Queensland Government

REGIONAL / LOCAL ANAESTHETIC
Analgesia 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

Local Anaesthetic Solution Commencement

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

Local Anaesthetic 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
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)		

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Monitoring and Care Guidelines for Regional / Local Analgesia

For ALL regional / local anaesthetic administration:

- Use a dedicated analgesia pump; and
- Only use yellow 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 catheter from filter
- Maintain intravenous access for duration of infusion

For regional / local anaesthetic administration use regional 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.**
- **Regional 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.**

Local Anaesthetic Toxicity

Signs and symptoms

Symptoms include:
- Agitation (new)
- Anxiety (new)
- Tingling around the mouth
- Ringing in the ears
- Muscle spasm
- Convulsions
- Respiratory depression and arrest
- Arrhythmias and cardiac arrest

Actions to be taken if above signs and symptoms occur

- Stop infusion / remove patient bolus button
- Notify APMS / anaesthetist or contact person listed immediately
- Administer oxygen and provide basic / advanced life support if needed
- Initiate emergency call
- Obtain 20% lipid emulsion for potential use by APMS / anaesthetist

Your nearest bag of lipid emulsion is kept:

See *AAGBI (The Association of Anaesthetists of Great Britain & Ireland) Safety Guideline Management of Severe Local Anaesthetic Toxicity 2010* for management of severe local anaesthetic toxicity

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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

Regional / Local Anaesthetic Catheter Insertion

Site / location:	Depth at skin: cm

Comments:

Initial local anaesthetic bolus? ☐ Yes ☐ No	Time of dose:	Medication(s) / dose given:

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

Regional / Local Anaesthetic 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. If daily review not recorded here, check progress notes. If no documented review by 16:00 hours, notify contact person.

Date	Time	Comments	Initials / Print name

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Analgesia Order – Adult

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Family name:
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NOT A VALID PRESCRIPTION UNLESS IDENTIFIERS PRESENT

Facility / Service: .....
Ward / Unit: ..... Year: 20.....

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

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

Orders

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 / / :	/ / :	/ / :
Route	**Regional** (specify)		
Local anaesthetic (concentration %)	%	%	%
Diluent (if required)			
Final volume (mL)	mL	mL	mL
Additional medication 1			
Amount 1			
Additional medication 2			
Amount 2			
Initial infusion rate (mL / hour)	mL / hr	mL / hr	mL / hr
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			

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

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