Your Hospital's Logo Here

ACUTE PAIN SERVICE FLOW SHEET

PATIENT IDENTIFICATION

ALLERGIES:

MEDICATIONS

(check one and indicate order date)

	Date Ordered		Date d/c'd
☐	______	**(1)** Levo-bupivacaine (Chirocaine) 0.125% (1/8th) + Dilaudid 20 mcg/ml at ______ ml/hr	______
☐	______	**(2)** Levo-bupivacaine (Chirocaine) 0.1% (1/10th) + Dilaudid 20 mcg/ml at ______ ml/hr	______
☐	______	**(3)** Levo-bupivacaine (Chirocaine) 0.0625% (1/16th) + Dilaudid 20 mcg/ml at______ ml/hr	______
☐	______	**(4)** Levo-bupivacaine (Chirocaine) 0.125% (1/8th) at ______ ml/hr	______
☐	______	**(5)** Ropivacaine (Naropin) 0.2% (1/5th) + Dilaudid 20 mcg/ml at ______ ml/hr	______
☐	______	**(6)** Ropivacaine (Naropin) 0.1% (1/10th)+ Dilaudid 20 mcg/ml at ______ ml/hr	______
☐	______	**(7)** Ropivacaine (Naropin) 0.2% (1/5th) ______ ml/hr	______
☐	______	Morphine 50mg/50ml **PCA IV**	______
☐	______	Morphine **IV INFUSION**	______
☐	______	Other ______	______

BASELINE ASSESSMENT

COMFORT GOAL: ______ RATING SCALE: ______

Vital Signs: BP ______ HR ______ RR ______ Motor Function: ______

Sedation Rating: ______ Pain Rating: ______ Sensory Level: ______

Epidural / Intrathecal: APS Drug Pack Available: ☐

PCA / Morphine Infustion: Narcan Available: ☐

Learning Needs	Knowledge Level *	Method * * *	Response * * * *	Date / Dept. Initial	Need Met Date / Initial
Importance of adequate pain control					
Preventive approach to pain					
Use of pain rating scale (0 - 10)					
Medication ______					
Route of admission					
Frequency of Dosing					
Onset					
Duration					
Potential Side Effects					

* KNOWLEDGE Codes
G = Good
F = Fair
P = Poor

* * * METHOD Codes	
V = Video	R = Role Play
E = Explain	H = Handout
D = Demonstration	
TV = Closed Circuit	
P = Post / Flip Chart	

* * * * RESPONSE Codes	
PT = Patient Taught	**FT = Family Taught**
1. Poor attention span	5. Verbalized recall of real knowledge
2. Refusal	6. Demonstrated ability / recall
3. Asked Questions	7. Anxious
4. Partial Comprehension	8. Needs follow-up reinforcement

PART OF THE MEDICAL RECORD

BOLUS ADMINISTRATION

Date:	Time:	Medication:	Dose:	Administered By:

APS FLOW SHEET

			Always monitor - with Narcotics and / or Local anesthetics					Intravenous						Epidural / Intrathecal				Narcotic Monitoring		Local Anesthetic Monitoring			
								PCA Pump Settings			IV Pump Settings			Pump settings									
Date:	Time:	Comfort Goal	Pain Score	BP	P	Side Effects/ Toxicities	IV Site Check	PCA Dose (mg / ml)	delay interval	base rate	ml / hr	Total Dose Given	Amount left in syringe / bag	Solution #	ml / hr	Total dose given	Epidural site check	Sedation Score	Respiratory Rate	Postural BP & P	Sensory Level	Motor Function	Initials

PART OF THE MEDICAL RECORD

ACUTE PAIN SERVICE FLOW SHEET

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APS FLOW SHEET

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								PCA Pump Settings			IV Pump Settings	Total Dose Given	Amount left in syringe / bag	Pump settings									
Date:	Time:	Comfort Goal	Pain Score	BP	P	Side Effects/ Toxicities	IV Site Check	PCA Dose (mg / ml)	delay interval	base rate	ml / hr			Solution #	ml / hr	Total dose given	Epidural site check	Sedation Score	Respiratory Rate	Postural BP & P	Sensory Level	Motor Function	Initials

PART OF THE MEDICAL RECORD

MONITORING THE PATIENT RECEIVING INTRATHECAL OR EPIDURAL PAIN MANAGEMENT

MONITORING THE PATIENT	AFTER BOLUS DOSE	CONTINUOUS INFUSION	THEREAFTER
Always Monitor - Both with narcotics and / or local anesthetics:			
PAIN SCORE	every 15 min x 4; every 30 min x 2; every 1 hr x 22 hrs;	every 15 min x 4; every 30 min x 2; every 1 hr x 22 hrs;	every 4 hrs
BP & P	every 15 min X 4; every 30 min X 2; every 1 hr X 22 hrs;	every 15 min x 4; every 30 min x 2; every 1 hr x 22 hrs;	every 4 hrs
Side Effects / Toxicities	every 15 min X 4	every 15 min x 4	every 4 hrs
Pump Settings	N / A	N / A	every 4 hrs
Catheter Site Inspection	every 8 hrs	every 8 hrs	every 8 hrs
Additional Monitoring - Narcotics:			
SEDATION SCORE	every 15 min x 4; every 30 min x 2; every 1 hr x 22 hrs;	every 15 min x 4; every 30 min x 2; every 1 hr x 22 hrs;	every 4 hrs
RESPIRATORY RATE	every 15 min X 4; every 30 min X 2; every 1 hr X 22 hrs;	every 15 min x 4; every 30 min x 2; every 1 hr x 22 hrs;	every 4 hrs
Additional Monitoring - Local Anesthetics:			
Postural BP & P	Prior to Ambulation	Prior to Ambulation	Prior to Ambulation
Sensory Level	every 15 min x 4	every 15 min x 4	every 4 hrs
Motor Function	every 15 min x 4	every 15 min x 4	every 4 hrs

If the patient receives an additional bolus dose of medication or their infusion rate is changed, the entire monitoring sequence should be restarted beginning with the every 15 minute monitoring intervals for pain, sedation and respiratory rate as well as every 15 min BP and P checks, etc

IV PCA / CONTINUOUS MORPHINE INFUSION: Monitor BP, P, R, Sedation, and Pain every 30 min x 4, then every 4th; 2 nurses verify initial pump settings and changes in addition to every 4th checks; IV site checks every hour.

PAIN SCALES:

WONG - BAKER: *(Faces)* 0 1 2 3 4 5

0-10 VISUAL: *(Numerical)* 0 1 2 3 4 5 6 7 8 9 10

VERBAL: No Hurt — Hurts Little Bit — Hurts Little More — Hurts Even More — Hurts Whole Lot — Worst Pain

WONG-BAKER FACES PAIN SCALE from Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Ahmann E, DiVito-Thomas PA, Whaley & Wong: Nursing Care of Infants & Children, 6th ed, St. Louis, MO: Mosby-Year Book Inc., 1999; 1153. Copyrighted by Mosby-Year Book, Inc. Reprinted with Permission.

NON-COGNITIVE: *(FLACC Scale)*

1. Sum of FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY Scores = FLACC Score
2. Record FLACC Score using the 0-10 VISUAL (NUMERIC) Scale above

_____ = FACE Score
0 = No particular expression or smile
1 = Occasional grimace or frown, withdrawn, disinterested
2 = Frequent to constant frown, clenched jaw, quivering chin

_____ = LEGS Score
0 = Normal position, or relaxed
1 = Uneasy, restless, tense
2 = Kicking, or legs drawn up

_____ = ACTIVITY Score
0 = Lying quietly, normal position, moves easily
1 = Squirming, shifting back & forth, tense
2 = Arched, rigid, or jerking

_____ = CRY Score
0 = No crying (asleep or awake)
1 = Moans or whimpers, occasional complaint
2 = Crying steadily, screams or sobs, frequent complaints

_____ = CONSOLABILITY Score
0 = Content, relaxed
1 = Reassured by touching/hugging/talking to, distractable
2 = Difficult to console or comfort

SEDATION

S = Normal sleep, easy to arouse, oriented when awakened, appropriate cognitive behavior
1 = Wide awake, alert (or at baseline), oriented, initiates conversation
2 = Drowsy, easily aroused, oriented, displays appropriate cognitive behavior when awake
3 = Drowsy, somewhat difficult to arouse, but oriented when awake
4 = Hard to arouse, confused, disoriented
5 = Unarousable

NARCOTIC SIDE EFFECTS:
0 = None
1 = Sedation Scale (3, 4, 5)
2 = Respiratory Rate < 10
3 = Pruritis
4 = Nausea / Vomiting
5 = Urinary Retention (Notify APS & Attending MD)

SENSORY ASSESSMENT:
0 = No change in Level > 4 hrs *
T4 = Nipple level *
T6 = Xiphoid level *
T8 = Lower ribs *
T10 = Umbilicus
T12 = Lower abdominal area

LOCAL ANESTHETIC SIDE EFFECTS:
5 = Urinary Retention *

LOCAL ANESTHETIC TOXICITIES:
6 = Metallic taste in mouth *
7 = Ringing in the ears *
8 = Numbness of tongue / lips *
9 = Dizzy and / or lightheaded *

MOTOR ASSESSMENT
0 = Patient unable to move toes or bend knees *
1 = Able to move toes, unable to bend knees *
2 = Able to move toes and bend knees, but weak *
3 = Able to move toes, bend knees easily, strong
4 = Ambulating, if appropriate

*** Stop infusion, call APS**

PART OF THE MEDICAL RECORD