

Summary of revisions to the NSW Neuraxial Opioid Single Dose chart (adult) 2017

The NSW Neuraxial Opioid Single Dose (adult) chart has been revised.

For detailed information regarding management of patients receiving morphine via the neuraxial route refer to your local hospital policy or procedure.

Neuraxial Opioid Management Guidelines page 1

Managing Neuraxial Opioid Adverse Effects and Management of Yellow and Red Zone observations moved from the back page to the front page.

Neuraxial opioid administration documentation page 2

<p>Statement regarding frequency of observations in bold font.</p>	<p>Neuraxial Opioid Single Dose (Adult) Date:</p> <p><i>This form is for morphine only</i></p> <p>Observations for this patient to be recorded: <input type="checkbox"/> Hourly for 6 hours OR <input type="checkbox"/> Hourly for 12 hours. Continue observations second hourly thereafter until 24 hours post administration</p>
<p>Statement added regarding antihistamines</p>	<ul style="list-style-type: none"> Antihistamines used for pruritus are generally ineffective and may contribute to sedation.

Observation pages

Yellow Zone for pain scores 7 to 10 has been added to correlate with Between the Flags instructions. Where a patient scores their pain 7 or above, the nurse/midwife must assess the current clinical pain management plan for the patient. For example: Have pain scores previously been in the White Zone (0 to 6)? Have additional prescribed analgesics been administered? Has the patient been reviewed by the Acute Pain Service or equivalent Medical officer? The assessing nurse may need to consult with the NURSE IN CHARGE to decide whether a CLINICAL REVIEW (or other CERS – Clinical Emergency Response) call should be made.

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
	8																	8
	7																	7

Motor block assessment Yellow Zone added from 6th hour. If motor function has not returned within 6 hours, contact Acute Pain Service or equivalent medical officer.

MOTOR BLOCK ASSESSMENT		Hourly assessment <u>until</u> return of motor function. Document "L" for left, "R" for right If motor function has not returned within 6 hours, contact Acute Pain Service or equivalent medical officer																
Unable to move feet or knees	3																	3
Able to move feet only	2																	2
Just able to move knees	1																	1
Full flexion of knees and feet	0																	0