NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

PAEDIATRIC PCA OR NCA PRESCRIPTION AND OBSERVATION CHART

(patient controlled or nurse controlled analgesia)

Paediatric PCA or NCA Management Guide

*Paediatric PCA/NCA is **ONLY** to be used in facilities with local governance structures in place to ensure its safe and effective use in children. These must include a PCA/NCA guideline (including specific paediatric information), appropriate environment, staff training, supervision and support.*

- **Paediatric Ward:** Children or adolescents with a PCA or NCA ***MUST*** be cared for in a dedicated paediatric ward or paediatric inpatient area with appropriately trained staff.
- **Pain** and **Sedation Observations** recorded HOURLY on this form for the duration of the PCA/ NCA or more frequently as the patient's clinical condition warrants.
- All other observations to be recorded HOURLY on a Standard Paediatric Observation Chart.
- Continuous pulse oximetry ***MUST*** be used.
- **Oxygen therapy** as required to maintain oxygen saturations above 95%.
- **No other opioids or sedatives** to be administered unless ordered by the Acute Pain Service or equivalent medical officer.
- **The PCA pump settings** to be checked by 2 nurses at the commencement of each shift, on transfer of care or patient transfer and when the syringe or bag is changed.
- **Pruritus or nausea or vomiting:** Administer PRN medication as prescribed on the Paediatric National Inpatient Medication Chart. If adverse effect continues contact the Acute Pain Service or equivalent medical officer.
- **PCA:** Only the child is to press the PCA button.
- **NCA:** Only the allocated registered nurse is to press the button.
- **A dedicated PCA giving set** with anti-reflux and anti-siphon device must be used.

(For detailed information regarding Paediatric PCA/ NCA prescribing, administering and management refer to local hospital procedures)

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

APPROPRIATE CLINICAL CARE FOR PATIENTS WITH YELLOW AND RED ZONE OBSERVATIONS:
1. ENSURE OXYGEN THERAPY IS IN PROGRESS
2. REMOVE PCA/NCA BUTTON FROM PATIENT AND STOP BACKGROUND INFUSION IF IN PROGRESS
3. ENSURE THAT THE ACUTE PAIN TEAM OR EQUIVALENT MEDICAL OFFICER IS CONTACTED
4. CONSIDER NALOXONE

BLUE ZONE RESPONSE

YOU MUST FOLLOW THE RESPONSE INSTRUCTIONS ON THE NSW STANDARD PAEDIATRIC OBSERVATION CHARTS (SPOC)

YELLOW ZONE RESPONSE

YOU MUST FOLLOW THE RESPONSE INSTRUCTIONS ON THE NSW STANDARD PAEDIATRIC OBSERVATION CHARTS (SPOC) AND INITIATE APPROPRIATE CARE AS STATED ABOVE

RED ZONE RESPONSE

YOU MUST CALL FOR A RAPID RESPONSE (as per local CERS), FOLLOW THE RED ZONE RESPONSE INSTRUCTIONS ON THE NSW STANDARD PAEDIATRIC OBSERVATION CHARTS (SPOC) AND INITIATE APPROPRIATE CARE AS STATED ABOVE

ACUTE PAIN SERVICE or equivalent medical officer CONTACT:

BUSINESS HOURS page/phone: **OUT OF HOURS page/phone:**

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PAEDIATRIC PCA OR NCA PRESCRIPTION AND OBSERVATION CHART

SMR130.026

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Date	Initials

COMPLETE ALERT SHEET IN MEDICAL RECORD

Sign.....Print.....Date.....

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First Prescriber to Print Patient Name and Check Label Correct:

Weight (kg) ..... Date Weighed ...../...../.....

Paediatric PCA OR NCA prescription guide

If the child has a weight over the 95th percentile then use 50th percentile weight as a start dose.

		Children less than 50kg	Children more than 50kg
OPIOID DILUTION	Morphine	**1 mg/kg** diluted to a total volume of 50 mL with 0.9% sodium chloride	**50 mg** diluted to a total volume of 50 mL with 0.9% sodium chloride
	Oxycodone	**1 mg/kg** diluted to a total volume of 50 mL with 0.9% sodium chloride	**50 mg** diluted to a total volume of 50 mL with 0.9% sodium chloride
	Fentanyl	**20 microgram/kg** diluted to a total volume of 50 mL with 0.9% sodium chloride	**1000 microgram** diluted to a total volume of 50 mL with 0.9% sodium chloride
BOLUS DOSE	Morphine	1 mL = (delivers) 20 microgram /kg	1 mL = 1 mg = 1000 microgram
	Oxycodone	1 mL = (delivers) 20 microgram /kg	1 mL = 1 mg = 1000 microgram
	Fentanyl	1 mL = (delivers) 0.4 microgram /kg	1 mL = 20 microgram
LOCKOUT	PCA	PCA 5 minutes	PCA 5 minutes
	NCA	NCA 15 minutes	NCA 15 minutes
BACKGROUND INFUSION* (recommended rates)		***Background infusions are generally for NCA as rarely required for PCA.***	
	Morphine	0.5 mL/hr = 10 microgram/kg/hr	0.5 mL/hr = 0.5 mg/hr = 500 microgram/hr
	Oxycodone	0.5 mL/hr = 10 microgram/kg/hr	0.5 mL/hr = 0.5 mg/hr = 500 microgram/hr
	Fentanyl	0.5 mL/hr = 0.2 microgram/kg/hr	0.5 mL/hr = 10 microgram/hr

**** Background Infusions require local guideline support as they are associated with increased risk.***

PRESCRIPTION PCA: ☐ or NCA: ☐ is valid for a maximum of 48 hours unless ceased

Route	Drug	Amount (microgram or mg) to be added to syringe/bag	Diluent **0.9% sodium chloride**	Total volume **50 mL**	Drug concentration (microgram/mL or mg/mL)

Date	Prescriber's signature	Print your name	Contact	Pharmacy

PROGRAM:

Date	Time	PCA bolus dose (mg or microgram or mL)	Lockout interval (minutes)	Background infusion (microgram/ hr or NIL)	Prescriber's signature	Prescriber's name

NALOXONE:

For sedation score 3 or 4 OR respiratory rate in the Red Zone on the SPOC chart *you must call for a Rapid Response (as per local clinical emergency response system (CERS).*
Recommended naloxone dosage:
5 microgram per kg, every 2 to 3 minutes

Dilute NALOXONE 0.4 mg to 20 mL with 0.9% sodium chloride
(this dilution = 20 microgram/mL)

Date:	**Time:**	**Medication:**
Route:	**Dose and frequency:**	
Pharmacy/additional information:		
Indication: *respiratory depression*	**Dose calculation:** 5 microgram/kg/dose to max 100 microgram/dose	
Prescriber's signature	**Print name**	**Contact**

CEASE PCA/NCA ACCORDING TO INSTRUCTIONS IN THE MEDICAL RECORD
See entry written in medical record on Date: ...../...../..... Time: .....:.....hrs

NO WRITING

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PAEDIATRIC PCA OR NCA ADMINISTRATION AND DISCARD

(patient controlled or nurse controlled analgesia)

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Record of PCA / NCA syringe / bag administration and drug discarded

Record of PCA / NCA bag or syringe administration					Record of PCA / NCA drug discarded				
	Date	Time	Signature 1	Signature 2	Date	Time	Total discarded drug (mL, mg or microgram)	Signature 1	Signature 2
1									
2									
3									
4									
5									
6									

Prescription is only valid for a maximum of 48 hours.
New prescription required if PCA/NCA needs to be re-started.

Record of Naloxone administered

	Date	Time	Route	Dose (microgram and mL)	Signature 1	Signature 2
1						
2						
3						
4						

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PAEDIATRIC PCA / NCA HOURLY OBSERVATIONS

DATE														
TIME														
PAIN SCORE Assess pain both at rest and with relevant movement (e.g. deep breathing, coughing). **Document "R" for rest and "M" for movement**														
Pain Scale used: ☐ FLACC ☐ Face Pain ☐ Visual Analogue ☐ FLACC-R	Severe pain	10												
		9												
		8												
		7												
	Moderate pain	6												
		5												
		4												
	Mild pain	3												
		2												
		1												
	No pain or asleep	0												
DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)														
Unrousable		4												
Deep sedation (deep sleep, rousable only with deep or significant physical stimuli)		3												
Moderately sedated (somnolent/sleeping, easily roused with light tactile stimulation or simple verbal command)		2												
Minimally sedated (may appear tired/ sleepy, responds to verbal conversation and/or sound)		1												
Awake and alert		0												
Asleep (rousable)		S												
RESPIRATORY RATE AND OXYGEN SATURATIONS to be recorded on the correct Standard Paediatric Observation Chart (SPOC)														
PCA DELIVERY (record hourly and at completion of each syringe / bag)														
Total primary PCA / NCA dose (cumulative) mg or microgram or mL (circle one)														
Background infusion rate (microgram/hr or mg/hr or mL/hr) (circle one)														
Total demands														
Successful demands														
PCA program checked (initial)														
ADVERSE REACTIONS (Y=Yes, N=No)														
Nausea or vomiting														
Pruritus														
COMMENTS / ACTIONS														
NURSE INITIAL:														
PCA / NCA Program changed (two initials for change of PCA/NCA program, clinical handover, transfer of care or syringe/bag change)														

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PAEDIATRIC PCA OR NCA PAIN ASSESSMENT TOOLS
(patient controlled or nurse controlled analgesia)

Paediatric Pain Scoring Tools

Choose a pain scoring tool appropriate to the age and development of the infant or child

Tool 1: FLACC observational pain scoring tool (revised)

Use for infants and non-verbal children (including cognitively impaired children) ***FLACC-R bold italic are descriptors validated in children with cognitive impairment***

FLACC Scale (3 months to 4 years)	**Score 0**	**Score 1**	**Score 2**
FACE	No particular expression or smile	Occasional grimace/frown withdrawn or disinterested, ***appears sad or worried***	Frequent constant quivering chin, clenched jaw, ***distressed looking face; expression of fright or panic***
LEGS	Normal position or relaxed	Uneasy, restless or tense, ***occasional tremors***	Kicking or legs drawn up, ***marked increase in spasticity, constant tremors or jerking***
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense, ***mildly agitated (e.g. head back & forth, aggression), shallow, splinting respirations, intermittent sighs***	Arched, rigid or jerking, ***severe agitation, head banging, shivering (not rigors), breath-holding, gasping or sharp intake of breath, severe splinting***
CRY	No cry (Awake or Asleep)	Moans or whimpers, occasional complaints, ***occasional verbal outburst or grunt***	Crying steadily, screams or sobs. Frequent complaints, ***repeated outbursts, constant grunting***
CONSOLABILITY	Content or relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort, ***pushing away caregiver, resisting care or comfort measures***
FLACC interpretation- add the scores from each of the five assessments for a score of 0-10			

Merkel SI, Voepel-Lewis, T. Shayevitz, J R. Malviya, S. The FLACC: A behavioural scale for scoring postoperative pain in young children. Pediatric Nursing. 1997 May-June; 23(3):293-7. Malviya S, Voepel-Lewis T, Burke C, Merkel S, Tait A. The revised FLACC observational pain tool: improved reliability and validity for pain assessment in children with cognitive impairment. Pediatric Anesthesia 2006 16: 258-265

Tool 2: Face Pain Scale (revised)

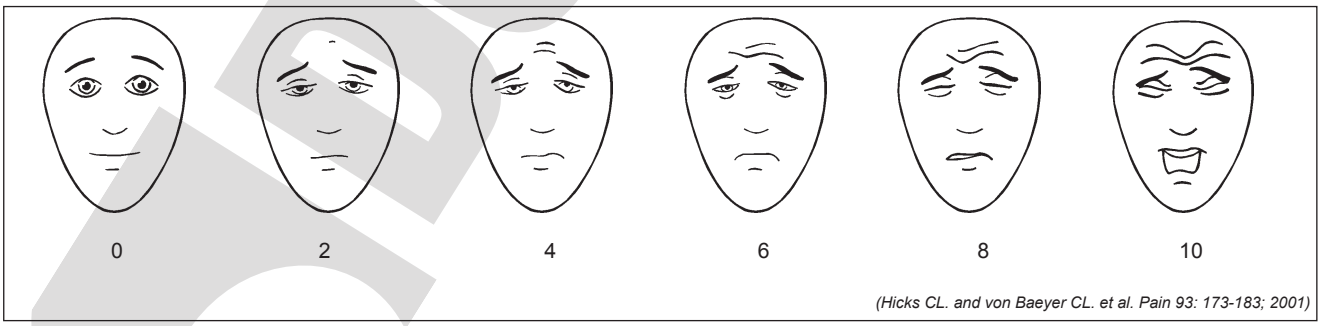
Use for verbal children over 4 years of age

In the following instructions, say "hurt" or "pain", whichever seems right for a particular child.

"These faces show how much something can hurt. This face [point to face on far left] shows no pain. The faces show more and more pain [point to each from left to right] up to this one [point to face on far right] - it shows very much pain. Point to the face that shows how much you hurt [right now]."

Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so "0" = "no pain" and "10" = "very much pain". Do not use words like "happy" or "sad".

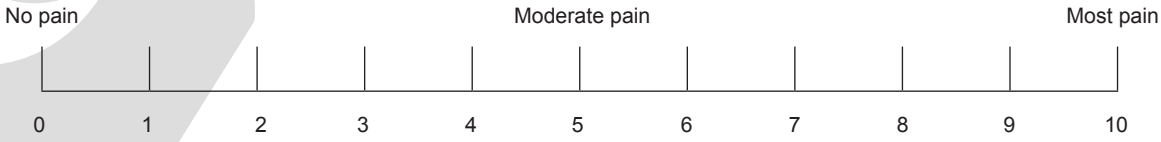
This scale is intended to measure how children feel inside, not how their face looks. *(Hicks CL. and von Baeyer CL. et al. Pain 93: 173-183; 2001)*



(Hicks CL. and von Baeyer CL. et al. Pain 93: 173-183; 2001)

Tool 3: Visual Analogue Scale

Use for verbal children over 7 years of age



Adapted from Scott DA & McDonald WM (2008) Assessment, Measurement and History. In: Textbook of Clinical Pain Management 2E edn. Macintyre PE, Rowbotham D and Walker S (eds). Acute Pain

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