



PALLIATIVE CARE SYRINGE PUMP CHART







LOCATION (circle): Hospital / Community	URN:	PH
WARD / CARE HOME:	SURNAME:	GRA
CONSULTANT / GP:	FIRST NAMES:	2550
NO. OF SYRINGE PUMPS: OF	ADDRESS:	ADDIC .
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		ΑI	MINIS	TRATI	ON	
DATE &	TOTAL	. VOLUME	MEDICINE ADDED TO SYRI	DA	TE ADM	INISTE	RED		
TIME			(draw a line through unused	rows)					
1 1	17mL	or 22mL	APPROVED DRUG NAME	DO	SE ADM	INISTERED			
:	(circle)								
DILUENT	ROUTE	DURATION							
	SC	24							
	30	HOURS							
PRESCRIE	BER'S SI	GNATURE		REASON FOR S (prescribe		PUMP	PHARMAC		
PF	RINT NAI	ΛΕ		End of life of	care				
ROLE	CONTA	CT NO.		Symptom mana	gement				
-	4.		STOP DATE	_ STOP TIME				_	
	continue nal line th		PRESCRIBER'S SIGNATURE						
prescription	on and re	mainder of	PRINT NAME						
admini	stration s	section	ROLE / CONTACT NO.						
			PREPARATION AND S	SET-UP					

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

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	Date																	Date	MONI	- (
	Time																	Time	TORING	
		Wher															(100110)	Pump delivering	MONITORING CHECKS	
	Amount discarded (mL)	e svringe																Rate (mL/hr)	Τ	
	ded (mL)	Where syringe contents are discarded complete the following section															()	Volume to be infused	complete every 4 hours (HCS sites / Hospice in-patient unit / Nur	
	7	re discard															()	Volume infused	4 hours (H	
	Reason	ed compl																Battery level (%)	CS sites /	
		ete the fo																Lock on (Yes/No)	Hospice in	
	Disca	llowing s															(100,10)	Solution checked	า-patient เ	
	Discarded by	ection															(100,10)	Line checked	ınit / Nursi	
	Witnessed by																	Site checked	ing home),	
	sed by																(100:10)	Dressing in place & date visible (Yes/No)	or <mark>each visit</mark> (F	
BR = Bruising C = Crystallisation CC = Colour Change L = Leakage	BL = Bleeding OC = (*Codes for spec																Specific problems (see codes*, or enter 'None')	atient own home	
Ø ₹ ₹ O	OC = Occlusion	rific problems:																Action taken / comments	rsing home), or each visit (Patient own home / Residential home)	
Other (specify)PainRednessSwelling	usion																	Signature		