Family Nursing & Home Care | Jersey Hospice Care | PRIMARY CARE BODY | States of Jersey

AMBULATORY SUBCUTANEOUS SYRINGE PUMP PRESCRIPTION CHART
(HOSPICE IN-PATIENT UNIT AND COMMUNITY)

GP: _____	URN: _____
GP SURGERY: _____	JHC INDEX NO: _____
GP TEL NO: _____	SURNAME: _____
NO. OF SYRINGE PUMPS ..... OF	FIRST NAMES: _____
	ADDRESS: _____
	DATE OF BIRTH: _____

ADDRESSOGRAPH

DILUENT	1. Generally use Water for Injections as the diluent. 2. On some occasions the diluent will need to be Sodium Chloride 0.9%. This information is available in the Ambulatory Syringe Pump Policy. 3. Use diluent to make up TOTAL VOLUME to 17ml (in a 20ml syringe) OR 22ml (in a 30ml syringe). BD Plastipak luer lock syringes are to be used.
SYRINGE PUMP DRUG COMPATIBILITY CHARTS	Refer to the Ambulatory Syringe Pump Policy for stability information when mixing TWO or THREE drug combinations.

If prescribing FOUR DRUGS in a single syringe pump there is a high risk of incompatibility. The Specialist Palliative Care Team should be contacted 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		PRESCRIBER TO TICK REASON FOR SYRINGE PUMP	
PRINT NAME		End of Life Care	
DESIGNATION / 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 _____ DESIGNATION / CONTACT NO. _____

Preparation and Administration

DATE & TIME START	SITE POSITION	SYRINGE PUMP ID NO.	BATTERY LEVEL (%)	START RATE (ml/hr)	START VOLUME (ml)	GIVEN BY	CHECKED BY	DATE & TIME STOP
/ / :								/ / :
/ / :								/ / :
/ / :								/ / :
/ / :								/ / :

AMBULATORY SUBCUTANEOUS SYRINGE PUMP MONITORING CHART

PATIENT'S NAME: _____ **URN:** _____ **DATE OF BIRTH:** _____

Monitoring Checks - complete every 4 hours (HSSD Sites / Hospice In-Patient Unit / Nursing Home) or each visit (Community) per Ambulatory Syringe Pump Policy

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, please complete the following section

Date	Time	Amount discarded (ml)	Reason	Discarded by (Signature)	Witnessed by (Signature)

***Codes for specific problems:**

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