		FAMILY NAME		MRN
NSW	NSW Health	GIVEN NAME		☐ MALE ☐ FEMALE
Facility:		D.O.B//	M.O.	
		ADDRESS	PRESC	RIPTION UNLESS
	EIGHT BASED PCA PUMP:		IDENT	IFIERS PRESENT
		LOCATION / WARD		
WEIGHT BASED PCA PUMP: PAEDIATRIC PCA OR NCA CHART PAIN ASSESSMENT TOOLS (patient controlled or nurse controlled analgesia)	COMPLETE ALL DETAILS	OR AFFIX F	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
FACE	No particular expression or smile	Occasional grimace/frown withdrawn or disinterested, 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
ACTIVITY	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, <i>repeated outbursts</i> , <i>constant grunting</i>
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

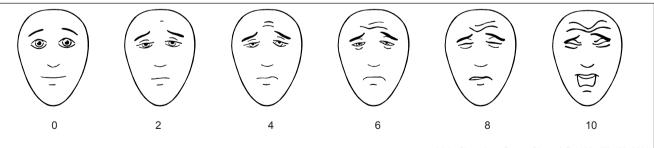
Tool 2: Face Pain Scale (revised)

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".



(Hicks CL. and von Baeyer CL. et al. Pain 93: 173-183; 2001,

Tool 3: Visual Analogue 9	Scal	е
Use for verbal children over 7	7 vea	rs

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

MR130031

MARGIN

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	FAMILY NAME	MRN				
NSW	GIVEN NAME		☐ MALE	☐ FEMALE		
	D.O.B//	M.O.				
Facility: WEIGHT BASED PCA PUMP: PAEDIATRIC PCA OR NCA CHAI	ADDRESS					
WEIGHT BASED PCA PUMP:		IDENTI	FIERS F	RESENT		
PAEDIATRIC PCA OR NCA CHART	LOCATION / WARD					
(patient controlled or nurse controlled analgesia)	COMPLETE ALL DETAILS	OR AFFIX P	ATIENT LA	BEL 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 <u>MUST</u> FOLLOW THE RESPONSE INSTRUCTIONS ON THE NSW STANDARD PAEDIATRIC OBSERVATION CHARTS (SPOC)

YELLOW ZONE RESPONSE

YOU <u>MUST</u> FOLLOW THE RESPONSE INSTRUCTIONS ON THE NSW STANDARD PAEDIATRIC OBSERVATION CHARTS (SPOC) AND INITIATE APPROPRIATE CARE AS STATED ABOVE

RED ZONE RESPONSE

YOU <u>MUST</u> 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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Page 8 of 8 NO WRITING Page 1 of 8

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			LOCATION / WARD				
COMPLETE ALE	RT SHEET IN MEDICAL RI	CORD	COMPLETE ALL DETAILS	OR AFFIX P	ATIENT LABEL HE	RE	
Sign	PrintDat	e	First Prescriber to Print Patient	Name and (Check Label Correc	t:	
			Weight (kg)	Date We	eighed//		
If the child is ove *Background infu	er the 95th percentile f sions are generally for t	or weight NCA as ra	on guide for a WEIG t, then use 50th percentile we prely required for PCA. Support as they are associated w	eight as th	e dosing weight	-	
Opioid	Concentration (amount in syri			ckout nutes	Background infusion*		
Children 10 to 5	0 kg Prescribe bolus dos	e as microg	n/kg - background infusion as mic	rog/kg/hr			

50 mg diluted to a total volume of Morphine 20 microg/kg 10 microgram /kg/hr PCA: 50mL with 0.9% sodium chloride 5 minutes 50 mg diluted to a total volume of Oxycodone 20 microg/kg 10 microgram /kg/hr 50mL with 0.9% sodium chloride NCA: 1000 microgram diluted to a total volume of 15 minutes 0.4 microg/kg Fentanyl 0.2 microgram /kg/hr 50mL with 0.9% sodium chloride Children more than 50 kg Prescribe bolus dose as mg or microgram - background infusion as mg/hr or microg/hr 50 mg diluted to a volume of Morphine 1 mg 0.5 mg/hr PCA: 50 mL with 0.9% sodium chloride 5 minutes 50 mg diluted to a volume of 1 mg Oxycodone 0.5 mg/hr 50 mL with 0.9% sodium chloride NCA: 1000 microgram diluted to a volume of 15 minutes Fentanyl 20 microgram 10 microgram/hr 50 mL with 0.9% sodium chloride

PRESCI	RIPTION PC	A:	is valid for a	maximum of	48 hour	s unless ceas	sed
Route	Drug	Amount (microgram or mg) to be added to syringe/bag	Diluent 0.9% sodium chloride	Total volume 50 mL		oncentration ram/mL or mg/m	nL)
Date	Prescriber's signature	Print your name		Contact	1	Pharmacy	

PROGRAM: for a WEIGHT BASED PCA pump:

DOSIN	G WEIG	SHT:		kg P	rescribing guide above is no	ot suitable for child	ren less than 10 kg
Date	Time	PCA bolus dose)	Lockout interval (minutes)	Background infusion	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 (pri	nt 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/pag						

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

BINDING MARGIN - NO WRITING

BINDING MARGIN - NO WRITING

(two initials for change of PCA/NCA program, clinical handover, transfer of

care or syringe/bag change)

-08021-					FAMI	LY NAME					MRN			
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☐ Visual Analogue	Moderate pain	5												
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Nausea or vomit	ting													
Pruritus														
COMMENTS / A	CTIONS													
NURSE INITIAL	:													
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Page 2 of 8

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NSW Health	FAMILY NAME		MRN					
NSW	GIVEN NAME		☐ MALE	☐ FEMALE				
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ADMINISTRATION AND DISCARD	LOCATION / WARD							
(patient controlled or nurse controlled analgesia)	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE							

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

Record of PCA / NCA bag or syringe administration					Record of PCA / NCA drug discarded									
	Date	Time	Signature 1	Signature 2	Date	Time	Total discarded drug (mL, mg or microgram)	Signature 1	Signature 2					
1		35												
2														
3														
4														
5														
6														

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												
	Date	Time	Route	Dose (microgram and mL)	Signature 1	Signature 2						
1												
2												
3												
4												

Page 6 of 8

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-1881.				FAMILY NAME							MRN				
NSW Health					GIVEN NAME						☐ MALE ☐ FEMALE				
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Page 4 of 8					NO WE	RITING	ì								



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