Southwestern Ontario
Maternal, Newborn, Child and Youth Network

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GUIDELINES FOR COMPLETION OF THE OBSTETRICAL PAIN MANAGEMENT MONITORING RECORD

The regional **Obstetrical Pain Management Monitoring Record.** has been developed by the Southwestern Ontario Perinatal Partnership (SWOPP) and is based upon input received from all of the hospitals offering birth care in the region. It is intended to promote a consistently high standard of intrapartum care throughout southwestern Ontario. Its intent is also to facilitate the assessment/documentation of Patient Controlled Analgesia, Patient Controlled Epidural Anesthesia and Epidural anesthesia at the bedside.

DATE/TIME INITIATED: Indicate the date and time that the pain management was initiated and initial.

DATE/TIME DISCONTINUED: Indicate the date and time that the pain management was discontinued and initial.

EPIDURAL TUBING REMOVED: Indicate the date and time that the epidural tubing was removed. Also indicate whether the epidural tubing was intact or not intact upon removal and initial. If it was obviously not intact, further documentation will be required in the hospital progress notes to indicate when the physician was notified and what interventions occurred.

PAIN MANAGEMENT MODALITY: Select the appropriate pain management modality to be used with a check mark (√)

- PCA – Patient Controlled Analgesia
- PCEA – Patient Controlled Epidural Anesthesia
- EPIDURAL – either continuous or intermittent

DRUG(S): Indicate the drug(s) to be used including the concentration.

DOSE: Indicate the dose including the appropriate unit of measure.

DELAY: Indicate the PCA/PCEA delay time (min.)

INITIAL BASAL RATE (CONTINUOUS): Indicate the initial PCA/PCEA basal rate/continuous infusion rate (mL/h).

MAXIMUM DOSE: Indicate the maximum dose.

INITIALS: The initials of the person completing this portion of the record should be included here. They should also be included together with the printed name and signature of the health care provider on the signature profile of the regional Labour Record if available, or on a hospital approved signature profile, elsewhere on the chart.

MONITORING SCALES: Use the monitoring scales provided to complete the assessments for the parameters listed in the table.

TIME: Indicate the time of assessment.

RESPIRATORY RATE: It is recommended that respirations be assessed at least every hour or more often as clinically indicated.

SEDATION SCALE: Assess sedation level using the scale provided. Hourly assessments are recommended or more often as clinically indicated.

PAIN SCALE: Use numerical indices from 0 (no pain) to 10 (worst pain) to document the patient's experience of pain. Further documentation may be required on the "Comments" section on the reverse side of the form if pain management is inadequate.

MOTOR BLOCKADE: It is recommended that motor blockade be assessed bilaterally for lower limbs every hour for women receiving epidural anesthesia.

SENSORY BLOCKADE: Assess cold sensation for women receiving epidural anesthesia using an alcohol swab or ice cube every hour. Document the level at which the patient can no longer feel cold according to the dermatome chart on the reverse side of the form.

SIDE EFFECTS: Nausea and pruritus should be assessed at least every four hours. Document according to the scale provided.

DOSE: Indicate the amount that the patient can receive each time she activates and qualifies for a dose of narcotic or local anesthetic. (PCA/PCEA only)

DELAY: Indicate the minimum allowable length of time(min.) between possible injections of narcotics and/or local anesthetics. (PCA/PCEA only)

INJECTIONS: Record the number of successful "injections" every hour. Obtain this from the history function of the PCA pump.

ATTEMPTS: Record the number of unsuccessful "attempts" every hour. Obtain from the history function of the PCA pump.

REMAINING SYRINGE VOLUME: The mls. remaining in the pump syringe should be documented every hour.

BOLUS OR CHANGES: Document any epidural/PCA bolus or changes in the pump settings (eg. Bolus 5 mLs. 0410 – Basal Rate increased to 10 mL/h. PCA dose increased to 1 mL/h).

INITIALS: The health care provider should initial each documentation entry and ensure that the corresponding signature is on the signature profile.

SYRINGE CHANGES: Document medication, dosage and concentration, time and initials with each syringe change as per hospital policy.

Adapted with permission from the London Health Sciences Centre, St. Joseph's Health Care – London, Acute Pain Management Bedside Monitoring Record. October 2000.