



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:
Poter to the Pollistive care, Syringe nump policy	for further information on set up 2 drug competibility

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

			Prescripti	on					Administ	tratio	n
DATE & TIME	TOTAL	. VOLUME	MEDICINE ADDED TO SYRINGE PUMP (draw a line through unused rows)					DA	ATE ADMIN	IISTE	RED
1 1	17mL or 22mL		APPROV	ED DRUG N	AME	DOSE		DC	OSE ADMIN	IISTEI	RED
:		circle)									
DILUENT	ROUTE	DURATION									
	sc	24 HOURS									
PRESCRI	BER'S SI	GNATURE					ON FOR SYRINGE PUMP (prescriber to tick)			MACY	
PRINT NAME						End of	ilife cai				
ROLE	/ CONTA	CT NO.				Symptom	manage	ement	t		
line throug	gh prescr	w diagonal ription and nistration	STOP DATE PRESCRIBE PRINT NAMI ROLE / CON	R'S SIGNAT		STOP	TIME _				- - -
			Pr	eparation	and set-	-up					
DATE & TIME	SITE	LINE	SYRINGE	BATTERY	START	START			CHECKED	DATE	& TIME

	Preparation and set-up											
DATE & TIME	SITE	LINE	SYRINGE	BATTERY	START	START	CIVEN BY	CHECKED	DATE & TIME			
START	POSITION	CHANGE (tick)	PUMP ID NO.	LEVEL (%)	RATE (mL/hr)	VOLUME (mL)	GIVEN BY	BY	STOP			
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:									:			
1 1									1 1			
:									:			
/ /									1 1			
:									:			
/ /									1 1			
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PATIENT'S NAME:									URN:			DATE OF BIRTH:			
Monite	oring cl	necks – d	omplete	every 4 hou	rs (HCS site	es / Hospi	ice in-pati	ent unit / N	lursing ho	me), or ea	ch visit (Patient	own home / Resid	lential home)		
Date	Time	Pump delivering (Yes/No)	Rate (mL/hr)	Volume to be infused (mL)	Volume infused (mL)	Battery		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	
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Data	T:			ntents are di				ring section		Witnes		*Codes for specifi	ic problems:		
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Discarded by	VA/*4			
Discarded by Witnessed by				
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BL = Bleeding OC = Occlusion

BR = Bruising O = Other (specify)

C = Crystallisation P = Pain R = Redness CC = Colour Change L = Leakage SW = Swelling