ORDERS

Date	Time	Drugs Added to Preservative Free N.S. 250ml	PCA Dose ml	Lookout Interval Mins	4 Hr MAX	Cont. Infusion ml/hr	Respiratory Assessment	PAIN SCORE (Ask pt. to rate pain intensity)	Sedation Assessment	Physical Findings
							S = Shallow R = Regular D = Deep L = Labored Sena/Motor Deficits Specify Location	0 No Pain 1 2 3 Mild Pain 4 5 Moderate Pain 6 7 Strong Pain 8 9 10 Worst Pain Possible S Patient Sleeping U Patient unable to give pain rating	0 = Alert, answers questions easily 1 = Drowsy 2 = Sleeping arouses readily 3 = Stuporous, encouragement need to arouse 4 = Unarousable	0 = No Complaints 1 = Nausea 2 = Vomiting 3 = Itching without rash 4 = Itching with rash 5 = Urinary retention 6 = Other, see "Comments" ✔ Catheter Site Check

Date	Time	Settings Verified (Initials)	Bolus Drug Dose	Continuous ml/hr	Cum. Total Dose (ml)	Bag Changed (Controlled Substance #)	Assessments: Resp	Sensory Deficit	Motor Deficit	Pain	Sedation	Phys find	Comments/Activity	RN Initials

KEY: Signature	Title	Initials	KEY: Signature	Title	Initials

DEPARTMENT OF NURSING
EPIDURAL OR INTRATHECAL ANALGESIA MONITORING RECORD

Patient Label

DEPARTMENT OF NURSING

EPIDURAL/INTRATHECAL (SPINAL) ANALGESIA
MONITORING RECORD GUIDELINES

Purpose

To provide documentation of patient assessment and drug delivery during administration or intermittent of continuous epidural or intrathecal (spinal) analgesia.

Guidelines

1. This form must be used whenever nursing staff is monitoring a patient receiving epidural or intrathecal analgesia and is initiated at the time monitoring by nursing staff is begun.

2. Circle either "EPIDURAL" or "INTRATHECAL" (same as spinal) at the top of this form to indicate the placement of the catheter.

3. ORDERS
Document new and updated physicians order in this section.

4. All entries, must include the date, time, and RN's initials as identified in the signature key.

5. SETTINGS VERIFIED
To document that two (2) RN's have verified that the device settings are updated and correct, two (2) RN's initials must be placed in the column marked "Settings Verified" at the beginning of every shift.

6. BOLUS DRUG DOSE
In this column document the amount of a bolus doles administered by a physician.

7. CONTINUOUS ML/hr
Every four (4) hours document in this column the ml per hour the patient is receiving.

8. CUM. TOTAL DOSE (ML)
Every four (4) hours document in this column the cumulative total dose in ML as it appears on the pump screen. When hanging a new bag, the cumulative total must be reset to "0".
Document the cumulative total of both bags in this manner
240 / 0

9. BAG CHANGE
Write the controlled substance number of the new bag of solution in this column to document that a new bag has been hung.

10. **ASSESSMENTS**

Respiratory Assessment — Document according to the key every four hours.

Sensory Deficit — Specify the location of numbness if present e.g. "R Leg" or "L Leg"
-OR-
If the patient has no numbness place 'NO' in this column.

Motor Deficit — Specify the location of extremity weakness if present e.g. "R Leg" or "L Leg"
-OR-
If the patient has no extremity weakness place 'NO' in the column.

PAIN ASSESSMENT:

Ask the patient to rate the intensity of his/her pain using a number on the scale of 0 to 10, where "0" means NO PAIN and "10" means the worst possible pain. Record the number in the column marked 'PAIN'.

If the patient is unable to understand the 0 to 10 scale, ask the patient to describe the pain as one of the following words, then record the corresponding number in the column marked 'PAIN'.

DESCRIPTOR	Pain Score
No pain	0
Mild pain	3
Moderate pain	5
Strong pain	7
Worst possible pain	10

If the patient is UNABLE to give a pain score or word description mark "U" in the column marked "PAIN"

If the patient is allowed to remain SLEEPING at the time of the assessment mark "S" in the column marked "PAIN"

Sedation Assessment — Document according to the key. Assess sedation q1 hr x first 24 hr then q4 hr. The q1 checks may be summarized and documented q4 hr by also writing in comments "q1 hr sedation checks done".

Physical Endings — Document according to the key. Assess and record q4 hr.
(Record a blood pressure and pulse q4 hr on the graphic record).

11. CATHETER SITE CHECK
Once a shift, place in this column indication that the catheter is intact and the site is unremarkable. Use the "COMMENTS" column to document catheter site problems.

12. COMMENTS/ACTIVITY
Use this column to document additional pertinent information.

13. Discard empty or unused bags of solution. Document wastage on the Controlled Substance Record according to policy.

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