Community Administered Medication Record Pink Card

Sheffield Teaching Hospitals NHS
NHS Foundation Trust

NHS Sheffield
Clinical Commissioning Group

St Luke's
Sheffield's Hospice

Please refer to the Sheffield Teaching Hospitals Foundation Trust (STHFT) protocol for the use of the T34™ Ambulatory Syringe Pump on setting up and using this equipment.

Card initiated by (signature): __________
Name: __________
Role: __________
Organisation: __________
Date: __________

Name: __________ **NHS number:** __________

Address: __________ **D.O.B.** __________

GP Practice: __________

Telephone: __________

Nurse Team contact number: __________

Allergies - including latex, please list:

OR
No known allergies ☐ (please tick if none known)
Signature: Date:
Name: Role:

BROADSWORD PROOF

GUIDELINES **Please refer to STHFT T34™ Ambulatory Syringe Pump Protocol and the Procedure for Use of Community Administered Medication Record Pink Card.**

- Completion of this card may be undertaken by a prescriber or transcriber. When transcribing is undertaken the names of the drugs, dose, route and frequency must be checked from original prescription (e.g. TTO/FP10/previous Community Administered Medication Record Pink Card). If there are any concerns the prescriber should be contacted for clarification.
- The prescriber / transcriber must date and sign each entry.
- It is good practice for the prescriber to write GMC number or NMP PIN when signing the prescription. A prescriber does not need a second check to be completed on the card.
- The transcribed record must be checked by a second Health Care Professional before the next dose is administered.
- Prescribing of the dose to be administered via a T34™ Ambulatory Syringe Pump should always be a specific dose and NEVER be a dose range.
- Clearly print all areas of the Pink Card, other than signatures. Approved names should be used for all drugs, unless the drug requires a brand name for clarity. Never use a trailing zero eg. write 5mg NOT 5.0mg.
- Discontinue a drug by drawing a 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.
- Any change in dosage or frequency MUST be authorised by writing a new entry. DO NOT alter existing instructions.
- When rewriting a medication record card please remember to rewrite the ORIGINAL start date of each drug and NOT the date of rewriting.
- All medicines should be administered in accordance with the prescribing instructions and the STHFT Medicine Code.Timeliness is crucial for those medicines included in the STHFT Critical Medicines List.
- Medication incidents outlined in section 4.8 of the STHFT Medicine Code must be reported in line with the STHFT Incident Management Policy.

Transcribers and Prescribers

- Check all other available 'administration charts' e.g. MAR charts, 'Drug Administration Record For Community Nursing' for duplications, drug interactions and doses last taken. Stop medications where appropriate.
- Check the compatibility of all drugs prescribed. Compatibility information can be found via:
  - The BNF/eBNF (Prescribing in Palliative Care section) www.medicinescomplete.com/mc/bnf/current/
  - STHFT Medicines Information Service: NGH 0114 2714371/RHH 0114 2712346 (9-5 Mon-Fri)
  - www.palliativedrugs.com (register for a free login) Access syringe driver compatibilities via SDSD tab.
- Use water for injections as a diluent with most drugs - exceptions include octreotide, granisetron, ondansetron, ketamine & ketoralac, which should be diluted in 0.9% sodium chloride.
- For support from the Palliative Care Team:
  Working hours - contact St Luke's Hospice Community team (Rapid Response) 0114 236 9911.
  Outside working hours - contact STHFT Palliative Care on-call Specialist Registrar 0114 243 4343.

Notes for Nurses Administering drugs via a syringe driver

- Please refer to STHFT T34™ Ambulatory Syringe Pump Protocol
- Only use a 30 millilitre Luer-Lok, Becton-Dickinson (BD) brand syringe
- Check battery level (%). Battery should be changed when less than 40%.

SEEK IMMEDIATE MEDICAL ADVICE FOR ANY MEDICATION ERRORS
(e.g. consider the need for Naloxone, dial 999)

Syringe Driver A	Serial Number:
Syringe Driver B	Serial Number:

Name: ______________________ Date of Birth: ____________ NHS Number: ____________

SYRINGE DRIVER A - SUBCUTANEOUS INFUSION MEDICATION RECORD

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	Start date:	Discontinuation date:

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	Start date:	Discontinuation date:

BROADSWORD PROOF

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	Start date:	Discontinuation date:

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	**Start date:**	Discontinuation date:

Name: ______________________ Date of Birth: ______________ NHS Number: ______________

SYRINGE DRIVER A - NURSE ADMINISTRATION RECORD

CHECK ALLERGY STATUS

ADMINISTRATION

Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

ADMINISTRATION

Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

BROADSWORD PROOF

ADMINISTRATION

Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

ADMINISTRATION

Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

Name: ______________________ Date of Birth: ______________ NHS Number: ______________

SYRINGE DRIVER B - SUBCUTANEOUS INFUSION MEDICATION RECORD

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	Start date:	Discontinuation date:

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	Start date:	Discontinuation date:

BROADSWORD PROOF

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	Start date:	Discontinuation date:

Approved name of medication	Dose	Total volume of fluid in syringe = 22ml
Drug 1		Infusion Time = 24 hours Transcriber / Prescriber (signature) Print Name: Role: Date: Transcribing checked by (signature) Print Name: Role: Date:
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:	Start date:	Discontinuation date:

Name: ______ Date of Birth: ______ NHS Number: ______

SYRINGE DRIVER B - NURSE ADMINISTRATION RECORD

CHECK ALLERGY STATUS

ADMINISTRATION		
Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

ADMINISTRATION		
Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

BROADSWORD PROOF

ADMINISTRATION		
Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

ADMINISTRATION		
Medicine/Diluent	Batch No.	Expiry
Drug 1		
Drug 2 (if needed)		
Drug 3 (if needed)		
Name of DILUENT:		

Date commenced	Time	Rate from pump (ml/hour)	Site	Signature

Print name:

Calculations:

Discarded by:	Date & Time:
Volume remaining:	Signature:

Name: ______ Date of Birth: ______ NHS Number: ______

ORAL / BUCCAL / SUBLINGUAL / NASAL MEDICATIONS

CHECK ALLERGY STATUS

1: Patient refused dose
2: Dose not available
3: Dose not given at nurse's discretion
4: Dose not given at doctor's request
5: Self administered

AFFIX ONE ADDITIONAL SHEET HERE IF REQUIRED

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date											
Time											
Dose Given											
Batch											
Expiry											
Initials											

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date											
Time											
Dose Given											
Batch											
Expiry											
Initials											

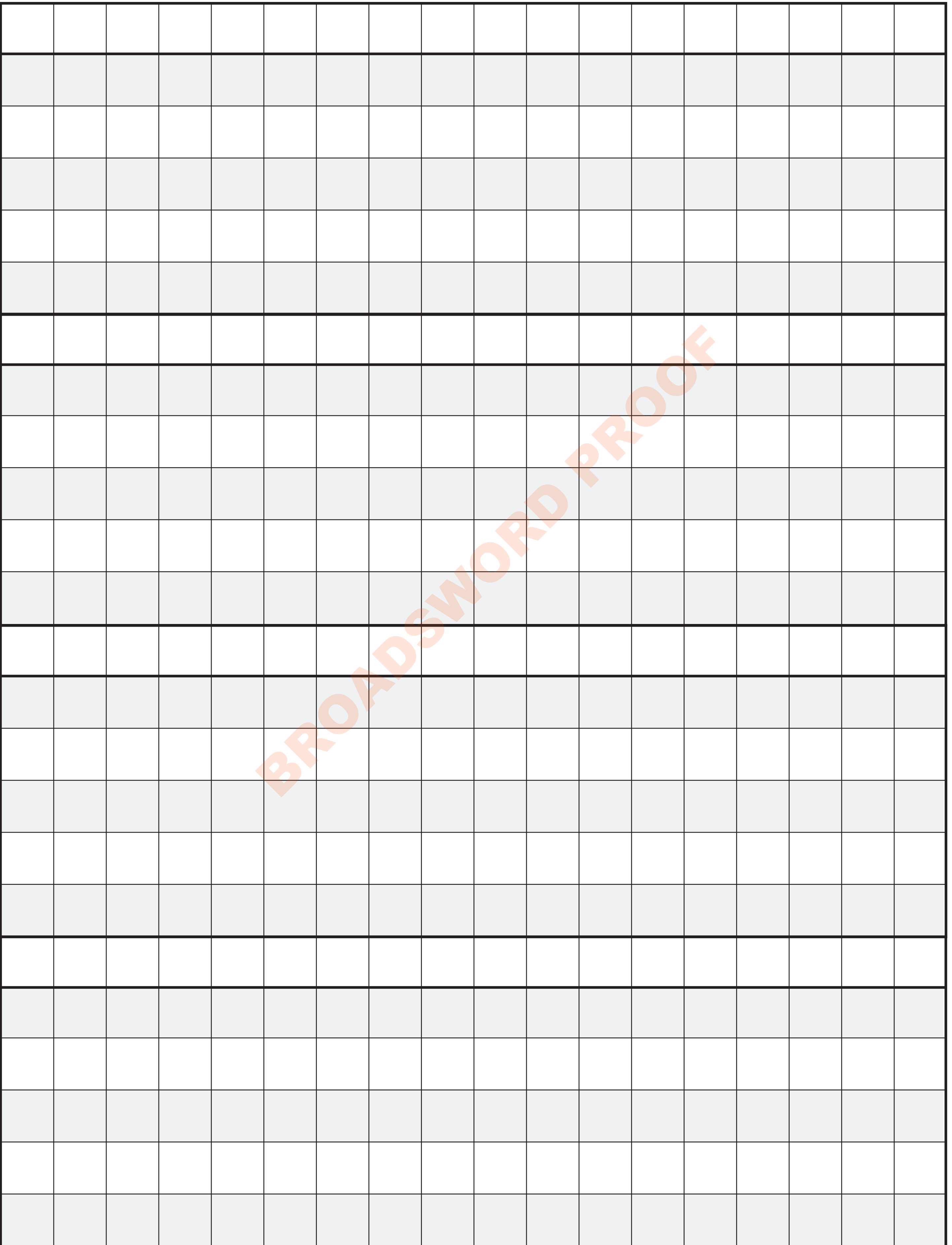
BROADSWORD PROOF

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date											
Time											
Dose Given											
Batch											
Expiry											
Initials											

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date											
Time											
Dose Given											
Batch											
Expiry											
Initials											



BROADSWORD PROOF

Name: ______________________ Date of Birth: ______________ NHS Number: ______________

Subcutaneous Injections - when required

(Use 'Drug Administration Record For Community Nursing' for Transdermal medication and Subcutaneous Fluids)

CHECK ALLERGY STATUS

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date	Time	Dose	Site	Batch No.	Expiry	Signature

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date	Time	Dose	Site	Batch No.	Expiry	Signature

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date	Time	Dose	Site	Batch No.	Expiry	Signature

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date	Time	Dose	Site	Batch No.	Expiry	Signature

Approved Name of Medicine	Dose
Additional instructions	Route
	Min. interval
Transcriber / Prescriber (signature) Print Name: Role: Date:	Max/24 hours
Transcribing checked by (signature) Print Name: Role: Date:	Start date

Date	Time	Dose	Site	Batch No.	Expiry	Signature

BROADSWORD PROOF

AFFIX ONE ADDITIONAL SHEET HERE IF REQUIRED