COMMUNITY MEDICATION ADMINISTRATION RECORD

gofal lliniarol CYMRU – WALES palliative care

DRUG ALLERGIES & SENSITIVITIES	PLEASE CIRCLE AS APPROPRIATE: NONE KNOWN YES SIGNED…… DATE…….. NAME……
Drug / Allergen:	Description of Reaction:

This section must usually be completed prior to administration of any medicine. Refer to local policies for further guidance.

HEALTH RECORD/NHS No:_____

SURNAME:_____

FIRST NAME:_____

ADDRESS:_____

_____

DATE OF BIRTH:_____

CONSULTANT/GP:_____

DISTRICT NURSE TEAM: _____

DETAILS OF SUPPLEMENTARY CHARTS
TICK APPROPRIATE BOX

SYRINGE PUMP ☐ OTHER (Please specify) ☐

If starting a syringe pump, use the 'All Wales Continuous Subcutaneous Infusion Medication Administration Record'.

REGULAR MEDICATION THAT IS STILL REQUIRED

ENTER DOSE AGAINST TIME REQUIRED. USE ONE ROUTE ONLY FOR EACH ENTRY

REGULAR MEDICINE | MONTH | YEAR

DATE

DATE →
ROUTE →
SPECIFY TIME IF REQUIRED | DOSE | SIGN | DOSE CHANGE | MEDICINE (Approved Name) | SPECIAL INSTRUCTIONS | PRESCRIBER'S SIGNATURE

Morning
Midday
Evening
Bedtime

REWRITE CHART

DATE →
ROUTE →
SPECIFY TIME IF REQUIRED | DOSE | SIGN | DOSE CHANGE | MEDICINE (Approved Name) | SPECIAL INSTRUCTIONS | PRESCRIBER'S SIGNATURE

Morning
Midday
Evening
Bedtime

REWRITE CHART

DATE	**Oxygen** (if required)	SPECIAL INSTRUCTIONS (Refer to local guidelines). Flow rate and delivery device: Target oxygen saturation (if appropriate): **Or** Indicate that oxygen use is for comfort measures only	PRESCRIBER'S SIGNATURE

QUICK REFERENCE GUIDE: COMMONLY USED AS-REQUIRED MEDICINES AND DOSES:

INDICATION	MEDICINE	USUAL STRENGTH	DOSE	FREQUENCY	ROUTE
Pain / breathlessness (if opioid-naïve)	Morphine	10mg/mL	2.5mg	2 hourly	SC
Agitation (anxiety)	Midazolam	10mg/2mL	2.5 or 5mg	2 hourly	SC
Agitation (delirium)	Haloperidol Levomepromazine	5mg/mL 25mg/mL	2.5mg 6.25 or 12.5mg	4 hourly up to 6 hourly	SC SC
Nausea / Vomiting	Cyclizine Haloperidol Levomepromazine	50mg/mL 5mg/mL 25mg/mL	50mg 1mg-1.5mg 6.25mg	4 hourly (max 150mg/24hours) 4 hourly 4 hourly (max 25mg/24hours)	SC SC SC
Noisy resp. secretions	Hyoscine hydrobromide Glycopyrronium	400mcg/mL 200mcg /mL	400 micrograms 200 micrograms	4 hourly (max 2.4mg/24hours) 4 hourly (max 1.2mg/24 hours)	SC SC

Remember to supply water for injection along with anticipatory medication

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PATIENT'S NAME…….. **HEALTH RECORD No.** ……

Important note 1: For some symptoms the same medicine is used in a different dose. If this is the case, please make a separate entry.
*** Important note 2:** It is good practice to indicate a maximum dose in 24 hours. This aids timely clinical review if frequent as-required doses are needed. The maximum dose indicated should include both as-required and regular medication (e.g. medication via CSCI).

AS REQUIRED MEDICINES				DATE	TIME GIVEN	DOSE/ ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE/ ROUTE	GIVEN BY	DATE	TIME GIVEN	DOSE/ ROUTE	GIVEN BY
INDICATION **Pain / Breathlessness**	MEDICINE (Approved name)														
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION **Agitation (Anxiety)**	MEDICINE (Approved name)														
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION **Agitation (Delirium)**	MEDICINE (Approved name)														
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION **Nausea / Vomiting**	MEDICINE (Approved name)														
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION **Noisy resp. secretions**	MEDICINE (Approved name)														
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION **Dry mouth**	MEDICINE (Approved name)														
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												
INDICATION	MEDICINE (Approved name)														
DOSE	ROUTE	FREQUENCY	MAX DOSE IN 24 HRS *												
PRESCRIBER'S SIGNATURE			DATE												