Queensland Government

Intravenous Patient Controlled Analgesia (PCA) Order – Adult

Facility / Service: .....

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

(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

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

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

Attach ADR Sticker

(See Medication Chart for details)

ADMINISTRATION RECORD

PCA Solution Commencement

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

PCA Solution Preparation and Discard

Solution Preparation

Date	Time	Opioid, Amount	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
Discarded by							
Witnessed 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)		

Record of Clinician Delivered Boluses (e.g nurse controlled analgesia)

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

DO NOT WRITE IN THIS BINDING MARGIN

DO NOT WRITE IN THIS BINDING MARGIN

v4.00 - 03/2017
Mat. No.: 10232496
SW153

For illustration purposes only

page fold

Cut Off Section

Monitoring and Care Guidelines for PCA

For ALL PCA administration:

- Use a dedicated analgesia pump;
- PCA infusion systems must incorporate **anti-syphon** valves and in non-dedicated lines **anti-reflux** valves.

For PCA administration use *blue intravenous labels* as well as medicine name label, according to national labelling standard.

IntraVENOUS Commenced: | IntraVENOUS Date ...../...../..... Time .....

- **General observations (e.g. vital signs) are to be recorded on the *Q*-ADDS, *Q*-MEWT or local early deterioration detection system.**
- **PCA 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 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.

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:

INTRAVENOUS PCA ORDER – ADULT

page fold

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

Initial neuraxial analgesia given? ☐ Yes ☐ No	Time of dose:	Medication(s) / dose 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 16:00 hours, or review documentation in progress notes.

Date	Time	Comments	Initials / Print name

DO NOT WRITE IN THIS BINDING MARGIN

For Illustration purposes only

page fold

© State of Queensland (Queensland Health) 2017
Licensed under: http://creativecommons.org/licenses/by-nc-nd/3.0/au/deed.en

Queensland Government

Intravenous Patient Controlled Analgesia (PCA) Order - Adult

(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.....

Attach ADR Sticker ☐ NKDA ☐ Unknown
(See Medication Chart for details)

First Prescriber to Print Patient Name and Check Label Correct: .....
Weight (kg): ..... Height (cm): .....

PCA Order

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.
** 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	/ / :	/ / :	/ / :	/ / :	/ / :
Opioid name		***Morphine sulphate***	***Fentanyl citrate***	***Oxycodone hydrochloride***		
Opioid amount*						
Diluent (if required)		0.85% to 0.9% sodium chloride	0.9% sodium chloride	0.9% sodium chloride		
Final volume (mL)		mL	mL	mL	mL	mL
Final opioid concentration*		1mg / mL	10 micrograms / mL	1mg / mL		
Additional medication 1						
Amount 1						
Additional medication 2						
Amount 2						
Bolus dose* units and (volume) *Specify micrograms or mg*						
Background (continuous) infusion rate (unit / hour)		Zero	Zero	Zero	..... / hr	..... / hr
Lockout time (minutes)		5 min	5 min	5 min	min	min
Limits (optional)						
Contact details						
Prescriber signature						
Print name						
Pharmaceutical review						

If additional space is needed: a *SW153a Intravenous Patient Controlled Analgesia (PCA) Order - Adult (Additional Page)* is available for order. Tick a box each time an extra page is added. ☐ 1 ☐ 2 ☐ 3

DO NOT WRITE IN THIS BINDING MARGIN

INTRAVENOUS PCA ORDER - ADULT

page fold