



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____ / ____ / ____		M.O.
ADDRESS		
LOCATION		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

CONTINUOUS OPIOID INFUSION (ADULT)

Continuous Opioid Infusion Management Guidelines

(For detailed information regarding continuous opioid infusion prescribing and management refer to local hospital policy)

- **Observations** on this form to be recorded hourly for 6 hours, then second hourly or more frequently if patient's clinical condition warrants.
- **Infusion pump settings** to be checked at the commencement of each shift, on patient transfer and when the syringe or bag is changed.
- **Additional bolus dose** may be given by a registered nurse to manage inadequate analgesia if prescribed on this form. Administration of this bolus dose must be witnessed by a second nurse or medical officer.
- **No other opioids or sedatives** to be administered unless ordered by the Acute Pain Service or equivalent medical officer.

Managing Adverse Effects

- **Pruritus or persistent nausea or vomiting:** Administer PRN medication as prescribed on the patient's National Inpatient Medication Chart. If adverse effect continues contact the Acute Pain Service or equivalent medical officer.
- **Urinary retention:** Contact the patient's surgical / medical team.
- **Constipation:** Prophylactic aperient therapy can be beneficial. Contact the patient's surgical / medical team.

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 ZONE OR RED ZONE OBSERVATIONS:

1. ENSURE OXYGEN THERAPY IS IN PROGRESS
2. STOP CONTINUOUS OPIOID INFUSION
3. ENSURE THAT THE ACUTE PAIN SERVICE OR EQUIVALENT MEDICAL OFFICER IS CONTACTED

YELLOW ZONE RESPONSE

IF YOUR PATIENT HAS ANY YELLOW ZONE OBSERVATIONS YOU **MUST** FOLLOW THE YELLOW ZONE RESPONSE INSTRUCTIONS ON THE NSW STANDARD OBSERVATION CHARTS AND INITIATE APPROPRIATE CLINICAL CARE AS STATED ABOVE

RED ZONE RESPONSE

IF YOUR PATIENT HAS ANY RED ZONE OBSERVATIONS YOU **MUST** CALL FOR A RAPID RESPONSE (as per local CERS), FOLLOW THE RED ZONE RESPONSE INSTRUCTIONS ON THE NSW STANDARD OBSERVATION CHARTS AND INITIATE APPROPRIATE CLINICAL CARE AS STATED ABOVE

ACUTE PAIN SERVICE or equivalent medical officer CONTACT:

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



SMR130024

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CONTINUOUS OPIOID INFUSION (ADULT)

SMR130.024

NH700040 090421

Attach ADR Sticker

ALLERGIES & ADVERSE DRUG REACTIONS (ADR)
 Nil known Unknown (tick appropriate box or complete details below)

Drug (or other)	Reaction/Type/Date	Initials

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

FAMILY NAME	MRN
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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: **Pain specialist referral Referring doctor name:**
 **Signature:**
 **Date:**

Continuous Opioid Infusion (Adult)

Prescription is valid for a maximum of 4 days unless ceased earlier.
 Refer to local hospital policy for standardised continuous opioid solutions

Route	Primary drug	Amount (mg or microgram)	Diluent	Total volume	Primary drug concentration (mg or microgram per mL)
	Additional drug	Amount (mg or microgram)	Sodium chloride 0.9%	mL	per mL
	Additional drug	Amount (mg or microgram)			

Continuous infusion range (mg or microgram per hour)
FROM: per hour = mL per hour **TO:** per hour = mL per hour

Start rate (mg or microgram per hour)
 per hour = mL per hour

Additional bolus dose (mg or microgram) to manage inadequate analgesia.
 A registered nurse may give a bolus dose of = mL

Minimum interval between bolus doses	Maximum number of bolus doses per hour
..... minutes

Date	Prescriber's signature	Print your name	Contact	Pharmacy
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NALOXONE: For sedation score 3 or when sedation score is 2 and respiratory rate less than or equal to 5 breaths per minute. STOP OPIOID INFUSION. Obtain urgent medical review. Commence resuscitation including administering prescribed naloxone (as below) until respirations greater than 10 breaths per minute and sedation score less than or equal to 2. Provide ventilatory assistance if required. (Recommended dosage up to 100 microgram, x4 every 2-3 minutes).

Date	Drug (Print 'naloxone')	Route	Dose (microgram)	Number of doses	Frequency (minutes)	Prescriber's signature	Print your name	Contact

OXYGEN: O₂ flow rate: ____ L per minute via nasal prongs face mask
 if needed to maintain SpO₂ range from ____ % to ____ %
 Signature _____ Name _____
 See medical record for clinical management of patients who have different oxygen requirements.

CEASE OPIOID INFUSION ACCORDING TO INSTRUCTIONS IN THE MEDICAL RECORD
 Refer to entry in the medical record written on _____ Date:..... Time:.....

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MALE FEMALE

D.O.B. ____/____/____

M.O.

Facility:

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CONTINUOUS OPIOID INFUSION (ADULT)

LOCATION / WARD

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Record of opioid syringe / bag administration and opioid discarded

Record of opioid administration

Record of opioid 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									
7									
8									
9									
10									
11									
12									
13									
14									

Record of naloxone administered

	Date	Time	Route	Dose	Signature 1	Signature 2
1						
2						
3						
4						

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---------------------------	------

ADDRESS

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LOCATION

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Facility:

CONTINUOUS OPIOID INFUSION (ADULT)

Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

DATE							
TIME							

PAIN SCORE Assess pain both at rest and with relevant movement. Document "R" for rest and "M" for movement

Severe pain	10							10
	9							9
Moderate pain	8							8
	7							7
Mild pain	6							6
	5							5
No pain	4							4
	3							3
	2							2
	1							1
	0							0

SEDATION

Difficult to rouse or unresponsive	3							3
Constantly drowsy, unable to stay awake	2							2
Easy to rouse	1							1
Wide awake	0							0

AIRWAY / BREATHING	Respiratory rate	35							35
		30							30
		25							25
		20							20
		15							15
		10							10
	5							5	
	Oxygen	O₂Lpm							O₂Lpm
		Device / mode							Device / mode
	Key: RA = Room air, NP = Nasal prongs, FM = Simple face mask, NRB = Non-rebreather, VM = Venturi mask								

Nausea or vomiting	<input checked="" type="radio"/> Yes <input type="radio"/> No							
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OPIOID INFUSION DELIVERY

Infusion rate (per hour) mg microgram or mL (Circle one)								
Total dose (if applicable) (Cumulative) mg microgram or mL (Circle one)								
Bolus dose mg microgram or mL (Circle one)								
Two initials required for administration of rescue bolus dose OR change of infusion rate								
Infusion program checked (initial)								

COMMENTS

INITIAL:

Holes Punched as per AS2828, 1: 2012
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	Device / mode																			Device / mode

Key: RA = Room air, NP = Nasal prongs, FM = Simple face mask, NRB = Non-rebreather, VM = Venturi mask

Nausea or vomiting ● Yes No

OPIOID INFUSION DELIVERY

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