FAMILY NAME	MRN		
GIVEN NAME	ı	☐ MALE ☐ FEMALE	
D.O.B//	M.O.	OT A VALID	
ADDRESS	PRESC	RIPTION UNLESS	
	GIVEN NAME D.O.B//	GIVEN NAME D.O.B// M.O.	

Paediatric Pain Scoring Tools

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

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

Tool 1: FLACC observational pain scoring tool (revised)

PAEDIATRIC PCA OR NCA PAIN ASSESSMENT TOOLS

(patient controlled or nurse controlled analgesia)

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FACE	No particular expression or smile	Occasional grimace/frown withdrawn or disinterested, <i>appears sad or worried</i>	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, <i>marked</i> increase in spasticity, constant tremors or jerking
Астічіту	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense, <i>mildly agitated</i> (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

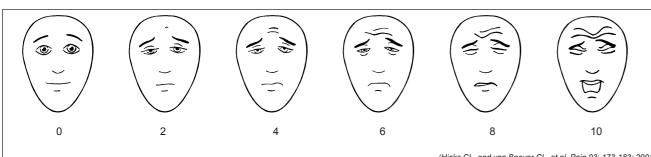
Merkel SI, Voepel-Lewis, T. Shayevitz, J R. Malviya, S. The FLACC: A behavioural scale for scoring postoperative pain in young children. Pediatric Nursing. 1997 May-June; 23(3):293-7 Malviya S, Voepel-Lewis T, Burke C, Merkel S, Tait A. The revised FLACC observational pain tool: improved reliability 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: V Use for ve					je						
No	pain				ľ	Moderate pa	ain				Most pain
C)	1	2	3	4	5	6	7	8	9	10

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 Pair

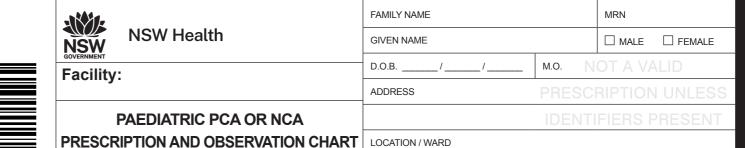


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Paediatric PCA or NCA Management Guide

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.

(patient controlled or nurse controlled analgesia)

- 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
- 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.

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

- 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:

Page 8 of 8 NO WRITING

NO WRITING Page 1 of 8

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			be added	to syninge	e/bag		0.9% sodium chloride	50	mL	(microgra	am/mL or mg/mL)		
Date	Pres	criber's signature	Print your	name			ı	Conta	ct	18	Pharmacy		
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NALO				Date:	N	Medic	cine (print gener	ric name	e):		1		
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linical emer lecommend	gency re ded nalo	sponse system (0 exone dosage:	CERS).	Pharmac	cy/addi	tiona	ıl information:						
		ery 2 to 3 minute	s	Indication	n:		Dose	calculati	on:				

(5 microgram/kg/dose to max 100 microgram/dose)

Print your name

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Contact/pager

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COMMENTS / A	CTIONS													
NURSE INITIAL	:													
PCA / NCA Prog (two initials for c	gram changed hange of PCA/NCA handover, transfer o	of												

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

Respiratory depression

Prescriber's signature

Page 2 of 8 NO WRITING

Dilute NALOXONE 0.4 mg to 20 mL with

0.9% sodium chloride (this dilution = 20 microgram/mL)

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Page 7 of 8

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NSW NSV	V Health				GIVE	N NAME						MALE	A VALID ION UNLESS RS PRESENT T LABEL HERE d "M" for movement				
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56	(patient controlled or nurse controlled analgesia)	COMPLETE ALL DETAILS	OR AFFIX P	ATIENT LABEL HERE	

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

	Record syring	of PCA / ge admi	NCA ba	g or n		Re	ecord of PCA / Note of PCA / N		
	Date	Time	Signature 1	Signature 2	Date	Time	Total discarded drug (mL, mg or microgram)	Signature 1	Signature 2
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Prescription is only valid for a maximum of 48 hours. New prescription required if PCA/NCA needs to be re-started.

			Reco	ord of Naloxone adminis	tered							
	Date	Time	Route	Dose (microgram and mL)	Dose (microgram and mL) Signature 1							
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Page 6 of 8

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Page 3 of 8

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