASON FOR SYRINGE PUMP** (prescriber to tick)	**PHARMACY**
PRINT NAME		**End of life care**	
ROLE / CONTACT NO.		**Symptom management**	

To discontinue draw a diagonal line through prescription and remainder of administration section

STOP DATE _____ **STOP TIME** _____

PRESCRIBER'S SIGNATURE _____

PRINT NAME _____

ROLE / CONTACT NO. _____

ADMINISTRATION

DATE ADMINISTERED			
DOSE ADMINISTERED			

PREPARATION AND SET-UP

DATE & TIME (START)	SITE POSITION	LINE CHANGE (tick)	SYRINGE PUMP ID NO.	BATTERY LEVEL (%)	START RATE (mL/hr)	START VOLUME (mL)	GIVEN BY	CHECKED BY	DATE & TIME (STOP)
/ / :									/ / :
/ / :									/ / :
/ / :									/ / :
/ / :									/ / :

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PATIENT'S NAME: _____ **URN:** _____ **DATE OF BIRTH:** _____

MONITORING CHECKS – complete **every 4 hours** (HCS sites / Hospice in-patient unit / Nursing home), or **each visit** (Patient own home / Residential home)

Date	Time	Pump delivering (Yes/No)	Rate (mL/hr)	Volume to be infused (mL)	Volume infused (mL)	Battery level (%)	Lock on (Yes/No)	Solution checked (Yes/No)	Line checked (Yes/No)	Site checked (Yes/No)	Dressing in place & date visible (Yes/No)	Specific problems (see codes*, or enter 'None')	Action taken / comments	Signature

Where syringe contents are discarded complete the following section

Date	Time	Amount discarded (mL)	Reason	Discarded by	Witnessed by

***Codes for specific problems:**

BL = Bleeding	OC = Occlusion
BR = Bruising	O = Other (specify)
C = Crystallisation	P = Pain
CC = Colour Change	R = Redness
L = Leakage	SW = Swelling

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