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

PERIPHERAL NERVE INFUSION (ADULT)

SMR130023

Continuous Peripheral Nerve Infusion Management Guidelines

(For detailed information regarding continuous nerve 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.
- **A dedicated infusion device** which is clearly labelled to be used for the delivery of the local anaesthetic
- **A dedicated infusion giving set** which is portless and labelled for regional infusion to be used
- **Infusion pump settings** (if applicable) to be checked at the commencement of each shift, on patient transfer and when the syringe or bag is changed.
- **Catheter site check** every 8 hours for
  - integrity of dressing
  - signs of leakage (if possible)
  - signs of inflammation (if possible)
- **Ensure limb support / protection** if applicable

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 AND RED ZONE OBSERVATIONS:

- ENSURE OXYGEN THERAPY IS IN PROGRESS
- STOP PERIPHERAL NERVE INFUSION
- ENSURE THAT THE ACUTE PAIN SERVICE OR EQUIVALENT MEDICAL OFFICER IS CONTACTED

YELLOW ZONE RESPONSE

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

*** Additional YELLOW ZONE Criteria for Local Anaesthetic Toxicity**

- Numbness and tingling around the mouth and tongue
- Metallic taste, tinnitus and dizziness

RED ZONE RESPONSE

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

*** Additional RED ZONE Criteria for Local Anaesthetic Toxicity**

- Muscular twitching
- Convulsion
- Cardiovascular collapse

ACUTE PAIN SERVICE or equivalent medical officer CONTACT:

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

NH700041 210917

PERIPHERAL NERVE INFUSION (ADULT)
SMR130.023

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.....

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1st *prescriber* to print patient Name and check label correct:

.....

Pain specialist referral
Referring doctor name:.....
Signature: .....
Date: .....

Peripheral nerve infusion adult: Prescription

Type of BLOCK (1):	Type of BLOCK (2):

PRESCRIPTION is valid for a maximum of 4 days unless ceased earlier.

Local anaesthetic % (BLOCK 1): %	Local anaesthetic % (BLOCK 2): %
Total VOLUME (BLOCK 1): (mL)	Total VOLUME (BLOCK 2): (mL)

Date	Prescriber's signature	Print your name	Contact	Pharmacy

☐ CONTINUOUS INFUSION prescription

(BLOCK 1) Continuous infusion RANGE (mL per hour):	(BLOCK 2) Continuous infusion RANGE (mL per hour):
FROM: ..... mL per hour TO: ..... mL per hour	FROM: ..... mL per hour TO: ..... mL per hour
Infusion START rate .....mL per hour / FIXED infusion rate .....mL per hour	Infusion START rate .....mL per hour / FIXED infusion rate .....mL per hour

Date	Prescriber's signature	Print your name	Contact	Pharmacy

☐ RESCUE BOLUS DOSE prescription

Rescue bolus of local anaesthetic to be administered via a dedicated pump delivering the local anaesthetic solution as prescribed above.	Bolus volume (mL)	Minimum interval between rescue bolus doses (hours or minutes)	Prescriber's signature	Print your name
ONLY registered nurses who have been assessed as competent can administer a rescue local anaesthetic bolus.		..... hours .....minutes		

☐ Patient Controlled Regional Analgesia (PCRA)

Background infusion (mL per hour) (Range minimum per hour to maximum per hour)	Start rate (mL per hour)	PCRA bolus dose (mL)	PCRA Lockout interval (minutes)	Prescriber's signature	Print your name
FROM ….mL per hour TO …..mL per hour					

☐ Programmed Intermittent Bolus (PIB)

Date	Time	PIB bolus dose (mL)	PIB lockout interval (minutes or hours)	Background infusion (if applicable) (mL per hour)	Delay time till first bolus (if applicable) (hours or minutes)	Prescriber's signature	Print your name

CEASE REGIONAL INFUSION ACCORDING TO INSTRUCTIONS IN THE MEDICAL RECORD

Refer to entry in the medical record written on Date: ..... Time: .....

NO WRITING

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Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

Catheter Insertion Information

(Or refer to anaesthetic record or operation record for surgically placed catheters)

Insertion comments:					
Date inserted:	Time inserted:	Person inserting signature	Print name	Designation	Contact

Block initiation drug administered

Block initiation drug administered:	Volume:	Time:	Medical officer or equivalent administering: (Signature and print name)
	mL		

Administration

Local anaesthetic administration

	Date	Time	Signature 1	Signature 2
1				
2				
3				
4				
5				
6				
7				
8				

Removal of regional catheter(s)

- For time delays between anticoagulant administration and removal of deep catheters - refer to local hospital policy and/or anticoagulant guidelines.
- Motor function can be affected for several hours post removal of catheter(s).
- Check motor function if applicable prior to mobilisation

Catheter 1 removed:	Catheter 2 removed:
Date: _____ Time: _____	Date: _____ Time: _____
Signature:_____ Print name:_____	Signature:_____ Print name:_____

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PERIPHERAL NERVE INFUSION (ADULT)

DATE	
TIME	

PAIN SCORE

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

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

INFUSION DELIVERY

Infusion rate (mL/hr) or **PCRA dose** (mL) or **PIB dose** (mL)	**BLOCK 1**
	BLOCK 2
Rescue bolus dose administered (mL)	**BLOCK 1**
	BLOCK 2
Infused total (mL) (Cumulative)	
Two initials required for administration of rescue bolus dose	
Pump program settings check if applicable (initial)	
Catheter site(s) check (initial) 8 hourly for integrity of dressing, signs of leaking, signs of infection	
INITIAL:	

LOWER LIMB ASSESSMENT (if applicable).

Every four hours and prior to mobilisation.

MOTOR BLOCK ASSESSMENT (Document "L" for left "R" for right)	
Unable to move feet or knees	3
Able to move feet only	2
Just able to move knees	1
Full strength at knees and ankles	0

SENSORY DERMATOME ASSESSMENT (if applicable).

DERMATOME LEVEL CHECK see local policy for guidelines	Left	Upper to Lower
	Right	Upper to Lower

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