A blue and white sign  Description automatically generated with low confidence 

*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

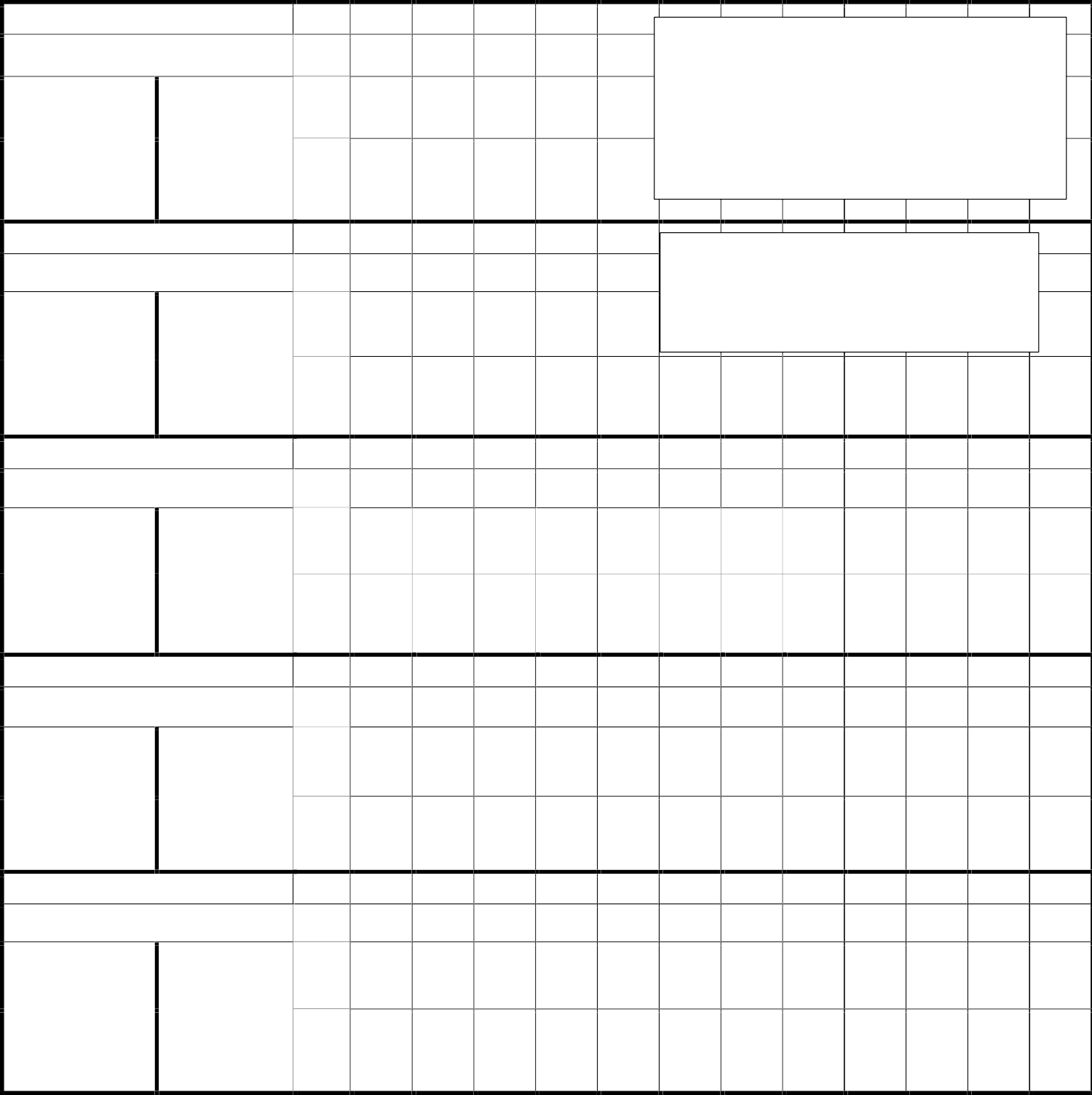
*This document will continue to be reviewed and re-released to reflect new and emerging evidence.*

# ‘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 Date:

**Medication: MORPHINE SULFATE**

Time:

## **\*\***if eGFR < 30- Prescribe oxycodone instead of

morphine, start dose range 1mg to 2mg

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:

**\*\* For patients already on opioids, please refer to NELFT Palliative Care EOL Quick Reference Guide V4 P6 or ring SFH Advice Line on 01708 758643** [www.sfh.org.uk/mint](http://www.sfh.org.uk/mint%20project/uploads/831325987.docx) [project/uploads/831325987.docx](http://www.sfh.org.uk/mint%20project/uploads/831325987.docx)

**Medication: LEVOMEPROMAZINE**

Time:

## **\*\***if history of Parkinson’s –prescribe

cyclizine instead: 50mg s/c frequency 4hrly

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:

## 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**

Frequency: **4 hrly max**

Other indication:

**Medication:**

Date:

Dose Range:

Frequency:

Max 24hour dose: **1.2mg**

Authoriser sign & print:

**YOUR**

**NAME/sign**

Max 24hour dose:

Authoriser sign & print:

Dose:

Sign:

Date: Time:

Dose:

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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| **Patient Information** | **Allergies and Adverse Reactions** | |  |
| Patient Name: e.g. Mr AB CRISIS | No Known Allergies: **☐** Known Allergies **☐**  If required, seek source of allergy  List Medicine/Substance and Reaction: PLEASE DO TICK BOX AND ADD ALLERGIES, | |  |
| NHS No: xxxxxxxxx  D.O.B aa/bb/cccc |
| PLUS REACTIONS IF P  Print, Sign & Date: | **\*\* For patients already on opioids, please refer to NELFT Palliative Cate EOL Quick Reference Guide V4 P6 or ring SFH Advice Line on 01708 758643** [www.sfh.org.uk/mint](http://www.sfh.org.uk/mint%20project/uploads/831325987.docx) [project/uploads/831325987.docx](http://www.sfh.org.uk/mint%20project/uploads/831325987.docx) | |
| Weight (for children): |

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

OSS

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Pain and / or Breathlessness** | | | | | | |
| Date: **xx/yy/zzzz** | Medication: **MORPHINE SULFATE** | Dose range: **10mg to 20mg**  (over 24 hours) | | | Authoriser sign & print:  **YOUR NAME /SIGN** | |
|  | \*\*If egFR < 30- prescribe aflentanil as safest opioid, starting dose range 500mcg to 1mg | | |  |
| **Nausea / Vomiting** | | |  |
|  | | | | | | |
| Date: **xx/yy/zzzz** | Medication: **LEVOMEPROMAZINE** | Dose range: **6.25mg to 12.5mg**  (over 24 hours) | | | Authoriser sign & print:  **YOUR NAME /SIGN** | |
| **Agitation / Distress IF NEEDED** | | | | | | |
| Date: **xx/yy/zzzz** | Medication: **MIDAZOLAM** | Dose range: **10mg to 20mg**  (over 24 hours) | | | 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** | | |

1. **CRISIS/EMERGENCY AND REGULAR INJECTIONS AUTHORISATION AND ADMINISTRATION CHART**

**V4**

This document should remain with the patient.

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| --- | --- |
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| 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): |

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

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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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