

Facility:

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

FAMILY NAME	MRN
GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O. NOT A VALID
ADDRESS	PRESCRIPTION UNLESS IDENTIFIERS PRESENT
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

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
F ACE	No particular expression or smile	Occasional grimace/frown withdrawn or disinterested, appears sad or worried	Frequent constant quivering chin, clenched jaw, distressed looking face; expression of fright or panic
L EGS	Normal position or relaxed	Uneasy, restless or tense, occasional tremors	Kicking or legs drawn up, marked increase in spasticity, constant tremors or jerking
A CTIVITY	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
C RY	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
C ONSOLABILITY	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

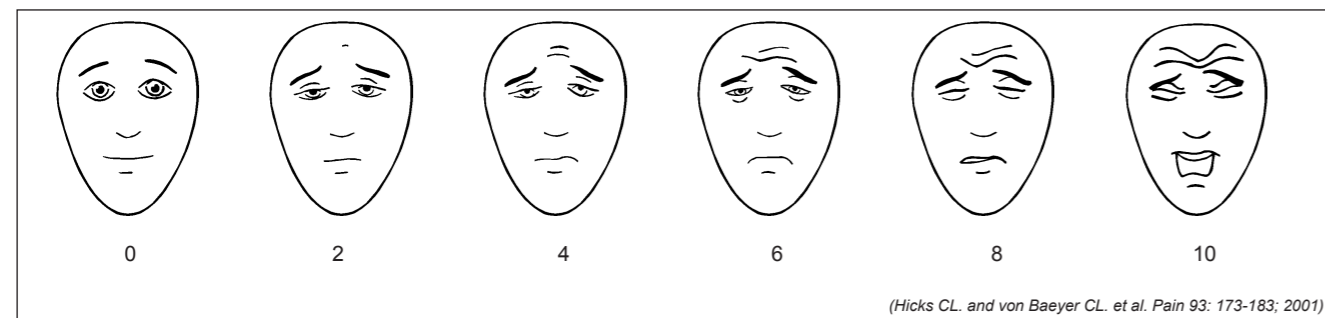
FLACC interpretation- add the scores from each of the five assessments for a score of 0-10

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)

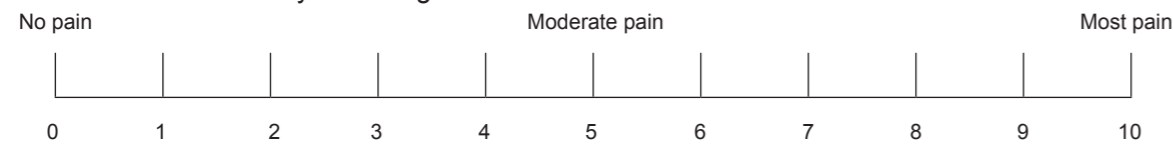
Use for verbal children over 4 years of age

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)



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

Facility:

PAEDIATRIC PCA OR NCA PRESCRIPTION AND OBSERVATION CHART
(patient controlled or nurse controlled analgesia)

FAMILY NAME	MRN
GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O. NOT A VALID
ADDRESS	PRESCRIPTION UNLESS IDENTIFIERS PRESENT
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

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, sedation, respiratory rate and oxygen saturations to be recorded HOURLY on this form and the Standard Paediatric Observation Chart for the duration of the PCA/NCA or more frequently as the patient's clinical condition warrants.
- 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 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

ADDITIONAL 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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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.....

FAMILY NAME _____ MRN _____
 GIVEN NAME _____ MALE FEMALE
 D.O.B. ____/____/____ M.O. NOT A VALID
 ADDRESS _____ PRESCRIPTION UNLESS IDENTIFIERS PRESENT
 LOCATION / WARD _____
 COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

First Prescriber to Print Patient Name and Check Label Correct:
 Weight (kg) Date Weighed/...../.....

Paediatric PCA or NCA prescription guide

If the child is over the 95th percentile for weight, then use 50th percentile weight as the dosing weight.

*Background infusions are generally for NCA as rarely required for PCA.

*Background infusions require local guidelines support as they are associated with increased risk.

Opioid	Concentration (amount in syringe)	PCA / NCA Bolus dose	Lockout Minutes	Background infusion*
Children 10 to 50 kg (this table is not suitable for children less than 10 kg)				
Morphine	1 mg/kg diluted to a total volume of 50mL with 0.9% sodium chloride	1 mL = 20 microg/kg	PCA: 5 minutes	0.5 mL/hr = 10 microgram /kg/hr
Oxycodone	1 mg/kg diluted to a total volume of 50mL with 0.9% sodium chloride	1 mL = 20 microg/kg		NCA: 15 minutes
Fentanyl	20 microgram/kg diluted to a total volume of 50mL with 0.9% sodium chloride	1 mL = 0.4 microg/kg		0.5 mL/hr = 0.2 microgram /kg/hr
Children more than 50 kg				
Morphine	50 mg diluted to a volume of 50 mL with 0.9% sodium chloride	1 mL = 1 mg = 1000 microgram	PCA: 5 minutes	0.5 mL/hr = 0.5 mg/hr = 500 microgram/hr
Oxycodone	50 mg diluted to a volume of 50 mL with 0.9% sodium chloride	1 mL = 1 mg = 1000 microgram		NCA: 15 minutes
Fentanyl	1000 microgram diluted to a volume of 50 mL with 0.9% sodium chloride	1 mL = 20 microgram		0.5 mL/hr = 10 microgram/hr

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	Total volume	Drug concentration (microgram/mL or mg/mL)
			0.9% sodium chloride	50 mL	
Date	Prescriber's signature	Print your name	Contact	Pharmacy	

PROGRAM:

DOSING WEIGHT: _____ kg

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/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: _____ Medicine (print generic name): _____
 Route: _____ Dose: _____ Frequency: _____ PRN Max PRN dose/24 hrs: _____
 Pharmacy/additional information: _____
 Indication: Respiratory depression Dose calculation: (5 microgram/kg/dose to max 100 microgram/dose)
 Prescriber's signature _____ Print your name _____ Contact/pager _____

CEASE PCA/NCA ACCORDING TO INSTRUCTIONS IN THE MEDICAL RECORD

See entry written in medical record on Date:/...../..... Time:hrs



NSW Health

FAMILY NAME _____ MRN _____
 GIVEN NAME _____ MALE FEMALE
 D.O.B. ____/____/____ M.O. NOT A VALID
 ADDRESS _____ PRESCRIPTION UNLESS IDENTIFIERS PRESENT
 LOCATION / WARD _____
 COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Facility:

PAEDIATRIC PCA OR NCA HOURLY OBSERVATIONS



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DATE	TIME																			
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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:		10																			
<input type="checkbox"/> FLACC	Severe pain	9																			
		8																			
		7																			
<input type="checkbox"/> Face Pain	Moderate pain	6																			
		5																			
		4																			
<input type="checkbox"/> Visual Analogue	Mild pain	3																			
		2																			
		1																			
<input type="checkbox"/> FLACC-R	No pain or asleep	0																			

DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)

		4																		
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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Facility:

PAEDIATRIC PCA OR NCA HOURLY OBSERVATIONS

Family Name, Given Name, D.O.B., M.O., Address, Location/Ward, MRN, Gender, and other patient details.

DATE TIME grid for recording observations.

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 table with categories: Severe pain (10-7), Moderate pain (6-4), Mild pain (3-1), No pain or asleep (0). Includes checkboxes for FLACC, Face Pain, Visual Analogue, and FLACC-R.

DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)

Depth of sedation scale table with levels: Unrousable (4), Deep sedation (3), Moderately sedated (2), Minimally sedated (1), Awake and alert (0), Asleep (rounable) (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)

PCA delivery table with rows for Total primary PCA / NCA dose, Background infusion rate, Total demands, Successful demands, and PCA program checked.

ADVERSE REACTIONS (Y=Yes, N=No)

Adverse reactions table with rows for Nausea or vomiting and Pruritus.

COMMENTS / ACTIONS

NURSE INITIAL:

Nurse initials grid with a note: PCA / NCA Program changed (two initials for change of PCA/NCA program, clinical handover, transfer of care or syringe/bag change).

Facility:

PAEDIATRIC PCA OR NCA ADMINISTRATION AND DISCARD (patient controlled or nurse controlled analgesia)

Family Name, Given Name, D.O.B., M.O., Address, Location/Ward, MRN, Gender, and other patient details.

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

Main table for recording PCA/NCA administration and drug discarded, split into 'Record of PCA / NCA bag or syringe administration' and 'Record of PCA / NCA drug discarded'.

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

Record of Naloxone administered table with columns for Date, Time, Route, Dose, Signature 1, and Signature 2.



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FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O. NOT A VALID	
ADDRESS PRESCRIPTION UNLESS IDENTIFIERS PRESENT		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

PAEDIATRIC PCA OR 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: <input type="checkbox"/> FLACC <input type="checkbox"/> Face Pain <input type="checkbox"/> Visual Analogue <input type="checkbox"/> FLACC-R	Severe pain	10																						
		9																						
		8																						
	Moderate pain	7																						
		6																						
		5																						
	Mild pain	4																						
		3																						
		2																						
	No pain or asleep	1																						
		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																						
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Awake and alert	0																						
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PCA DELIVERY (record hourly and at completion of each syringe / bag)																							
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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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FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O. NOT A VALID	
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LOCATION / WARD		
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PAEDIATRIC PCA OR NCA HOURLY OBSERVATIONS

DATE
TIME

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	No pain or asleep	1																						
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DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)

Unrousable	4																						
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PCA program checked (initial)																							

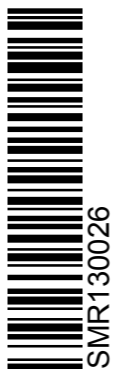
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Nausea or vomiting																							
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COMMENTS / ACTIONS

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