

I.V.
Patient Controlled Analgesia Orders

1. Check desired medication
 - Morphine Sulfate 1mg/ml 50ml cassette (recommended adult dose 1mg q 5-15 minutes. Average dose 4-6 mg/hour)
 - Hydromorphone 1mg/ml 50 ml cassette (6 times as potent as Morphine-recommended adult dose 0.2mg q 5-15 minutes. Average dose 0.8 to 1 mg/hour)
 - Other: _____.
2. Route of Administration: **IV**
3. Continuous Rate: _____ mg per hour
4. Bolus/PCA Dose: _____ mg (dose patient receives each time the button is pushed)
5. Lockout Time Interval: _____ minutes (time interval patient is allowed to push button again)
6. Maximum Dose per hour: _____ mg (maximum dose patient is allowed to receive in an hour)
7. Assessment:
 Vital Signs, Pain Assessment, Level of Sedation and Assessment of Side Effects every hour x 4 and then q 4 hours for duration of therapy. If sedation level is **2** or greater, assess respiratory status hourly, do stat pulse ox and call MD for order for continuous pulse oximeter until pCA discontinued. Record Pain Assessment, Level of Sedation, Presence of Side Effects, and Respiratory Rate/Depth on PCA Flowsheet. Other vital signs on graphic sheet.
8. For respiratory rate less than 10/minute or unresponsive: **Stop PCA infusion immediately** and notify physician. Administer oxygen and support ventilation as necessary. Administer naloxone 0.1 mg IV push and repeat every 5 minutes prn up to total dose of 0.4 mg to keep respiratory rate greater than 10/minute.
9. While on PCA device, patient should not receive other opioid analgesics unless specifically ordered by physician.
10. For pain not controlled the nurse may administer a bolus as ordered above STAT and notify Attending Physician for further orders.
11. For nausea/vomiting (choose one of the following):
 - Promethazine 12.5 mg IV q2 hours prn x 2
 - Droperidol 0.625 mg IV q2 hours prn x 2
 - Metoclopramide 5 mg IV q4 hours prn x 2
12. Specify medication for analgesia when PCA is discontinued:
 _____.

***Check appropriate orders or cross out any items not appropriate for this patient**

Date: ____/____/____ Time: _____ Verbal Order: _____,RN/ _____,MD

Date: ____/____/____ Time: _____ MD Signature: _____, MD

Verbal Order Verification: _____

Patient Identification

CHH-827

Originated: 3/7/1990

Revised: 4/1992, 8/2001, 10/2003, 9/2004, 1/2005