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

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

Version: 5
Agreed date: 16/10/24
Review date: 16/10/26

Contents

1 Introduction

1.1 Many patients who are deteriorating and 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 difficulty swallowing).

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

1.3 Symptom control of these patients may require medications 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 Medications can include controlled drugs (CDs) such as opioids and midazolam that are considered to be high risk and require careful attention when prescribing, monitoring, and recording and disposal.

1.5 The MAAR chart has been developed for safe administration of complex injectable regimens in the community or other setting where local medication charts (either paper or digital) do not provide the necessary spaceand scope. By doing so, the MAAR chart supports the patient to live and/ or die in their preferredplace of care, which is often their home, or the place they know as home.

1.6 The MAAR chart is for use in primary care, including those patients moving from secondary care into primary care. Where a person is in a care home, the care home may have their own processes for recording the authorisation and administration of end of life care medication. This may be a paper or electronic system (eMAAR). Where medications are being transcribed from the end of life care MAAR chart onto the “local” system, this must always be completed in line with the care home’s own policy. PLEASE NOTE: there may be a risk of clinical error if two separate medication authorisation and administration systems (ie two MAAR charts) are used alongside each other. Local policies and processes should take steps to mitigate this risk though training, use of appropriately qualified staff and appropriate documentation.

1.7 All healthcare professionals involved in the administration, monitoring and disposal of medications share governance and a joint responsibility for the safe and effective use of the MAAR chart.

1.7.1 The “Policy for using the Pan-London Symptom Control Medication Authorisation and Administration Record (MAAR): Chart for subcutaneous and intramuscular medication in the community setting” should be read in conjunction with this Procedure.

1.7.2 The Policy recommends a framework of good collaborative practice between healthcare professionals when it comes to prescribing, authorising and administering medications for symptom control when these responsibilities lie across the boundaries of more than one organisation that cares for that patient. This alliance working aims to reduce the risk of confusion, improve information sharing and increase the chances of the patient being able to live and/ or die in the place of their choice and by doing so aligns with the recommendations of the NHS Long Term Plan in supporting people in the community.

1.8 The MAAR chart can be used for any patient who requires medications to be administered as single subcutaneous or intramuscular doses given on an “as required” (PRN) basis for a flare in symptoms or in response to a crisis/ emergency situation (e.g. bleed out or seizure), or as a

continuous subcutaneous infusion via a syringe pump.

1.9 The MAAR chart offers a clear, proforma-style layout that facilitates the optimal use of medications in this setting based on legislation and best practice. The chart includes space to record:

1.9.1 Medication name, form, dose / max 24hr dose, frequency.

1.9.2 Indication for use, medication for first-line use and alternatives for second line use where appropriate.

1.9.3 Allergies.

1.9.4 GMC/ NMC/ GPhC number, signature and date.

1.9.5 Contact details for the local Palliative Care team.

1.10 The MAAR chart is not a prescription and therefore cannot be used to obtain medications. It is a chart used to authorise the administration of medications that have already been obtained with a prescription.

1.10.1 Medications can be obtained on a hospital prescription, also known as a 'To Take Away / Out' (TTA/O) for patients being discharged from an in-patient setting, or on an FP10 prescription from a community pharmacy for patients at home or in a care home.

1.10.2 Ensure that adequate supplies of medications and equipment (e.g. needles, syringes, sharps bin) are ordered to avoid running out.

1.11 The MAAR chart can be used for authorising medications that are already being administered and for medications that have been prescribed in anticipation of future need ("anticipatory" prescribing).

1.12 Clinical advice, including recommendations for prescribing minimum and maximum doses, prescribing doses in ranges and dose increments in between, drug compatibilities mixed in a syringe pump and the appropriate diluents can be found in the Palliative Adult Network Guidelines ("PANG") available online at: https://book.pallcare.info/, or the Association for Paediatric Palliative Medicine Master Formulary, which is available online at: https://www.appm.org.uk/guidelines-resources/appm-master-formulary/. Advice may also be obtained from the local Palliative Care team or local hospital Medicines Information department.

1.13 It is recommended that a 24-hour syringe driver is authorised as close to the time of its need as possible, and where possible, a senior clinician assesses the patient before it is initiated, to ensure that reasons for deterioration are considered and that there is safe prescribing – as outlined here.

1.14 A patient/ carer information leaflet explaining the purpose of the medications and where to get more help is available (see appendix 2 in the Policy document that accompanies this Procedure, for an example leaflet).

1.15 Specialist advice and information is available from your local Palliative Care team.

2 Guidance for authorisers[1]

2.1 The MAAR chart has 3 sections that authorisers should consider completing:

2.1.1 'AS REQUIRED' (PRN) SUBCUTANEOUS INJECTIONS AUTHORISATION AND ADMINISTRATION CHART.

2.1.2 24 HOURS CONTINUOUS SUBCUTANEOUS INFUSION (SYRINGE PUMP) AUTHORISATION CHART.

2.1.3 CRISIS/EMERGENCY AND REGULAR INJECTIONS AUTHORISATION AND ADMINISTRATION CHART.

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

Sections 4 to 6 of the chart are used to support safe administration of the medications that have been authorised in sections 1 to 3.

2.2 There are two options for authorising and sending the MAAR Chart.

Option 1: The authoriser can complete the chart by hand:

- The authoriser must print off, complete in full and 'wet' sign the original MAAR chart.
- The authoriser must ensure that his/her name and GMC/NMC/GPhC number is recorded on each completed section 1-3.
- The completed, original signed MAAR chart should then be handed to the patient (if appropriate), family member/carer or a member of the community nursing staff to deliver to the patient's home. Alternatively, the completed MAAR chart can be scanned in and emailed from the authoriser's secure validated email (e.g. nhs.net) account to a secure validated email account of the community nursing staff.
- The authoriser should then archive the completed MAAR chart that was sent identifying that a scanned version has been sent and is in use.

Option 2: The authoriser can complete the MAAR chart electronically:

- The authoriser must ensure that his/ her name and GMC/ NMC/ GPhC number is recorded on each separate section from 1 to 3 of the MAAR chart.
- The authoriser must type his/her initials in the 'Authoriser sign & print' area for each of the medications that he/she authorises.
- The completed MAAR chart must then be emailed from the authoriser's validated secure email (e.g. nhs.net) account to another validated secure email account, for example a member of the Community Nursing staff. A generic team email address must not be used to send the completed chart; use of the authoriser's validated secure email account serves to authenticate this method of transmission.

[1] 'Authoriser' refers to clinician authorising medication on the MAAR chart, 'Prescriber' refers to clinician prescribing medication on a prescription – see Policy for further information.

2.3 It is strongly recommended that the clinician who prescribes the medication (e.g. on an FP10) should also authorise their administration on the MAAR chart. Where MAAR charts are "pre-fill" by one person requiring signature only from the authoriser, partners should work towards alignment with our recommendation. When taking specialist advice from other professionals about what to prescribe and authorise, this should be written advice, and it is essential that the clinician who is completing and authorising the chart understands that they take sole responsibility for the medications authorised. See procedure for further details.

2.4 When authorising dose ranges, use 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 the MAAR chart is handwritten.

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

2.6 Where two medications are written for the same indication, clearly state which medication is to be used first-line and which is to be used second line and under what circumstances this switch is to be considered.

2.7 When converting from the oral to the subcutaneous route remember to consider the number of oral PRN doses (in addition to the regular doses), administered in the preceding 24 hours when calculating the new dose.

2.8 The doses of medication authorised on the PRN section of the MAAR chart must take into consideration other relevant regular medication already authorised (i.e. medication given via the syringe pump and/or a transdermal opioid patch if in situ)

2.9 The maximum 24-hour dose of PRN medication authorised for each medication on the PRN section of the MAAR Chart refers to the maximum dose to be administered PRN. It does not include the medication administered via the 24hrs syringe pump. This will require careful consideration for certain drugs to ensure that the maximum recommended dose is not exceeded (e.g. cyclizine). Seek specialist advice if needed.

2.10 If more than one 'as required' chart or more than one 24hours continuous subcutaneous infusion chart is needed, indicate that this is the case using the tick boxes at the top of each chart.

2.11 When to review the MAAR that is not currently in use i.e. medications have been authorised in anticipation of future need:

2.11.1 There is no legal requirement for how long the MAAR chart is valid for from the point it is authorised. We have therefore written these documents based on current best practice and will review them as further evidence develops.

2.11.2 Best practice suggests the MAAR chart should be reviewed regularly enough to ensure the medications and doses that have been authorised remain appropriate for the patient's clinical condition at the point treatment is initiated.

2.11.3 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, the MAAR chart is updated accordingly.

2.11.4 When the MAAR chart is required for the initiation of treatment, a clinical review of the patient should be undertaken by a GP or a member of the palliative care team or a senior community clinician to ensure the medications and doses authorised on the MAAR chart remain clinically appropriate.

2.11.5 NB: It is recommended that a 24-hour syringe driver is authorised as close to the time of its need as possible. A GP, a member of the palliative care team or a senior community clinician should - where possible - assess the patient before it is initiated. This is to ensure that reasons for deterioration are considered and that there is safe prescribing –as outlined here.

2.11.6 Any member of the healthcare team who has a query or concern about medications authorised on the MAAR chart must seek further advice before administering to the patient.

2.12 Any change following a review of a MAAR chart requires the change to be signed and dated by the authoriser undertaking the review.

2.12.1 If a 24hr infusion is authorised at a different time point to the authorisation of the PRN chart – i.e. after PRN medications have been administered – the PRN Chart should be reviewed, to ensure that appropriate doses of each PRN medication are authorised.

2.12.2 If a new chart is required, the authoriser should strike through, sign and date the old MAAR chart.

2.12.3 Where an instruction has been made by the authoriser to another clinician to make any changes to the MAAR Chart, the person making the changes should also include the name of the authoriser who instructed this action and the date and time the instruction was given, including when they have been asked to strike through, sign and date the old MAAR chart.

2.12.4 The old MAAR chart must be filed in the patient's notes to ensure it is taken out of use.

2.12.5 When changes/updates to the MAAR chart are required, it is best practice to re-write the whole chart. Amendments to an existing chart should only occur when re-writing the chart would case unnecessary delay.

2.13 When to review the MAAR chart that is currently in use:

2.13.1 Once medication has been initiated, the MAAR chart should be reviewed regularly enough to meet the clinical needs of the patient.

2.13.2 It is anticipated that in these circumstances the patient is being reviewed on a regular basis by the community healthcare team (GP, Adult / Children's Community Nursing and possibly the Palliative Care team).

2.13.3 Where the nurse has almost filled all available administration sections of the "As required (PRN) subcutaneous injections authorisation and administration" MAAR chart, a clinical review should be undertaken, and a new MAAR chart completed taking into consideration the instructions outlined in section 2.9.

2.13.4 There may be more than one section from the MAAR chart in use during an episode of care.

2.13.5 If there are more than 3 PRNs in 24 hours, the MAAR chart should be reviewed.

3 Guidance for clinicians administering medicines

3.1 Sections 1 to 3 of the MAAR Chart are completed by prescribers and authorise the administrationof medication either 'as required' (section 1), via a 24hr continuous subcutaneous infusion (section 2), for a crisis situation (e.g. large haemorrhage), or regularly (section 3). Authorisers will complete sections that are to be used for each individual patient.

3.2 Sections 4 to 6 of the MAAR Chart are completed by nursing or other staff who administer medication that has been authorised. The following are included: a Controlled Drug stock balancechart (section 4) a Non-controlled drug stock balance chart (section 5) and a 24hr continuous subcutaneous infusion administration record and checklist (section 6).

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

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

3.3.2 Know how to obtain supplies of these labels.

The contents of the syringe pump should also be clearly documented in section 6 (24hr continuous subcutaneous infusion administration record and checklist) of the MAAR chart. Where a medication is either added or withdrawn from the syringe pump, any blank boxes on the MAAR chart for preceding or subsequent days should be clearly crossed through.

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

3.4.1 Use at least two sources of information to do this (e.g. the syringe pump label, syringe pump administration record and checklist, discharge / referral letter).

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

3.5 When filling-out section 6:

3.5.1 Cross through the columns with empty boxes due to unused days

3.5.2 'Visual volume checked (yes/no)' means checking/reassuring yourself that on visual inspection the volume in the syringe looks accurate/as you expected

3.5.3 'Keypad locked (✓)' means verifying that the keypad itself is locked, not that the box is locked

3.6 Ensure adequate supplies of medication and equipment (e.g. syringe pump labels, needles, syringes, sharps bin) are available in the home.

3.6.1 Plan for public holidays and weekends and order medications in advance.

3.6.2 Be aware of local schemes to provide medications for patients nearing the end of life, e.g. contact your local ICS to confirm a list of community pharmacies commissioned to hold emergency supplies of these medications.

3.6.3 Refer to the Stock Balance Charts (sections 4 and 5) to help maintain adequate supplies of medications. E.g. there should be a CD Stock Balance Chart in use for Schedule 2 and Schedule 3 CDs. Some areas may also keep a Stock Balance Chart for other, non-CD injectable medications.

3.7 The MAAR chart is for injectable medications only.

3.7.1 Be aware that other medication charts may also be used in the community (e.g. for opioid patches and enemas).

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

3.8 If a range of doses is authorised, aim to administer the lowest possible dose of medication to control symptoms.

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

4 Guidance on the disposal of medications

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

4.2 Advise family member/ carer to return unused medications to a community pharmacy for safe disposal.

4.2.1 This does not have to be the pharmacy that dispensed the medications.

4.3 Healthcare professionals should follow local policy/ procedure when considering removal of unwanted medications from a patient's home.

4.3.1 Local policy/ procedure should outline the circumstances in which this is appropriate e.g. where they consider there to be a risk if the medications are left in the home.

4.4 Where local policy/ procedure allows:

4.4.1 Medications should be returned to a community pharmacy as soon as possible by avoiding breaks in the journey and/ or storage elsewhere overnight.

4.4.2 If breaks in the journey are unavoidable or overnight storage required after all other options have been exhausted, refer to local guidelines for information

4.4.3 Consent should be obtained from the patient (if appropriate), family member/ carer to remove unwanted medication on their behalf.

4.4.4 Document this consent in the clinical record and, where the medications are controlled drugs, complete the CD Stock Balance Chart to ensure a clear audit trail is in place.