NHS London Clinical Networks

Procedure for the use of a Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) Chart for subcutaneous and intramuscular medication in the community setting

This procedure should be read in conjunction with the policy on the use of the Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR) Chart for subcutaneous and intramuscular medication in the community setting

Version: 3
Circulated date: 2.7.2020
Agreed date: 2.7.2020
Review date: 2.7.2021

Contents

1 Introduction

1.1 Many patients nearing the end of life wish to remain in their own home, or the place they know as home e.g. a care home. In addition, patients with an advanced life-threatening illness may not be able to swallow oral medications (e.g. because of uncontrolled vomiting or because of difficulty swallowing).

1.2 This procedure applies to patients of all ages (children and adults).

1.3 Symptom control of these patients requires medicines to be administered by the subcutaneous (and sometimes intramuscular) route often in complex regimens that may be less familiar to healthcare staff working in the community.

1.4 Medicines can include controlled drugs such as opioids and midazolam that are high risk and require careful attention when prescribing, monitoring, record-keeping and disposal.

1.5 The Pan-London Symptom Control MAAR chart has been developed for safe administration of complex injectable regimens to overcome the risks of administering complex injectable regimens in the community or other setting where local medication charts do not provide the necessary space and scope. By doing so, the MAAR chart supports the patient to live and/or die in their preferred place of care, which is often their home, or the place they know as home.

1.6 The MAAR chart can be used for any patient who requires medicines to be administered as single subcutaneous or intramuscular doses given on an “as required” (PRN) basis or as a continuous subcutaneous infusion via a syringe driver.

1.7 The MAAR chart offers a clear, proforma-style layout that facilitates the optimal use of medicines in this setting based on legislation and best practice. They include:

- 1.7.1 Space to enter medicine name, form, dose / maximum dose in 24 hours, frequency.
- 1.7.2 Indication for use, medication for first line use and alternatives for second line use where appropriate.
- 1.7.3 Allergies.
- 1.7.4 GMC/NMC/GPhC number, signature and date.
- 1.7.5 Contact details for Clinical support / Specialist Services

1.8 The MAAR chart can be used for medicines that are already being administered and for medicines that have been prescribed in anticipation of future need.

1.9 The MAAR chart is not a prescription and therefore cannot be used to obtain medicines.

- 1.9.1 Medicines should be obtained via a discharge prescription - on a hospital pharmacy prescription for patients being discharged from an in-patient setting, or on an FP10 prescription for patients in the community which requires dispensing from a Community Pharmacy.
- 1.9.2 Ensure that adequate supplies of medicines and equipment (e.g. needles, syringes, sharps bin etc) are ordered to avoid running out.

1.10 The prescriber and all other members of the healthcare team involved in the patient's care should refer to Palliative Adult Network Guidelines (PANG) (available online at: https://book.pallcare.info/), or the Association for Paediatric Palliative Medicine Master Formulary found here. The PANG guidelines provide broad based information. Of note these advise on minimum and maximum doses, ranges and dose increments, as well as compatibility of different drugs within a syringe driver and appropriate diluents. In addition, Pharmacy/Medicines Information will be able to provide further guidance on compatibility. Locally approved guidelines on end of life (EOL) symptom management and anticipatory prescribing should be referred to when prescribing medicines including checking syringe driver compatibility. In addition, consider the following:

1.10.1 The MAAR chart may be used differently for anticipatory prescribing e.g. the syringe driver section of the MAAR chart can be completed prior to needing a continuous subcutaneous infusion via a syringe driver in the near future.

1.10.2 A patient information leaflet explaining the purpose of the medicines and where to get more help (see appendix 2 in the policy document for an example patient information leaflet).

1.10.3 Specialist advice and information is available from your local Palliative Care Team.

1.11 The MAAR chart procedure should be read in conjunction with the policy for the use of the MAAR chart.

1.12 Both prescribers and healthcare professionals administering, monitoring and disposing of medications share governance and responsibility for the safe and effective use of the MAAR chart.

2 Guidance for Prescribers

2.1 The MAAR chart has 3 sections:

2.1.1 24 hours continuous subcutaneous infusion from a syringe driver authorisation and administration chart

2.1.2 "As required" (PRN) subcutaneous injections authorisation and administration chart

2.1.3 Crisis/emergency and regular injections authorisation and administration chart e.g. midazolam for catastrophic bleed.

Each section records the patient's demographics, including name, date of birth, NHS number and allergies and the Authorising Clinician's name and professional body registration number.

2.2 Wherever possible, the authorising clinician must print off and 'wet' sign the authorisation chart. The completed chart can then be scanned and emailed to the Community Nursing staff or handed to the patient / family / staff for use.

However, in exceptional circumstances, the authorising clinician can complete the chart electronically. In this circumstance, it is essential that the authorising clinician follows the procedure outlined below in order to protect him/herself, the administering staff and the patient:

2.2.1 The authorising clinician must enter his/her name and GMC/NMC/GPhC number on each of pages 1 to 3 of the chart

2.2.2 The authorising clinician must type his/her initials in the 'Prescriber sign & print' area for each of the medications that he/she authorises.

2.2.3 The completed Pan-London Symptom Control MAAR chart must then be emailed from the authorising clinician's validated nhs.net account to another validated nhs.net account.

2.3 When prescribing dose ranges, use of the word “to” rather than a dash (which may be mistaken for a decimal point) e.g. morphine 5 mg to 10 mg. This is especially important where charts are handwritten.

2.4 Doses less than 1 mg should be written in micrograms e.g 500 micrograms to 1 mg alfentanil, 600 micrograms to 1.2 mg glycopyrronium

2.5 Where two medicines are written for the same indication, clearly state which medicine is to be used first line and which is to be used second line and under what circumstances this switch is to be considered.

2.6 When converting from the oral to the subcutaneous route remember to consider the number of oral PRN doses administered in a 24-hour period as well as the regular doses.

2.7 When stating a maximum PRN dose of medicine, if a syringe driver is also in use at the same time containing the same drug, where applicable ensure both the ‘prn’ and regular doses are taken into account to avoid exceeding maximum doses within same 24-hour period.

2.7.1 e.g. the dose of cyclizine administered via a syringe driver over 24 hours will determine the number of additional doses of cyclizine that may be given on a PRN basis in the same 24-hour period e.g. cyclizine 50mg via syringe driver would allow up to a further 100mg cyclizine to be administered PRN, since the maximum total dose allowed in a 24 hour period is 150mg cyclizine.

2.8 Review of anticipatory prescribing of medication on the MAAR chart:

2.8.1 The community healthcare team (Adult or Children’s Community Nursing Team and GP) who are responsible for the patient should ensure that the patient is reviewed regularly and as the patient’s condition changes, from the date that the MAAR chart is written i.e. when the anticipatory medicines are prescribed on the MAAR chart.

2.8.2 Prescribing on the MAAR Chart should be clear and unambiguous.

2.8.3 At the time a MAAR chart is required for the initiation of treatment, please ensure a clinical review is undertaken by a GP or a member of the palliative care team or a senior community clinician.

2.8.4 There is no legal requirement for how long these charts are valid for from the point they are written. A national group is reviewing this issue following Gosport and this document will be updated to reflect those outcomes and agreed best practice when available.

2.8.5 Best practice suggests they should be reviewed regularly enough to meet the clinical requirements of the individual patient to ensure that the medication is still clinically required and appropriate. Be aware that local arrangements/governance requirements may vary so please check local relevant policies.

2.8.6 When deciding whether to administer medication as authorised on these charts please consider:

2.8.6.1 Is the current situation consistent with the clinical scenario in which this MAAR chart was completed/intended? i.e. meant to be used when person is dying. For example, if the person is not dying and has fallen and broken hip then the MAAR chart is not valid.

2.8.6.2 Has the patient’s condition has changed significantly from the intended circumstances leading to this authorisation – be aware that medication requirements may increase, decrease or stop.

2.8.7 If you are unsure whether administering medication as per this MAAR chart is appropriate, please seek further advice/assessment.

2.8.8 NB: See PANG and/or local clinical guidelines for detailed advice on minimum and maximum doses, ranges and dose increments.

2.8.9 Any change following a review of a MAAR chart requires the change to be signed and dated by the prescriber undertaking the review. If a new chart is required, the prescriber should strike through, sign and date the old MAAR chart, or give clear instruction to the clinician administering medication using the chart to do this. The old chart must be filed in the patients notes to ensure it is taken out of use.

2.9 Review of the in-use MAAR Chart (for regular and PRN medication)

2.9.1 Once medication has been initiated, the review of the MAAR chart should be in line with individual needs of the patient and changing clinical requirement.

2.9.2 It is anticipated that in these circumstances the patient is being reviewed on a very regular basis by the wider community team (GP, adult / children's community nursing and possibly palliative care team).

2.9.3 Where community nurses have almost filled all available administration sections of the "As required" MAAR chart, a clinical review should be undertaken, and a new MAAR chart prescribed.

2.9.4 There may be more than one MAAR chart in use during an episode of care. All prescribing on the MAAR chart should be clear and unambiguous.

2.9.5 A Coroner's investigation will be required following a patient's death if the GP has not reviewed the patient 14 days prior to his/her death. Whilst the UK is responding to COVID-19, this requirement has been extended to 28 days as outlined in the Coronavirus Act 2020 here.

3 Guidance for Nurses

3.1 The contents of the syringe driver should be written clearly on a standard syringe driver label attached to the barrel of the syringe.

3.1.1 Attach the label to the barrel of the syringe so that the information can still be read once the syringe is attached to the driver.

3.1.2 Know how to obtain supplies of these labels.

3.2 Confirm the contents of the current syringe driver in use when the patient is transferred across different care settings.

3.2.1 Use at least two sources for medicines reconciliation e.g. the syringe driver label, syringe driver infusion and administration record and checklist, discharge / referral letter.

3.2.2 Always contact the referring team if any of this information is missing or unclear.

3.3 Ensure adequate supplies of medicines and equipment (e.g. syringe driver labels, needles, syringes, sharps bin) are available in the home.

3.3.1 Plan in advance for public holidays and weekends and order medicines in advance.

3.3.2 Be aware of local schemes to provide End of Life (EOL) medications, e.g. contact your local CCG to confirm a list of Community Pharmacies commissioned to hold an emergency supply of EOL medication

3.3.3 Refer to the Stock Balance Chart to help maintain adequate supplies of medicines.

3.3.3.1 e.g. there should be a Controlled Drug (CD) Stock Balance Chart in use for Schedule 2 and Schedule 3 CDs.

3.3.3.2 Some areas may also keep a Stock Balance Chart for other injectables.

3.4 The MAAR chart is for injectable medicines only. Be aware that other medication charts may also be used locally in the community e.g. for opioid patches and enemas.

3.4.1 The MAAR chart includes a checkbox to alert the nurse of this.

3.5 If a range of doses is prescribed, aim to administer the lowest possible dose of medicine to control symptoms.

3.5.1 If symptoms remain uncontrolled or if you need further advice, contact your Palliative Care team.

4 Guidance on the disposal of medicines

4.1 Medicines that have been prescribed for patients remain their own property.

4.2 Advise carers to return unused medicines to any Community Pharmacy for safe disposal

4.3 Healthcare professionals should follow local policy/procedure when considering removal of unwanted medicines from a patient's home. Local policy/procedure should outline the circumstances in which this is appropriate e.g. where they consider there to be a risk if left in the home.

4.4 Where local policy procedure allows:

- Medicines should be returned to a Community Pharmacy as soon as possible avoiding breaks in the journey and/or storage elsewhere overnight. If breaks in the journey are unavoidable or overnight storage required after all other options have been exhausted, please refer to local guidelines for storage information
- Consent should be obtained from the patient/carer to remove unwanted medication on their behalf
- Document in the clinical record and on the Stock Balance Chart to ensure a clear audit trail for the CDs