Community Administered Medication Record Pink Card
KEY POINTS TO REMEMBER when completing IN COMMUNITY

A completed Pink Card is required for adult patients prescribed pre-emptive medications with or without a subcutaneous infusion via a syringe pump (also known as a syringe driver).

Patients discharged from Sheffield Teaching Hospitals & St Luke's Hospice with pre-emptive medications +/- a subcutaneous infusion via a syringe pump will be issued with a completed Pink Card. For these patients confirm if a Pink Card has been issued before completing another card.

1. Prescriber / Trained Transcriber Details & Guidance

- At the top of page 1, complete the 'Card initiated by' box and record the number of cards in use.
- For each medication you complete: sign, print name, indicate role and date.
- Pink Cards completed by trained transcribers **must be** checked by a second trained transcriber before the next dose is administered (checker to complete the 'Transcribing checked by' box for each medication). Although a check is not mandatory for Pink Cards completed by prescribers, it is good practice.
- **A Pink Card must not be used for subcutaneous fluids, insulin or transdermal patches**. These medications must be recorded on a green 'Drug Administration Record for Community Nursing' card. Be alert that there may be other medication administration (MAR) charts in the patient's Home / Care Home. **Take care to avoid medication duplication.**
- When one section of the Pink Card is full, a new Pink Card must be written. Multiple Pink Cards must not be used for a patient except when more than two syringe pumps are in use.
- When completing or transcribing a new Pink Card for a patient, the previous card must be crossed through on each page with a single line without obscuring the details of the doses administered. Page 1 of the card must be annotated 'discontinued' and must be signed and dated.
- Completed Pink Cards that are no longer in use must be returned to the Community Nursing base to be scanned into the patient's Community SystmOne records before being shredded or placed in confidential waste.
- If the Pink Card is written in advance of need, a prescriber review may be required to ensure that medication is still appropriate at the point of need. Please use the table at the bottom of page 1 to record when a review has been undertaken.
- For dose changes authorised under a written instruction follow the guidance on page 12 of the Pink Card.

2. Patient Details

- In the box on page 1 complete:
  - the patient's details (name, date of birth, NHS number and address)
  - the GP Practice name and GP contact number
  - the Community Nursing Team contact number (if known).
- From page 4 onwards, record the patient's name, date of birth and NHS number at the top of each page where this is requested.

3. Allergy Status

- This **must** be checked and the 'Allergies' box on page 1 completed.

4. Syringe Pump (if applicable)

- On page 4 complete the section 'SYRINGE PUMP A - SUBCUTANEOUS INFUSION MEDICATION RECORD' for the first syringe pump (the patient may only have one).
- If the patient has a second syringe pump complete on page 6 the section 'SYRINGE PUMP B - SUBCUTANEOUS INFUSION MEDICATION RECORD'.
- A second Pink Card will need to be created if the patient has more than two syringe pumps in use.

- Up to 3 drugs can be combined in a syringe pump where compatibility allows. For sources of information on compatibility see page 3 of the Pink Card.
- Document the diluent in full, not abbreviated, e.g. water for injection, 0.9% sodium chloride.
- Record the start date, i.e. when administration of the drug(s) at this dose/combination of doses first commenced via a syringe pump.
- When setting up the syringe pump(s), document on page 1 the serial number(s) of the syringe pump device(s).
- Any change in dose or drug combination must be authorised and a new entry written on the Pink Card. DO NOT alter existing instructions. Record the discontinuation of use of a syringe pump by drawing a line through the drug name(s). Write down the reason and authorisation for stopping, the stop date and your initials. Complete the 'Discontinuation date' in the grey box. The person who physically disconnects the syringe pump must complete the grey 'Discarded by' information section. Record the volume remaining even if this is zero (**this is a legal requirement**).

5. Oral / Buccal / Sublingual / Nasal Medications

- This section (pages 8 and 9) is **only** for the administration of medications by the Sheffield Teaching Hospitals (STHFT) Intensive Home Nursing Team. The transcription of medications onto page 8 can be completed by a Community prescriber / trained transcriber.
- Be alert that there may be other medication administration (MAR) charts in the patient's Home / Care Home. Take care to avoid medication duplication.
- For the strength and dose prescribed, document in the 'Additional instructions' box the actual volume of liquid to be given in mls or for tablets/capsules the actual number of these to be given. Support workers cannot administer a medication unless this information is recorded.
- Complete all the boxes, including a minimum interval and maximum dose in 24 hours.
- Record the start date, i.e. when the prescription of the drug at this dose first commenced.
- Any change in dose or frequency MUST be authorised and a NEW entry written on the Pink Card. DO NOT alter existing instructions. Discontinue a drug by drawing a single line through BOTH the drug name and the unused recording panels. Enter the stop date and initial the final column. Write the reason and authorisation for stopping/discontinuation over the remaining administration record section.

6. Subcutaneous Injections – when required

- On pages 10 and 11 complete this section for 'when required' ('PRN') subcutaneous medications.
- Complete all the boxes, including a minimum interval and maximum dose in 24 hours.
- Where the same drug is also prescribed regularly (e.g. in a syringe pump) prescribers must specify in the 'Additional instructions' box whether the PRN maximum in 24 hours does or does not include the regular dose.
- Record the start date, i.e. when the prescription for the subcutaneous drug at this dose first commenced.
- Any change in dose or frequency MUST be authorised and a NEW entry written on the Pink Card. DO NOT alter existing instructions. Discontinue a drug by drawing a single line through BOTH the drug name and the unused recording panels. Enter the stop date and initial the final column. Write reason and authorisation for stopping/discontinuation over the remaining administration record section.
- Remember that subcutaneous pre-emptive medications should not replace the patient's usual oral 'as required' medications if they remain able to take oral medication and such medication is still clinically appropriate. Ensure this is communicated to the patient and their family/carer. This will prevent Community Nurses being unnecessarily called out to administer injections of subcutaneous pre-emptive medications.

Support & Advice

- For further advice see the guidelines on pages 2 and 3 of the Pink Card as well as the documents 'Guidance for Medicines Management of Adult Patients in the Last Few Days of Life' and 'Use of the Community Administered Medication Record Pink Card - Procedure'
- Medication or Pink Card completion errors must be reported in line with your organisation's policy.
- To provide feedback on the Pink Card process, please contact the STHFT Pink Card Team via: sth.pinkcard@nhs.net