EPIDURAL
Analgesia Order – Adult

Queensland Government

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Facility / Service: .....

Ward / Unit: ..... Year: 20.....

First Prescriber to Print Patient Name and Check Label Correct: .....

Weight (kg): ..... Height (cm): .....

Attach ADR Sticker

(See Medication Chart for details)

ADMINISTRATION RECORD

Epidural Solution Commencement

Pump no.:	Time infusion started:	Commenced by:	Checked by:

Epidural Solution Preparation and Discard

Solution Preparation	Date	Time	Local Anaesthetic (concentration %)	Diluent (if required)	Additional medications, Amount	Final volume	Prepared by	Checked by
					1			
					2	mL		
					1			
					2	mL		
					1			
					2	mL		
					1			
					2	mL		
					1			
					2	mL		
					1			
					2	mL		
					1			
					2	mL		

Solution Discard								
Date								
Time								
Volume discarded	mL	mL	mL	mL	mL	mL	mL	mL
Discarded by								
Witnessed by								

Record of Clinician Delivered Boluses

Date	Time	Dose given	Given by	Checked by	Date	Time	Dose given	Given by	Checked by

Record of Setting Changes

Date	Time	Details of program change (e.g. bolus dose increased)			Changed by	Checked by
		Infusion rate	Bolus	Lockout time (minutes)		

v4.00 - 03/2017
Mat. No.: 10232494
SW151

Monitoring and Care Guidelines for Epidural Infusions

For ALL epidural administration:

- Use a dedicated analgesia pump;
- Only use epidural administration lines or lines without injection ports
- The line must contain an in-line **filter** and a one-way **anti-syphon valve** between patient and infusion device
- Never disconnect epidural catheter from filter
- Maintain intravenous access for duration of epidural infusion.

For epidural administration use *yellow epidural labels* according to national labelling standard.

- **General observations (e.g. vital signs) are to be recorded on the *Q*-ADDS, *Q*-MEWT or local early deterioration detection system.**
- **Epidural specific observations are to be recorded on the *Intravenous, PCA, Epidural and Regional Analgesia MONITORING Form*. Complete required actions according to the ASSESSMENT / INTERVENTION GUIDELINES.**

Naloxone Protocol (IV or subcutaneous)

If sedation score = 2 and respiratory rate less than 8 / minute *OR* if sedation score = 3, a Registered Nurse / Midwife is hereby authorised to:

1. Dilute naloxone 400 micrograms (1 ampoule) with 0.9% sodium chloride to a total volume of 4mL (100 micrograms / mL).
2. Give IV or subcutaneous naloxone 100 micrograms (1mL) every 2 minutes until sedation score is less than 2 or a maximum dose of 400 micrograms has been given.
3. **Ensure contact person has been notified and patient is receiving oxygen.** Remain with patient and continue monitoring every 15 minutes for a further 2 hours, then every 30 minutes for 2 hours, then hourly for 2 hours. If sedation score returns to greater than or equal to 2, follow recommended intervention (as on monitoring form) and repeat steps 1–3.

Any administered naloxone doses must be recorded on the front page of the patient's Medication Chart under Nurse Initiated Medicines.

Management of Hypotension

If systolic blood pressure is below 90 mmHg ***OR*** if there is an equal to or greater than 40 mmHg drop from baseline a Registered Nurse / Midwife is hereby authorised to:

For obstetric labour patients	For all other patients
Lie patient on their left side, administer oxygen (as per oxygen order below)	Elevate feet and administer oxygen (as per oxygen order below)

Fluid bolus order (optional)

Fluid type:	Amount: mL	Prescriber signature:	Print name:
Date given:	Time given:	Given by:	Checked by:
Notify contact person immediately.			

Oxygen Order (medical officer to tick appropriate option/s) If not completed, use option (A) as default

Give oxygen:

☐ ***(A) overnight*** at a *minimum* of 2L / min via nasal prongs or 6L / min via Hudson Mask *(ensure oxygen saturation is equal to or greater than 95%)*. Notify contact person if the required flow rate exceeds 6L / min via Hudson Mask OR oxygen saturation falls below 95% for more than 1 minute; ***OR***

☐ ***(B)*** to maintain a *minimum* oxygen saturation of 95%.
Notify contact person if oxygen flow rate exceeds ..... L / min via Hudson Mask; ***OR***

☐ ***(C)*** to maintain oxygen saturation in a range of ..... to ..... %
Notify contact person if oxygen flow rate exceeds ..... L / min via Hudson Mask; ***OR***

☐ ***(D) via CPAP to patients with obstructive sleep apnoea; OR***

Exceptions: ☐ ***(E)*** (specify) .....

Prescriber signature:	Print name:

Cut Off Section

Contact person details

Acute Pain Management Service (APMS) / on call anaesthetic registrar

OR Other - contact name: ..... Contact number: .....

Relevant Medical History (tick boxes below)

Opioid tolerant? ☐ Yes ☐ No

If *Yes*, tolerance to which medication(s)?

.....

Contraindication to paracetamol? ☐ Yes ☐ No

Contraindication to NSAIDs? ☐ Yes ☐ No

Other contraindication *(specify)*:

.....

Renal impairment (eGFR below 60mL / min / 1.73m²)? ☐ Yes ☐ No

Obstructive sleep apnoea? ☐ Yes ☐ No

Asthma / COPD? ☐ Yes ☐ No

Anticoagulated? ☐ Yes ☐ No

Epidural Catheter Insertion

Site / location:	Depth to epidural space: cm	Depth at skin: cm
Comments:		

Initial neuraxial analgesia given? ☐ Yes ☐ No	Time of dose:	Medication(s) / dose given:

Inserted by (print name):	Signature:	Date:	Time:

Epidural Catheter Removal

Is your patient on an oral or parenteral anticoagulant?
Consult Acute Pain Management Service (APMS) / anaesthetist for removal instructions.

Removed by (print name):	Signature:	Date:	Time:
Intact tip viewed by (print name):	Signature:	Date:	Time:

ONCE ONLY Top Up Dose Orders

Date prescribed	Time prescribed	Medication	Route	Dose	Prescriber Signature	Prescriber Print name	Given by	Checked by	Time given

Daily Clinical Review

Authorised person to sign to indicate daily review and continuation of order for further day. Notify contact person (as above) if not reviewed by 16:00hrs, or review documentation in progress notes.

Date	Time	Comments	Initials / Print name

DO NOT WRITE IN THIS BINDING MARGIN

page fold

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Facility / Service: .....

Ward / Unit: ..... Year: 20.....

Attach ADR Sticker

☐ NKDA
☐ Unknown

(See Medication Chart for details)

First Prescriber to Print Patient Name and Check Label Correct: .....

Weight (kg): ..... Height (cm): .....

Orders

NB: No other sedating medications should be given to patients (e.g. antihistamines such as promethazine, benzodiazepines such as temazepam, other opioids) without review by contact person.

† *Administration of clinician delivered bolus doses must be recorded on page 4*

* *Opioid doses correlate more to age than weight, INCREASING AGE requires LOWER DOSES*

Cross out invalid order(s) - all sections must be complete for order to be valid. Should be reviewed daily and is valid for up to seven days.

Date / Time	/ / :	/ / :	/ / :
Local anaesthetic (concentration %)	%	%	%
Diluent (if required)			
Final volume (mL)	mL	mL	mL
Opioid name			
Opioid amount*			
Final opioid concentration*			
Additional medication 1			
Amount 1			
Additional medication 2			
Amount 2			
Initial infusion rate (mL / hour)	mL / hr	mL / hr	mL / hr
Background (continuous) infusion rate range (mL /hour)	..... to ..... mL / hr	..... to ..... mL / hr	..... to ..... mL / hr
Bolus dosing control *Please tick*	☐ Nil regular bolus dosing *OR* ☐ Clinician delivered bolus† *AND / OR* ☐ Patient controlled bolus *AND / OR* ☐ Programmed intermittent bolus	☐ Nil regular bolus dosing *OR* ☐ Clinician delivered bolus† *AND / OR* ☐ Patient controlled bolus *AND / OR* ☐ Programmed intermittent bolus	☐ Nil regular bolus dosing *OR* ☐ Clinician delivered bolus† *AND / OR* ☐ Patient controlled bolus *AND / OR* ☐ Programmed intermittent bolus
Bolus dose* (volume)	mL	mL	mL
Lockout time (minutes)	min	min	min
Programmed intermittent bolus (volume)	mL	mL	mL
Programmed intermittent bolus interval (hours / minutes)	hr min	hr min	hr min
Auto bolus to patient bolus lockout time (minutes)	min	min	min
Limits (optional)			
Contact details			
Prescriber signature			
Print name			
Pharmaceutical review			

EPIDURAL ANALGESIA ORDER – ADULT

page fold