Pain Management Task Force
Policies and Procedures

Report on the Harrison Hospital Pain Management Task Force
Patient Care Guidelines
Patient Admission Record
Morphine Continuous IV Infusion Standing Orders
Epidural/Spinal Opioid Analgesia Physician's Orders
Chronic Pain Control Via Epidural Catheter Standing Orders
Patient Controlled Analgesia Physician Order Sheet

Developed by:
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Pat Alexander, Rph
of
Harrison Memorial Hospital
Bremerton, Washington
The Harrison Hospital Pain Management Task Force was formed in January, 1994 to develop tools, protocols and procedures to address pain experienced by patients at Harrison Hospital, the hospital which serves the area in and around Bremerton, Kitsap County, Washington. This is a multi-disciplinary team which includes physicians, pharmacists and nurses.

The initial focus was on oncology and home health patients. The focus has been expanded to include pre-surgery admit, PACU and post operative nursing.

The task force has developed two protocols for morphine drip and for epidural pump for chronic pain. Pain assessment has been included as part of the new charting system as well as on the MARs. We have also done a survey about the patients' satisfaction with the way their pain has been treated.

We are working with Hospice of Kitsap County to improve the transition of our terminal patients from the hospital to home.

Another accomplishment of the task force was the one day seminar for community and hospital nurses on pain management. I have taught classes on pain management for 4 West YED (yearly education day), Float Team YED and 2 South (post-op) YED.

The Joint Commission was pleased with and gave the hospital a commendation for the protocols on pain management and having the multi-disciplinary task force in place.

Dr. Lou Saeger, M.D., Pat Alexander, RPH, and myself have been the writers of the protocols with input from members of the Pain Management Task Force. All of the protocols from Harrison Memorial Hospital are available for the asking. We at Harrison feel that pain management should be a cooperative measure not only among disciplines but between institutions as well.

The task force held a CME on pain management for physicians in April 1995.

Attached hereto are the protocols for Patient Care Guidelines for Acute and Chronic Pain Management.

Thanks to the Mayday Foundation and to Dr. Betty Ferrell for your continued support of better pain management for patients.

Dianne Monreal, R.N.
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(360) 876-2728, home
Pain Management Task Force

Role and Scope

To provide pain management services to:
1. in-patients with acute and chronic pain related to terminal illness.
2. in-patients with chronic pain related to chronic disease

Goals

1. Patient assessment and recommendations for pain relief following referrals.
2. Physician education.
3. Staff nurse education through YED and in-services as requested by the unit coordinator.

Policy

To provide pain control and relief with the most cost effective and least invasive method available.
2. Physical therapy and TENS unit.
3. IV narcotics.
4. Epidural catheters and other invasive treatments.

Procedure

1. ATC analgesics with PRN meds for breakthrough pain.
2. MS gtt.protocol.
3. Epidural/CADD pump protocol.

Committee members

1. Medical oncologist
2. Anesthesiologist
3. Pharmacist
4. Nursing Administration
5. Staff nurses 4W, 2SE, 3W, 3N

Future plans

To expand the focus of the Pain Services Committee to include in-patients with pain related to surgery, trauma, cardiac problems, and child birth.
To include out-patient treatment of chronic disease.
To focus on Hospice patients.
The expanded committee would include an Internist, Cardiologist, Pediatrician, and Surgeon.
Nurses from each specialty would be included.
I. ASSESSMENT

1. Include history, physical, allergies, etc.

2. Assess patient for previous experiences of acute or chronic pain: i.e.;
   a. circumstances of onset;
   b. location;
   c. description of pain;
   d. duration;
   e. intensity;
   f. aggravating/alleviating factors;
   g. previous treatments and effectiveness of those treatments.

3. Obtain history regarding usual patterns of:
   a. bowel elimination;
   b. cognitive function;
   c. sleep;
   d. communication;
   e. physical history;
   f. medical history.

4. Psychosocial assessment:
   a. understanding of diagnosis/causes of pain;
   b. expectations of treatment;
   c. concerns/knowledge of pain control;
   d. barriers to reporting pain.

II. PATIENT TEACHING

1. Discuss with the patient and family probably physiological causes of pain that might be specific to patient (e.g., mass pressing on nerve, tumor obstructing bowel, etc.).

2. Teach the patient and family some non-invasive methods which might help prevent or alleviate pain (e.g., distraction, music, reading, prayer, meditation, guided imagery, massage therapy, etc.).

3. Discuss with the patient and family concepts of pain and pain management (e.g., reality of pain, variability and individuality of pain perception, etc.). Teaching to include self pain assessment, being able to rate pain on a 0-10 scale, and to identify location, aggravating factors and relieving factors.
III. NURSING CARE

1. Initiate pain management flow sheet.

2. Monitor vital signs as ordered or as warranted.

3. Implement measures to alter patient's perception of pain:
   a. administer prescribed analgesics;
   b. titrating medications, dosage, frequency within prescribed parameters (consult pharmacist on safe and effective parameters);
   c. offering non-invasive methods to alleviate discomfort (e.g., prayer, meditation, music, etc.).

4. Monitor the patient for side effects of analgesics and implement measures to combat or manage side effects (i.e., routine bowel care, antiemetics, ointments, warm or cold therapy, etc.).

5. Assess patient at regular intervals for:
   a. adequate pain control;
   b. bowel elimination;
   c. change in LOC/cognitive function;
   d. general appearance and behavior;
   e. nutritional status.

6. Consult with MD regarding Physical Therapy referral for:
   a. TENS unit;
   b. active and passive ROM exercises;
   c. braces and splints as needed;
   d. assistive devices (walkers, canes, etc.)

7. Encourage patients and family participation in pain management regimen.

8. Notify MD of changes in patient or inadequate pain control.


IV. DISCHARGE TEACHING

1. Involve the family if possible.

2. Discharge form filled out and discussed with patient.

3. Advise patient and family of: expected side effects, possible complications and when to call physician.

4. Encourage keeping a pain management diary using a 0-10 pain scale.

5. Provide AHCPR guidelines for patients when appropriate.

6. Provide other written patient teaching material when appropriate.
## Patient Admission Record

### Admit

- **Admitted:** Date __________________________  Time ____________________  Via:  ___ Ambulatory   ___ Wheelchair   ___ Stretcher
- **Language spoken/read:** __________________________
- **Physician's admitting diagnoses:** __________________________
- **Patient's description of illness:** __________________________
- **Patient's understanding of tx:** __________________________
- **Patient/family expects length of stay to be:** __________________________  **Primary MD:** __________________________

### Pain

- **Location:** __________________________
- **Intensity (0-10):** __________________________
- **Description:** __________________________
- **Management:** __________________________

### Advance Directives

- **Living will:** __ yes  __ no  **Durable POA:** __ yes  __ no  **Organ donor:** __ yes  __ no  **Information given:** __ yes
- **ID Band:** __________________________  **Room orientation:** __________________________  **PT rights/responsibilities:** __________________________  **Lights: call/BR. emerg.:** __________________________  **visiting hours/smoking policy:** __________________________

### Medications

<table>
<thead>
<tr>
<th>Medication Name and Strength</th>
<th>Frequency</th>
<th>Last Dose</th>
<th>Medication Name and Strength</th>
<th>Frequency</th>
<th>Last Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription</td>
<td></td>
<td></td>
<td>Prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contraceptives</td>
<td></td>
<td></td>
<td>Non-Prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug/alcohol use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Sent home:** ___  **Sent to pharmacy:** ___  **None:** ___  **Frequency of missed doses:** ___  **Never**  ___ 1-3/week  ___ >3/week

- **Who manages medications at home:** __________________________

### Allergies/Reactions

- **Latex allergy:** __ Yes  __ No  **Allergy protocol initiated:** __ Yes  __ No

### History

**Assess medical/surgical history, previous hospitalizations and immunizations**

- **Diabetes:** __________________________  **Insulin:** __________________________  **Diet:** __________________________
- **Oral:** __________________________  **Heart Disease:** __________________________  **Kidney disease:** __________________________
- **Respiratory Disease:** __________________________  **Seizures:** __________________________  **Thyroid:** __________________________
- **CVA:** __________________________  **Blood Disorder:** __________________________

- **Did you participate in a rehabilitation program for any of the above:** __ No  __ Yes  **date/diagnosis/location:** __________________________

### Recent hospitalizations

- **Surgeries:** __________________________

### Immunizations

- **Tetanus:** __________________________  **Influenza:** __________________________  **Pneumovax:** __________________________  **Polio:** __________________________  **HIB:** __________________________  **DPT:** __________________________  **MMR:** __________________________  **Hepatitis:** __________________________

- **Dates:** __________________________  __________________________  __________________________  __________________________  __________________________  __________________________  __________________________  __________________________
**Mental-Assess LOC, cognition, mental status**

- Alert, oriented X___
- Alert, disoriented ___
- Arousable, oriented X___
- Lethargic, oriented X___
- Stuporous ___
- Semicoma ___
- Coma ___

- Attentive ___
- Distracted ___
- Memory intact ___
- Follows instructions ___
- Impulsive ___
- Withdrawn ___
- Sedated ___

**Language/Communication-Assess communication abilities**

- Clear ___
- Slurred ___
- Jargon ___
- Incoherent ___
- Non-verbal ___
- Intubated ___
- Tracheostomy ___
- Laryngectomy ___

- Is speech referral indicated for Pt? Yes ___ No ___

**Sensory-Assess hearing, vision and sensation**

- Hearing ___
  - Normal ___
  - Deaf ___
  - HOH ___
  - Hearing Aid ___

- Sensation ___
  - Intact ___
  - Numb ___
  - Tingling ___

- Where: ________________

- Size: R____ L____
- Reaction: R____ L____
- Cataracts: R____ L____
- Gaze: R____ L____
- Field cut: R____ L____
- Visual: Intact ___ Impaired ___

**Motor-Assess and identify areas of neurological motor function**

- Moves on command ___
- Decerebrate ___
- Decorticite ___
- Flaccid ___
- Rigid ___
- Tremor ___
- Withdrawal ___

- Facial Droop: R____ L____
- Ambulates independently ___
- Ambulates with equipment ___
- Walker ___
- Crutches ___
- Atrophy ___
- Swelling ___
- Spasm ___
- Cast ___

**Neurological**

- Balance: ___
- Contracture ___
- Rigid ___
- Tremor ___
- Withdrawal ___

- Size: R____ L____
- Reaction: R____ L____
- Cataracts: R____ L____
- Gaze: R____ L____
- Field cut: R____ L____
- Visual: Intact ___ Impaired ___

**Assess musculoskeletal strength, mobility, coordination, and equipment**

- Strength: S = Strong W = Weak N = None
- Ambulation: Amputation ___
- Hand Grip: R____ L____
- Arm Pull: R____ L____
- Extremity: R____ L____
- Balance: Canine ___ Quad Cane ___
- ROM: Non-ambulatory ___
- Functional ___
- Transfers ___
- Stiff ___
- Requires supervision ___
- Painful ___
- Requires assist ___
- Passive only ___
- Transfer ___
- Contracture ___
- Dependent ___

**Musculoskeletal**

- Ambulation: Wheelchair ___
- Ambulates independently ___
- Requires assist ___
- Non-ambulatory ___

- Currently receiving: PT ___ OT ___
- Where: ________________

**Cardiovascular**

- Rhythm ___
- S1S2 ___
- Syncope ___
- Pacemaker % ___
- Pedal pulses ___
- LDP ___
- LPT ___
- RDP ___

- Edema: Sacral ___ Ankle ___ JVD ___ Pitting ___ Non-Pitting ___

**Respiratory**

- Breathing pattern ___
- Breathing sounds ___
- O2 Support and Cough ___
- Smoking History ___

- Color ___
- Consistency ___
- Amount ___

**Exercise Habits ___**
### Gastrointestinal

Assess weight, abdomen, bowel habits, swallowing, bowel tones, and comfort

<table>
<thead>
<tr>
<th>Abdomen</th>
<th>Bowel Tones</th>
<th>Bowel Function</th>
<th>Last BM</th>
<th>Oral Mucosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft</td>
<td>Present</td>
<td>Diarrhea</td>
<td></td>
<td>Dry</td>
</tr>
<tr>
<td>Distended</td>
<td>Absent</td>
<td>Constipation</td>
<td></td>
<td>Moist</td>
</tr>
<tr>
<td>Rigid</td>
<td>Absent</td>
<td>Incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain/Tenderness</td>
<td>Hyperactive</td>
<td>Stoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mass</td>
<td></td>
<td>Type/Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tubes/Drains</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### NUTRITION

Assess appearance, dietary history, swallow, chewing, and feeding

- Swallowing problems: No, Yes
- Chewing problems: No, Yes
- Oral pain: No, Yes
- Nausea or vomiting: No, Yes
- Muscle wasting prominent: No, Yes
- Intake <usual> 7 days: No, Yes
- Unintentional wt. loss > 10 lbs: No, Yes
- Is dietitian referral indicated for this patient: No, Yes
- Is speech referral indicated for patient? No, Yes

- Swallowing problems: No, Yes
- Special diet: No, Yes
- Prior Education: No, Yes
- Caffeine intake per day: cups of per day

### GENITOURINARY

Assess urinary frequency, control, color, consistency, odor, comfort, Gyn-bleeding, discharge, and pregnancy

- Urine: Incontinent
- Date of last menstrual period: ________________
- Method of contraception: ________________
- Pregnant: No, Yes
- EDC: ________________
- Current Prenatal Status: ________________
- # Live Births: ________________
- #Pregnancies: ________________
- Active Infections: ________________
- # Infections: ________________
- Active Infections: ________________
- #Pregnancies: ________________
- Active Infections: ________________
- #Pregnancies: ________________
- Active Infections: ________________
- #Pregnancies: ________________

### INTEGUMENT

Assess skin color, texture, turgor, and integrity

- Normal color
- Peripheral IV sites: ____________
- Medi: ____________
- Vascular access: ____________
- Pale
- Flushed
- Diaphoretic
- Cyanotic
- Janudice
- Hot
- Warm
- Clammy
- Friction/Shear
- No concerns
- Potential Problem
- Scarring (S)
- Occasionally slides down in bed, requires minimal assistance: ____________
- Wounds: laceration (L)
- surgical/skin tear/abrasion/denuded
- Problem
- Ulcers: (U)
- pressure/diabetic/venous-arterial
- Frequently slides down in bed, requires frequent repositioning with maximum assistance: ____________
- Braden Scale: ____________
- Total: ____________
**Assess independence prior to admission in self care and environmental barriers**

<table>
<thead>
<tr>
<th>Ind</th>
<th>Ind with assist</th>
<th>Needs equip</th>
<th>Needs equip</th>
<th>Unable</th>
<th>Residence prior to admit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeding</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hygiene</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Mgt.</td>
<td>Yes</td>
<td>No</td>
<td></td>
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</tr>
</tbody>
</table>

Does patient intend to return to same home at discharge?

- Yes
- Yes, with help
- No, plans to go

Former/current occupation 

Lives with

Local support/caregiver

Other support/caregiver

Is patient caregiver to another?

- Yes
- No

If yes, are person's care needs being met?

- Yes
- No

# of children

Is patient currently receiving home health care or agency help?

- Yes
- No

Does patient have the necessary skills, help, and/or services necessary for discharge?

- Yes
- No

Who makes legal decisions for patient?

- Patient
- Durable POA
- Other
- Not identified

Recent life stresses:

Who or what helps patient handle stress/change?

Patient's response during admission interview

- Appropriate
- Anxious
- Agitated
- Flat affect
- Combative

*Is social work referral indicated for patient?

- Yes
- No

Comments/Impressions

Identify teaching needs on Plan of Care form

Initial if referral made

- OT*
- PT*
- DIETITIAN
- SOCIAL WORK
- RT*
- SPEECH*
- OTHER

*Obtain MD order

Data collected by

Reviewed by RN and plan of care/discharge plan documentation started

signature date

signature date
**MORPHINE CONTINUOUS IV INFUSION**

1. Morphine IV Infusion via Life Pump
   - □ Morphine 125 mg/250 ml D5W (Conc. 0.5 mg/ml)
   - □ Morphine 250 mg/250 ml D5W (Conc. 1 mg/ml)
   - □ Other: Morphine _______________________
     Dilaudid _______________________

2. Starting Dose/Rate
   - □ __________ mg/hr
     Optional: Dose/Rate by Pharmacy (Based on Patient's Current Analgesic Regimen)

3. Dosage Adjustment
   - □ Increase: __________ mg/hr every __________ minutes
   - □ Bolus: __________ mg IV every __________ minutes
     prn __________
   - □ Per Pharmacy:

4. Supplemental Analgesic ____________________________________________________________

5. Anti-emetic Medications:
   - □ Prochlorperazine 10 mg IV Q __________ hr prn
   - □ Droperidol __________ V Q __________ hr prn
   - □ Metoclopropamide __________ mg IV Q __________ hr prn
   - □ Benadryl __________ mg IV Q __________ hr prn
   - □ Scopolamine Patch Q 72 hours
   - □ Other ____________________________________________________________

6. Standing Bowel Care:
   - □ Docusate 100/250 mg PO ____________________
   - □ Senokot - S PO ____________________
   - □ MOM 30 ml PO ____________________
   - □ Other ____________________________________________________________________

__________  ____________________________________________________________________
Date                                                   Signature of Physician

Checked By ____________________________ R.N.   Time ________  Date __________

**HARRISON MEMORIAL HOSPITAL**
**BREMERTON, WASHINGTON**
**FORM NO. 668     REV. 11-94**

**MORPHINE CONTINUOUS IV INFUSION**
**STANDING ORDERS**
H.M.H. PROTOCOL PRECAUTIONS & MONITORING FOR EPIDURAL/SPINAL OPIOID ANALGESIA

1. Epidural infusion via lifepump, or similar, (with all injection ports taped over) at ____________________ cc/hour, per 250 cc normal saline:
   - Duramorph _______________ mg
   - Dilaudid _______________ mg
   - Other (specify) ____________________ (amount) __________________
   - With Epinephrine 1:200,000 (add only if checked)

2. Keep Epidural catheter taped in loop at hub, and keep distal infusion tubing taped to patient's shoulder to prevent tension at hub-cath junction. Check Q shift.

3. Management of ventilatory depression (rate under 10, or significant hypoventilation):
   - Coach patient to breathe deeply at 10/minute.
   - Page patient's Anesthesiologist (if unavailable, page the Anesthesiologist on call).
   - Give Narcan 0.1 mg (1/4 cc) I.V. PRN
   - After 10 minutes, repeat Narcan dose if spontaneous breathing remains under 10/minute.

4. Management of other side effects:
   - Scopolomine patch behind ear while Epidural in use. Change Q 72 hours or PRN; discontinue if patient becomes confused, disoriented, or has significant visual disturbance.
   - Benadryl _______________ mg Q 3-4 hours, PRN itching.
   - Nalbuphine 10 mg subcutaneous Q 4 hours, PRN itching.
   - Droperidol _______________ mg Q 1-2 hours, PRN nausea.

5. Page Dr. _________________________ PRN: (Call ____________________ to page).
   A. Inadequate pain control.
   B. Problems with side effects (Somnolence, decreasing ventilation; itching or nausea not easily controlled).
   C. Need for sedative-hypnotic or anxiolytic medication order.
   D. Problems with Epidural catheter.
   E. Need to change or discontinue any epidural protocol orders.

6. Supplemental Analgesic □ _____________________________________________________________

   ________________________________ ______________________________
   Date Signature of Physician

Checked By ___________________________ R.N. Time __________ Date __________

HARRISON MEMORIAL HOSPITAL
BREMERTON, WASHINGTON
FORM NO. 668     REV. 11-94

MORPHINE CONTINUOUS IV INFUSION
STANDING ORDERS
1. **Epidural Pump:** infusion at __________ ml/hr (max. 15 mls/hr per 250 ml NS bag).
   - Morphine ______________ mg.
   - Hydromorphone ______________ mg.
   - Other (specify) __________________
   - With Epinephrine 1:200,000 (add only if checked).
   - Marcaine ______________ mg.

2. **Patient Controlled Dose:**
   - Yes ______________ ml/hr, Frequency: up to Q ______________ min.
   - No.

3. **Management of Ventilatory Depression:** (rate under 10, or significant hypoventilation):
   - Turn off pump.
   - Coach patient to breathe deeply at 10/min.
   - Page patient's Anesthesiologist (if unavailable, page the Anesthesiologist on call).

4. **Management of other side effects:**
   - Benadryl ______________ mg IV or PO Q 3-4 hours, PRN itching.
   - Droperidol ______________ mg IV Q 1-2 hours, PRN nausea.
   - Reglan ______________ mg PO QID AC/HS.
   - Scopolamine Patch Q 72 hours.

5. **Bag and filter:**
   - Change when empty.
   - Maximum of 72 hours or if system is opened.

6. **Page Dr. ____________________ prn:** (Call ____________________ to page)
   - if any of the following situations arise:
     A. Inadequate pain control.
     B. Problems with side effects (somnolence; decreasing ventilation; itching or nausea not easily controlled).
     C. Need for sedative-hypnotic or anxiolytic medication order.
     D. Problems with epidural catheter.
     E. Need to change or discontinue any epidural protocol orders.

7. **Supplemental Analgesic:** __________________________________________________________

   Date __________________ Signature of Physician __________________

   Checked By ___________________ R.N. __________ Time __________ Date __________

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HARRISON MEMORIAL HOSPITAL
BREMERTON, WASHINGTON
FORM NO. 668 REV. 11-94

MORPHINE CONTINUOUS IV INFUSION STANDING ORDERS
1. ANALGESIA VIA PCA INFUSER
   - MORPHINE (1 mg/ml)
   - MEPERIDINE (10 mg/ml)
   - OTHER: ___________________________________________________________________________

2. LOADING DOSE: _____ MG
   □ PRN □ SINGLE DOSE □ AS NEEDED EVERY 4 HOURS
   SUGGESTED: (MORPHINE 1 - 5 mg) (MEPERIDINE 10 - 20 mg)
   NOTE: LOADING DOSE INCLUDES INITIAL DOSE(S) GIVEN IN PAR

3. MODE OF ADMINISTRATION:
   □ PCA ONLY □ CONTINUOUS ONLY
   □ PCA PLUS CONTINUOUS ___________ HOURS FOR CONTINUOUS MODE.
   SUGGESTED: (2200-0600 FOR CONTINUOUS MODE IN POST-OP PATIENT)

4. MAINTENANCE (PCA) DOSE: _____ mg
   SUGGESTED: (MORPHINE 1 - 2 mg) (MEPERIDINE 10 - 20 mg)

5. CONTINUOUS DOSE (if using that mode) ___________mg/hr
   SUGGESTED: (MORPHINE 1 mg/hr - USUAL RANGE .05 - 2 mg/hr)
   (MEPERIDINE 10 mg/hr - USUAL RANGE 5 - 20 mg/hr)

6. LOCKOUT INTERVAL: __________ minutes
   SUGGESTED: 8 - 10 minutes

7. FOUR HOUR LIMIT: _____ mg (maximum dose to be delivered in any 4 hour period).
   SUGGESTED: (MORPHINE 20 - 25 mg) (MEPERIDINE 200 - 250 mg)

8. CHART RESPIRATORY RATE EVERY 2 HOURS TIMES TWO, THEN AS NEEDED.

9. THE PCA PUMP REQUIRES A RUNNING IV SOLUTION. IF PATIENT DOES NOT CURRENTLY
   HAVE AN IV, ORDER A TKO IV SOLUTION AS FOLLOWS:

10. IF PATIENT COMPLAINS OF INADEQUATE ANALGESIA, CHECK THE PATENCY OF THE I.V. IF
     PATENT, INCREASE DOSE VOLUME BY 0.5 ml INCREMENTS (AT ONE HOUR INTERVALS) WITHIN THE
     PRESCRIBED RANGE.

Comments: __________________________________________________________________________
                        __________________________________________________________________________
                        __________________________________________________________________________
                        __________________________________________________________________________
                        __________________________________________________________________________

_________________________________ ___________________________________
Date Signature of Physician

Checked By ______________________________R.N. Time __________ Date __________

HARRISON MEMORIAL HOSPITAL
BREMERTON, WASHINGTON
FORM NO. 763     REV. 9-90
PATIENT CONTROLLED ANALGESIA
PHYSICIAN ORDER SHEET