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

NEURAXIAL OPIOID SINGLE DOSE (ADULT)

SMR130029

Neuraxial Opioid Management Guidelines

(For detailed information regarding management of patients receiving an intrathecal / epidural opioid, refer to local hospital policy)

Delayed sedation and respiratory depression is possible with neuraxial opioids.

- **Observations** on this form to be recorded either: hourly for 6 hours OR hourly for 12 hours Then second hourly until 24 hours post administration. Observations to occur more frequently if the patient's clinical condition warrants.

  Hourly motor blockade assessment until return of motor function. If motor function not returned within 6 hours contact Acute Pain Service or equivalent medical officer.

- **No other opioids or sedatives** to be administered unless ordered by the Acute Pain Service or equivalent medical officer.
- **Intravenous access** should be maintained for a minimum of 24 hours post epidural / intrathecal opioid dose.Some patient groups may be an exception from this requirement. Refer to local hospital policy.

Managing Neuraxial Opioid Adverse Effects

- **Pruritus** is more common when opioids are administered neuraxially. A medical officer may consider prescribing low dose IV naloxone on the patient's National Inpatient Medication Chart.
- **Antihistamines** used for pruritus are generally ineffective and may contribute to sedation.
- **Urinary retention:** Contact the patient's surgical / medical team.
- Persistent nausea or vomiting: Administer PRN medication as ordered on the patient's National Inpatient Medication Chart. If adverse effect continues contact the Acute Pain Service or equivalent medical officer.

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. 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 RESPONE 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:**

NH606623 130217

NEURAXIAL OPIOID SINGLE DOSE (ADULT) SMR130.029

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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NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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: .....

Neuraxial Opioid Single Dose (Adult)

This form is for morphine only

Observations for this patient to be recorded: ☐ *Hourly for 6 hours* *OR* ☐ *Hourly for 12 hours.*

Continue observations second hourly thereafter until 24 hours post administration

Date	Time	Opioid name (Print 'morphine' below)	Route	Dose given (mg or microgram)	Medical officer administering (Signature and print name)	Contact

OXYGEN THERAPY: Give oxygen at 2 to 4 litres per minute via nasal prongs or 6 litres per minute via face mask at all times unless otherwise ordered.

NALOXONE: For sedation score 3 or when sedation score is 2 and respiratory rate less than or equal to 5 breaths per minute. *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. A naloxone standing order may exist in some hospitals- see local hospital policy. (Recommended naloxone 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

Record of naloxone administered

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

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☐ Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION

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SMR130029

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

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
	8	8
	7	7
Moderate pain	6	6
	5	5
	4	4
Mild pain	3	3
	2	2
	1	1
No pain	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	O_2 Lpm	O_2 Lpm
	Device / mode	Device / mode
Key: RA = Room air, NP = Nasal prongs, FM = Simple face mask, NRB = Non-rebreather, VM = Venturi mask		
MOTOR BLOCK ASSESSMENT Hourly assessment until 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
Nausea or vomiting •	Yes	Yes
	No	No
Pruritus •	Yes	Yes
	No	No
COMMENTS		
INITIAL:		

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	4																4
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	2																2
	1																1
No pain	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
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INITIAL:																	

NO WRITING