



Drug Administration Document [REDACTED] for Babies, Children and Young People Requiring Symptom Management

Name:	DOB:
Address:	
Post Code:	
NHS Number:	Weight & Date:
GP:	
GP Address:	
Telephone No.	Fax No.
Known Allergies:	
Date of Known Allergies:	
Allergy Reaction & Type:	
Syringe Pump No.	[REDACTED]

Review date:
March 2020

Name: _____ NHS No: _____

The Prescriber has given permission for the medication on this page to be mixed into one infusion
The use of whole numbers for doses is required e.g. 250 micrograms rather than 0.25 mg.

Authorisation for daily medication to be given by continuous infusion over 24 hours via a syringe pump			Administration		Compatability of medications checked by			
Drug	Date		Date					
Route			Time					
Starting dose over 24 hours			Dose					
Indication			Given by					
If required and confirmed appropriate, future increased doses for symptom management:-			Expiry Date					
1st:	2nd:	3rd:	Batch No.s					
Prescribers Signature								
Print Name								
Confirmed appropriate to commence (initials and date)								

Drug	Date		Time					
Route			Dose					
Starting dose over 24 hours			Given by					
Indication								
If required and confirmed appropriate, future increased doses for symptom management:-			Expiry Date					
1st:	2nd:	3rd:	Batch No.s					
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Drug	Date		Time					
Route			Dose					
Starting dose over 24 hours			Given by					
Indication								
If required and confirmed appropriate, future increased doses for symptom management:-			Expiry Date					
1st:	2nd:	3rd:	Batch No.s					
Prescribers Signature								
Print Name								
Confirmed appropriate to commence (initials and date)								

The medication prescribed on this page can be diluted in any combination using water for injection / 0.9% sodium chloride/..... (delete as appropriate) upto..... mls
Prescribers signature..... Date.....

Administration									
Date									
Time									
Dose									
Given by									
Expiry Date									
Batch No.s									

Time									
Dose									
Given by									
Expiry Date									
Batch No.s									

Time									
Dose									
Given by									
Expiry Date									
Batch No.s									

For guidance an example can be found within:
West Midlands Children and Young People’s Palliative Care Toolkit

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If required and confirmed appropriate, future increased doses for symptom management:-			Expiry Date					
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Drug	Date		Time					
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For guidance an example can be found within:
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Name:

NHS No:

'Break Through' Medication Authorisation

'Break Through' Medication Authorisation

In case of _____

(state symptom indication)

In case of _____

(state symptom indication)

Please administer (drug, dose and frequency) _____

Please administer (drug, dose and frequency) _____

by _____ route

by _____ route

Further Instructions _____

Further Instructions _____

Prescribers Signature _____

Prescribers Signature _____

Print Name _____

Print Name _____

Date	Time	Dose	Signature	Was Administration Effective?

Date	Time	Dose	Signature	Was Administration Effective?

Name:

NHS No:

'Break Through' Medication Authorisation

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In case of _____ (state symptom indication)

In case of _____ (state symptom indication)

Please administer (drug, dose and frequency) _____

Please administer (drug, dose and frequency) _____

_____ by _____ route

_____ by _____ route

Further Instructions _____

Further Instructions _____

Prescribers Signature _____

Prescribers Signature _____

Print Name _____

Print Name _____

Date	Time	Dose	Signature	Was Administration Effective?

Date	Time	Dose	Signature	Was Administration Effective?

Check parent/carers/self medication chart before administering

Name:

‘Just In Case’ Medication Authorisation

In case of _____ (state symptom indication)

Please administer (drug, dose and frequency) _____

_____ by _____ route

Further Instructions _____

Prescribers Signature _____

Print Name _____

Date	Time	Dose	Signature	Was Administration Effective?

NHS No:

‘Just In Case’ Medication Authorisation

In case of _____ (state symptom indication)

Please administer (drug, dose and frequency) _____

_____ by _____ route

Further Instructions _____

Prescribers Signature _____

Print Name _____

Date	Time	Dose	Signature	Was Administration Effective?

Name:

NHS No:

‘Just In Case’ Medication Authorisation

‘Just In Case’ Medication Authorisation

In case of _____ (state symptom indication)

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_____ by _____ route

_____ by _____ route

Further Instructions _____

Further Instructions _____

Prescribers Signature _____

Prescribers Signature _____

Print Name _____

Print Name _____

Date	Time	Dose	Signature	Was Administration Effective?

Date	Time	Dose	Signature	Was Administration Effective?

Check parent/carers/self medication chart before administering

Name: _____ NHS No: _____

Drug & Concentration: _____

To be checked on every occasion when medication is used

Controlled Drug Stock Record

Date	Time	Check Number of stock on arrival	Stock received into home	Number of ampoules used	Check number of stock remaining	Amount discarded	Batch Number	Signature
Total amount disposed of <hr style="border: 0; border-top: 1px solid red; margin-top: 5px;"/>						Signature 1 Signature 2		

Name: _____ NHS No: _____

Drug & Concentration: _____

To be checked on every occasion when medication is used

Controlled Drug Stock Record

Date	Time	Check Number of stock on arrival	Stock received into home	Number of ampoules used	Check number of stock remaining	Amount discarded	Batch Number	Signature
Total amount disposed of						Signature 1		
<hr/>						Signature 2		

Patient's Name: _____ NHS No: _____

Drug & Concentration: _____

To be checked on every occasion when medication is used

Controlled Drug Stock Record

Date	Time	Check Number of stock on arrival	Stock received into home	Number of ampoules used	Check number of stock remaining	Amount discarded	Batch Number	Signature
Total amount disposed of _____						Signature 1		
						Signature 2		

Patient's Name: _____ NHS No: _____

Drug & Concentration: _____

To be checked on every occasion when medication is used

Controlled Drug Stock Record

Date	Time	Check Number of stock on arrival	Stock received into home	Number of ampoules used	Check number of stock remaining	Amount discarded	Batch Number	Signature
Total amount disposed of						Signature 1		
_____						Signature 2		

T34 Pump Infusion Record Subcutaneous/Central Line Assessment Sheet

Name..... DOB..... NHS number.....

Date	Time	T34 Syringe Pump Checks								Comments	Signature				
		Syringe size	Rate ml/hr	Volume to be Infused	Volume Infused	Battery Level %	Label in Place	Site of infusion	Light Flashing			Keypad Locked	Pain Score		

T34 Pump Infusion Record Subcutaneous/Central Line Assessment Sheet

Name..... DOB..... NHS number.....

Date	Time	T34 Syringe Pump Checks										Comments	Signature			
		Syringe size	Rate ml/hr	Volume to be Infused	Volume Infused	Battery Level %	Label in Place	Site of infusion	Light Flashing	Keypad Locked	Pain Score					

Name: _____ NHS No: _____

Regular Medication for Information Only:-

Name: _____ NHS No: _____

Carers record for photocopying

Date	Time	Dose	Medication	Was Administration Effective?

Name: _____ NHS No: _____ Date/Time _____

Temperature: _____ Heart Rate: _____ Respiratory Rate: _____

**Example:- Symptom Care Flow Sheet Aide-mémoire
For Photocopying**

Appearance:	Same	Better	Worse	Well	Unwell
Distress:	Nil	Mild	Moderate	Severe	
Pain:	Controlled	Some Breakthrough	Uncontrolled		
Sleep Pattern:	Normal	Changed			
Communication:	Normal	Fluctuating	Deteriorating		
Conscious Level:	Normal	Reduced			
Convulsions:	N/A	Controlled	Uncontrolled		
Breathing:	Normal	Abnormal			
Colour:	Normal	Pale	Mottled	Cyanosed	Flushed
Cough:	Nil	Occasional	Frequent	Unable to cough	
Secretions:	Normal	Productive			
Feeding:	Nil Orally	Oral	Tube Fed		
Appetite:	Normal	Increased	Decreased		
Vomiting:	Nil	Nausea	Occasional	Frequent	
Mouth:	Moist	Dry	Sore		
Abdominal Pain:	Nil	Occasional	Frequent	Distention	
Bowels:	<1	2	3	4	>5
Urinary Output:	Continent	Incontinent	Dysuria	Retention	Catheter
	Good Volume	< than usual	> than usual		
Posture/Movement:	Normal	Reduced	Spasm		
Sensation:	Reduced	Normal	Hypersensitive		
Skin:	Dry	Normal	Sore	Itchy	Oedema
	Intact / Broken	Risk Assessment	Yes	No	

Pain Tools For Photocopying

Sedative Effects		Site Check		Respiratory Pattern	
Unconscious	1	No redness	1	Regular	R
Asleep /Rousable	2	Tracking /Warm	2	Tachypnoea	T
Awake /Comfortable	3	Swollen	3	Wheezing	W
Agitated	4	Inflammation /Tenderness	4	Dyspnoea	D
				Cheyne Stokes	C

Out of the following 3 Pain Tools use the one you think is appropriate

1 FLACC Behavioural Pain Assessment Tool

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractable	Difficult to console or comfort

Each of the five categories: face, legs, activity, cry and consolability is scored from 0-2. The scores from each category should be added together for a final score.

2 Wong & Baker Visual Analogue Self-report Pain Assessment Tool



0
No hurt
Alert
Smiling



2
Hurts little bit
No humour
Serious, flat
Can be ignored



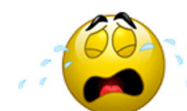
4
Hurts little more
Furrowed brow
Pursed lips
Breath holding
Interferes with tasks



6
Hurts even more
Wrinkled nose
Raised upper lip
Rapid Breathing
Interferes with concentration



8
Hurts whole lot
Slow blink
Open mouth



10
Hurts worst
Eyes closed
Moaning,
crying

3 Numerical Pain Assessment Tool



0	= No pain
1 - 3	= Mild pain
4 - 7	= Moderate pain
8 - 10	= Severe pain

Is an intervention required if so what?
Implement intervention or interventions.
Re-score at an appropriate interval to evaluate the effectiveness of intervention or interventions.

General instructions for use

This Drug Administration Document is intended for use by qualified/Clinical Staff. Where prior medication continues to be necessary please refer to relevant drug chart from your organisation.

- The chart should be written legibly in indelible ink, should be dated, and should state the full name, address and date of birth of the baby, child or young person.
- The charts should be signed for each medication authorised to be given.
- Use of whole numbers is required e.g. 250 micrograms rather than 0.25 mg.
- When decimals are unavoidable a zero should be written in front of the decimal point where there is no other figure e.g., 0.5ml not .5ml.
- Micrograms should not be abbreviated.
- Following zeros should not be used e.g., 3mg. not 3.0mg.
- The names of drugs and preparations should be written clearly and not abbreviated, using approved titles only.
- Any change in the drug therapy must be ordered by a new authorisation. Do not alter existing instructions.
- Discontinue a drug by drawing a line through it. Enter the date of cancellation and sign in the margin.
- The nurses responsible for setting up the syringe pump must check the compatibilities of the prescribed drugs and discuss the appropriate diluent and volume to be infused with the prescriber and document on pages 1 and 3.
- Where more than one syringe pump is used at any one time, one booklet should be used for each syringe pump.

References:-

- Association Of Paediatric Palliative Medicine (APPM) Formulary 2015
- Childrens BNF 2013
- Coventry and Warwickshire Partnership Trust
- NHS North Staffordshire Community Nursing Authorisation and Administration Record for Patients Requiring Supportive Care.
- NHS South Birmingham Footprints. Pain assessment tools. 5/5/2008
- Worcestershire Health and Care NHS Trust

Approved by:

- BCH Drug and Therapeutics Committee March 2015.
and in consultation with lead pharmacists and medicines managers, paediatricians, nursing staff and policy leads within the West Midlands

Review date:

- Review March 2017