PALLIATIVE CARE SYRINGE PUMP CHART

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

ADDRESSOGRAPH

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 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)	
/ / :	17mL or 22mL (circle)		APPROVED DRUG NAME	DOSE
DILUENT	ROUTE	DURATION		
	SC	24 HOURS		

Administration

DATE ADMINISTERED			
DOSE ADMINISTERED			

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 diagonal line through prescription and remainder of administration section

STOP DATE _____ **STOP TIME** _____

PRESCRIBER'S SIGNATURE _____

PRINT NAME _____

ROLE / CONTACT NO. _____

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
/ / :									/ / :
/ / :									/ / :
/ / :									/ / :
/ / :									/ / :

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 contents are discarded complete the following section

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

***Codes for specific problems:**

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