NSW Health

Facility:

WEIGHT BASED PCA PUMP:
PAEDIATRIC PCA OR NCA CHART PAIN ASSESSMENT TOOLS
(patient controlled or nurse controlled analgesia)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX 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FACE	No particular expression or smile	Occasional grimace/frown withdrawn or disinterested, ***appears sad or worried***	Frequent constant quivering chin, clenched jaw, ***distressed looking face; expression of fright or panic***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, ***marked increase in spasticity, constant tremors or jerking***
ACTIVITY	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense, ***mildly agitated (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)

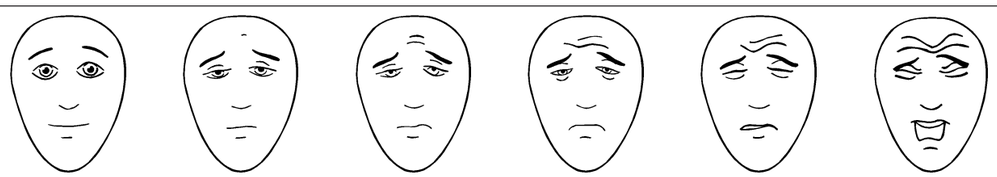
Use for verbal children over 4 years of age

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".

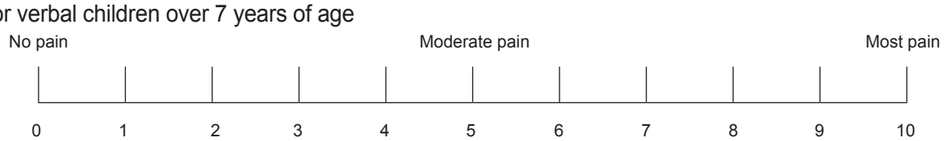
This scale is intended to measure how children feel inside, not how their face looks. *(Hicks CL. and von Baeyer CL. et al. Pain 93: 173-183; 2001)*



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

Tool 3: Visual Analogue Scale

Use for verbal children over 7 years of age



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 Pain

NO WRITING

NSW Health

Facility:

WEIGHT BASED PCA PUMP:
PAEDIATRIC PCA OR NCA CHART
(patient controlled or nurse controlled analgesia)

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL 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 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:**

NH700964 040923

Attach ADR Sticker

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

Drug (or other)	Reaction/Date	Initials

COMPLETE ALERT SHEET IN MEDICAL RECORD

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

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
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:

Weight (kg) ..... Date Weighed ...../...../.....

Paediatric PCA or NCA prescription guide for a WEIGHT BASED PCA pump

If the child is over the 95th percentile for weight, then use 50th percentile weight as the dosing weight.
**Background infusions are generally for NCA as rarely required for PCA.*
**Background infusions require local guidelines support as they are associated with increased risk.*

Opioid	Concentration (amount in syringe)	PCA / NCA Bolus dose	Lockout Minutes	Background infusion*
Children 10 to 50 kg *Prescribe bolus dose as microg/kg - background infusion as microg/kg/hr*				
Morphine	50 mg diluted to a total volume of 50mL with 0.9% sodium chloride	20 microg/kg	**PCA:** 5 minutes **NCA:** 15 minutes	10 microgram /kg/hr
Oxycodone	50 mg diluted to a total volume of 50mL with 0.9% sodium chloride	20 microg/kg		10 microgram /kg/hr
Fentanyl	1000 microgram diluted to a total volume of 50mL with 0.9% sodium chloride	0.4 microg/kg		0.2 microgram /kg/hr
Children more than 50 kg *Prescribe bolus dose as mg or microgram - background infusion as mg/hr or microg/hr*				
Morphine	50 mg diluted to a volume of 50 mL with 0.9% sodium chloride	1 mg	**PCA:** 5 minutes **NCA:** 15 minutes	0.5 mg/hr
Oxycodone	50 mg diluted to a volume of 50 mL with 0.9% sodium chloride	1 mg		0.5 mg/hr
Fentanyl	1000 microgram diluted to a volume of 50 mL with 0.9% sodium chloride	20 microgram		10 microgram/hr

PRESCRIPTION PCA: ☐ or NCA: ☐ is valid for a maximum of 48 hours unless ceased

Route	Drug	Amount (microgram or mg) to be added to syringe/bag	Diluent **0.9% sodium chloride**	Total volume **50 mL**	Drug concentration (microgram/mL or mg/mL)
Date	Prescriber's signature	Print your name		Contact	Pharmacy

PROGRAM: for a WEIGHT BASED PCA pump:

DOSING WEIGHT: **kg** *Prescribing guide above is not suitable for children 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 (print 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/pager

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

NSW GOVERNMENT NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O. NOT A VALID
ADDRESS	PRESCRIPTION UNLESS
	IDENTIFIERS PRESENT
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

WEIGHT BASED PCA PUMP: PAEDIATRIC PCA OR NCA CHART HOURLY OBSERVATIONS

DATE													
TIME													
PAIN SCORE Assess pain both at rest and with relevant movement (e.g. deep breathing, coughing). **Document "R" for rest and "M" for movement**													
Pain Scale used: ☐ FLACC ☐ Face Pain ☐ Visual Analogue ☐ FLACC-R	Severe pain	10											
		9											
		8											
		7											
	Moderate pain	6											
		5											
		4											
	Mild pain	3											
		2											
		1											
	No pain or asleep	0											
DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)													
Unrousable		4											
Deep sedation (deep sleep, rousable only with deep or significant physical stimuli)		3											
Moderately sedated (somnolent/sleeping, easily roused with light tactile stimulation or simple verbal command)		2											
Minimally sedated (may appear tired/ sleepy, responds to verbal conversation and/or sound)		1											
Awake and alert		0											
Asleep (rousable)		S											
RESPIRATORY RATE AND OXYGEN SATURATIONS to be recorded on the correct Standard Paediatric Observation Chart (SPOC)													
PCA DELIVERY (record hourly and at completion of each syringe / bag)													
Total primary PCA / NCA dose (cumulative) mg or microgram or mL (circle one)													
Background infusion rate (microgram/hr or mg/hr or mL/hr) (circle one)													
Total demands													
Successful demands													
PCA program checked (initial)													
ADVERSE REACTIONS (Y=Yes, N=No)													
Nausea or vomiting													
Pruritus													
COMMENTS / ACTIONS													
NURSE INITIAL:													
PCA / NCA Program changed (two initials for change of PCA/NCA program, clinical handover, transfer of care or syringe/bag change)													

NSW GOVERNMENT NSW Health

Facility:

WEIGHT BASED PCA PUMP: PAEDIATRIC PCA OR NCA CHART HOURLY OBSERVATIONS

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

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

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

DATE													
TIME													
PAIN SCORE Assess pain both at rest and with relevant movement (e.g. deep breathing, coughing). **Document "R" for rest and "M" for movement**													
Pain Scale used: ☐ FLACC ☐ Face Pain ☐ Visual Analogue ☐ FLACC-R	Severe pain	10											
		9											
		8											
		7											
	Moderate pain	6											
		5											
		4											
	Mild pain	3											
		2											
		1											
	No pain or asleep	0											
DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)													
Unrousable		4											
Deep sedation (deep sleep, rousable only with deep or significant physical stimuli)		3											
Moderately sedated (somnolent/sleeping, easily roused with light tactile stimulation or simple verbal command)		2											
Minimally sedated (may appear tired/ sleepy, responds to verbal conversation and/or sound)		1											
Awake and alert		0											
Asleep (rousable)		S											
RESPIRATORY RATE AND OXYGEN SATURATIONS to be recorded on the correct Standard Paediatric Observation Chart (SPOC)													
PCA DELIVERY (record hourly and at completion of each syringe / bag)													
Total primary PCA / NCA dose (cumulative) mg or microgram or mL (circle one)													
Background infusion rate (microgram/hr or mg/hr or mL/hr) (circle one)													
Total demands													
Successful demands													
PCA program checked (initial)													
ADVERSE REACTIONS (Y=Yes, N=No)													
Nausea or vomiting													
Pruritus													
COMMENTS / ACTIONS													
NURSE INITIAL:													
PCA / NCA Program changed (two initials for change of PCA/NCA program, clinical handover, transfer of care or syringe/bag change)													

NO WRITING

SMR130031

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

NSW GOVERNMENT NSW Health

Facility:

WEIGHT BASED PCA PUMP: PAEDIATRIC PCA OR NCA CHART ADMINISTRATION AND DISCARD

(patient controlled or nurse controlled analgesia)

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

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

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

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									
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						

NO WRITING

NSW GOVERNMENT NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

WEIGHT BASED PCA PUMP: PAEDIATRIC PCA OR NCA CHART HOURLY OBSERVATIONS

DATE														
TIME														
PAIN SCORE Assess pain both at rest and with relevant movement (e.g. deep breathing, coughing). **Document "R" for rest and "M" for movement**														
Pain Scale used: ☐ FLACC ☐ Face Pain ☐ Visual Analogue ☐ FLACC-R	Severe pain	10												
		9												
		8												
		7												
	Moderate pain	6												
		5												
		4												
	Mild pain	3												
		2												
		1												
	No pain or asleep	0												
DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)														
Unrousable		4												
Deep sedation (deep sleep, rousable only with deep or significant physical stimuli)		3												
Moderately sedated (somnolent/sleeping, easily roused with light tactile stimulation or simple verbal command)		2												
Minimally sedated (may appear tired/ sleepy, responds to verbal conversation and/or sound)		1												
Awake and alert		0												
Asleep (rousable)		S												
RESPIRATORY RATE AND OXYGEN SATURATIONS to be recorded on the correct Standard Paediatric Observation Chart (SPOC)														
PCA DELIVERY (record hourly and at completion of each syringe / bag)														
Total primary PCA / NCA dose (cumulative) mg or microgram or mL (circle one)														
Background infusion rate (microgram/hr or mg/hr or mL/hr) (circle one)														
Total demands														
Successful demands														
PCA program checked (initial)														
ADVERSE REACTIONS (Y=Yes, N=No)														
Nausea or vomiting														
Pruritus														
COMMENTS / ACTIONS														
NURSE INITIAL:														
PCA / NCA Program changed (two initials for change of PCA/NCA program, clinical handover, transfer of care or syringe/bag change)														

NO WRITING

NSW GOVERNMENT NSW Health

Facility:

FAMILY NAME | MRN
GIVEN NAME | ☐ MALE ☐ FEMALE
D.O.B. ____/____/____ | M.O.
ADDRESS
LOCATION / WARD

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

WEIGHT BASED PCA PUMP: PAEDIATRIC PCA OR NCA CHART HOURLY OBSERVATIONS

DATE														
TIME														
PAIN SCORE Assess pain both at rest and with relevant movement (e.g. deep breathing, coughing). **Document "R" for rest and "M" for movement**														
Pain Scale used: ☐ FLACC ☐ Face Pain ☐ Visual Analogue ☐ FLACC-R	Severe pain	10												
		9												
		8												
		7												
	Moderate pain	6												
		5												
		4												
	Mild pain	3												
		2												
		1												
	No pain or asleep	0												
DEPTH OF SEDATION (as measured using the University of Michigan Sedation Scale UMSS score)														
Unrousable		4												
Deep sedation (deep sleep, rousable only with deep or significant physical stimuli)		3												
Moderately sedated (somnolent/sleeping, easily roused with light tactile stimulation or simple verbal command)		2												
Minimally sedated (may appear tired/ sleepy, responds to verbal conversation and/or sound)		1												
Awake and alert		0												
Asleep (rousable)		S												
RESPIRATORY RATE AND OXYGEN SATURATIONS to be recorded on the correct Standard Paediatric Observation Chart (SPOC)														
PCA DELIVERY (record hourly and at completion of each syringe / bag)														
Total primary PCA / NCA dose (cumulative) mg or microgram or mL (circle one)														
Background infusion rate (microgram/hr or mg/hr or mL/hr) (circle one)														
Total demands														
Successful demands														
PCA program checked (initial)														
ADVERSE REACTIONS (Y=Yes, N=No)														
Nausea or vomiting														
Pruritus														
COMMENTS / ACTIONS														
NURSE INITIAL:														
PCA / NCA Program changed (two initials for change of PCA/NCA program, clinical handover, transfer of care or syringe/bag change)														