

*Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR): Chart for subcutaneous and intramuscular medication in the community setting*

Version 4

Circulated Date: 8th February 2022 Agreed Date: 8th December 2021 Review Date: 8th December 2023 Use from: 3rd May 2022

*This document will continue to be reviewed and re-released to reflect new and emerging evidence.*

# ‘AS REQUIRED’ (PRN) SUBCUTANEOUS INJECTIONS AUTHORISATION AND ADMINISTRATION CHART V4

## Please indicate here ☐ if there is more than one ‘As required’ authorisation and administration chart in use

|  |
| --- |
| **This document should remain with the patient. These charts are only for injectable medicines.****Tick this box if another Community Drug Chart is in use e.g. for Patches, Enemas etc. ☐** |
| **Palliative Care Team Contact Details:****Add a local contact: in Redbridge = Redbridge Mac Team 03003001901. In B&D Havering and Brentwood = Saint Francis Hospice 01708 758643** | **Authorising clinician name and GMC/NMC/GPhC number:****YOUR NAME IN CAPITALS AND YOUR GMC NUMBER or NMC or GPhC number** |
| **Patient Information** | **Allergies and Adverse Reactions** |
| Patient Name: e.g. Mr AB CRISIS | No Known Allergies: **☐** Known Allergies **☐** |
| If required, seek source of allergy |
| NHS No: xxxxxxxxx | List Medicine/Substance and Reaction: PLEASE DO TICK BOX AND ADD ALLERGIES, PLUS REACTIONS IF POSS |
| D.O.B aa/bb/cccc | Print, Sign & Date: |
| Weight (for children): |

Check if there is an analgesic transdermal patch: Y ☐ N  Drug name: Dose:

NB: Max 24hour dose below = *PRN medications only* (i.e. does not include medication administered via syringe pump)

Pain +/or Breathlessness

**Medication: MORPHINE SULFATE**

Date: Time:

For patients already on opioids, refer to NELFT Palliative Care EOL Quick Reference Guide V4 P6 or ring SFH Advice Line on 01708 758643

Date: **x.y.zz**

Dose Range:

2.5mg to 5mg

Frequency:**1 hrly max**

Nausea / Vomiting

Max 24hour dose: **15mg**

Authoriser sign & print:

**YOUR**

**NAME/sign**

Dose:

Sign:

Date:

**If eGFR < 30**, or if high clinical suspicion of severe renal failure, use **oxycodone** instead of morphine, **start dose range 1mg to 2mg.**

## Frequency 1hrly max. Max 24hr dose 10mg

If severe renal failure a/a, or frail ++, use Haloperidol for

Medication: LEVOMEPROMAZINE Time: nausea as less sedating/favoured. Dose 500 micrograms to 1mg Frequency 4 hrly max. Max 24hour dose 5mg

Date: **x.y.zz**

Dose Range:

**6.25mg to 12.5mg**

Frequency: **4 hrly max**

Max 24hour dose: **25mg**

Authoriser sign & print:

**YOUR**

**NAME/sign**

Dose:

Sign:

|  |  |
| --- | --- |
| **If history of Parkinson’s** | . |
| Use **cyclizine** instead of levomepromazine, |
| **Dose 50mg (cannot give a range)** |

##  Frequency 4hrly max. Max 24hour dose 150mg

Agitation / Distress

**Medication: MIDAZOLAM**

Date: Time:

Date: **x.y.zz**

Dose Range:

2.5mg to 5mg

Frequency:**1 hrly max**

Max 24hour dose: **15mg**

Authoriser sign & print:

**YOUR**

**NAME/sign**

Dose:

Sign:

Respiratory secretions

**Medication: GLYCOPYRRONIUM**

Date: Time:

Date: **x.y.zz**

Dose Range:

**200micrograms to**

|  |  |  |
| --- | --- | --- |
| **300 micrograms** | print: |  |
| Frequency: **4 hrly max** | **YOUR****NAME/sign** |
| **Other indication:** |  | Date: |
| **Medication:** |  | Time: |
| Date: | Max 24hour dose: | Dose: |
| Dose Range: |  |  |

Max 24hour dose: **1.2mg**

Authoriser sign &

Dose:

Sign:

Frequency:

Authoriser sign & print:

Sign:

# 24 HOURS CONTINUOUS SUBCUTANEOUS INFUSION (SYRINGE PUMP) AUTHORISATION CHART V4

NB: If more than one syringe pump is being used at the same time, please use a separate Authorisation Chart for each pump, and indicate here:

Pump (insert no) of (insert no)

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| NHS No: xxxxxxxxx | List Medicine/Substance and Reaction: PLEASE DO TICK BOX AND ADD ALLERGIES, PLUS REACTIONS IF POSS |
| D.O.B aa/bb/cccc | Print, Sign & Date: |
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## Check if there is an analgesic transdermal patch: Y ☐ N  Drug name: Dose:

Pain and / or Breathlessness For patients already on opioids, refer to NELFT Palliative Care EOL Quick Reference Guide V4 P6 or ring SFH Advice Line on 01708 758643

Date: **xx/yy/zzzz** Medication: **MORPHINE SULFATE**

Nausea / Vomiting

Dose range: **10mg to 20mg**

(over 24 hours)

**If eg R < 30**, or if high clinical suspicion of severe renal failure, use **Alfentanil** as safest opioid, **starting dose range 500mcg to 1mg**

If severe renal failure a/a, or frail ++, use

Authoriser sign & print:

**YOUR NAME /SIGN**

Date: **xx/yy/zzzz**

Medication: **LEVOMEPROMAZINE**

Dose range: **6.25mg to 12.5mg**

(over 24 hours)

Halop ridol for nausea as less sedating/is favoured, starting dose range 1.5mg to 3mg

**If history of Parkinson’s** and already on

Authoriser sign & print:

**YOUR NAME /SIGN**

Agitation / Distress IF NEEDED

Date: **xx/yy/zzzz** Medication: **MIDAZOLAM** Dose range: **10mg to 20mg**

(over 24 hours)

cyclizine prn ring **SFH Advice Line for advice**

Authoriser sign & print:

**YOUR NAME /SIGN**

Respiratory tract secretions IF NEEDED

Date: **xx/yy/zzzz** Medication: **GLYCOPYRRONIUM** Dose range: **600 micrograms to 1.2mg**

(over 24 hours)

Authoriser sign & print:

**YOUR NAME /SIGN**

Other medication – specify indication here:

Date: Medication: Dose range: (over 24 hours)

Authoriser sign & print:

Other medication – specify indication here:

Date: Medication: Dose range: (over 24 hours)

Authoriser sign & print:

Diluent

Date: **xx/yy/zzzz** Diluent: **WATER FOR INJECTIONS** Authoriser sign & print:

**YOUR NAME /SIGN**

## CRISIS/EMERGENCY AND REGULAR INJECTIONS AUTHORISATION AND ADMINISTRATION CHART

**V4**

This document should remain with the patient.

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| If required, seek source of allergy |
| NHS No: xxxxxxxxx | List Medicine/Substance and Reaction: PLEASE DO TICK BOX AND ADD ALLERGIES, PLUS REACTIONS IF POSS |
| D.O.B aa/bb/cccc | Print, Sign & Date: |
| Weight (for children): |

CRISIS / EMERGENCY SUBCUTANEOUS AND INTRAMUSCULAR INJECTIONS

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| --- | --- | --- | --- |
| **Indication: SEIZURES** | **Administration record:** | **Administration record:** | **Administration record:** |
| Medication: MIDAZOLAM | **Date:** |  | **Date:** |  | **Date:** |  |
| **Time:** |  | **Time:** |  | **Time:** |  |
| Dose: 5mg to 10mg | Route: IM | **Dose:** |  | **Dose:** |  | **Dose:** |  |
| Max 24hour dose: 60mg | Frequency: 1/2hr | **Sign:** |  | **Sign:** |  | **Sign:** |  |
| Authoriser sign, print & date: **YOUR NAME /SIGN/ xx/yy/zzzz** |
| **Indication: LARGE HAEMMORHAGE** | **Administration record:** | **Administration record:** | **Administration record:** |
| Medication: MIDAZOLAM | **Date:** |  | **Date:** |  | **Date:** |  |
| **Time:** |  | **Time:** |  | **Time:** |  |
| Dose: 5mg to 10mg | Route: IM | **Dose:** |  | **Dose:** |  | **Dose:** |  |
| Max 24hour dose: 60mg | Frequency: 1/2hr | **Sign:** |  | **Sign:** |  | **Sign:** |  |
| Authoriser sign, print & date: **YOUR NAME /SIGN/ xx/yy/zzzz** |

REGULAR DOSE SUBCUTANEOUS INJECTIONS

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Indication: IF UNABLE TO MANAGE ORAL STEROID** | Date: |  |  |  |  |  |  |  |  |  |
| Medication: DEXAMETHASONE | Enter administration times | 10am |  |  |  |  |  |  |  |  |  |
| Dose: 6.6mg OD |  |  |  |  |  |  |  |  |  |  |
| Authoriser sign, print & date: |  |  |  |  |  |  |  |  |  |  |
| **YOUR NAME /SIGN/ xx/yy/zzzz** |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |
| **Indication:** | Date: |  |  |  |  |  |  |  |  |  |
| Medication: | Enter administration times |  |  |  |  |  |  |  |  |  |  |
| Dose: |  |  |  |  |  |  |  |  |  |  |
| Authoriser sign, print & date: |  |  |  |  |  |  |  |  |  |  |
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