Children's Hospital Oakland Opioid Weaning Flowsheet and Guidelines for Use of the Form

Analgesia/sedation orders (drug/dose/frequency)

Date			
Drug			
Administration time			
Dose ↑ or ↓ or freq change			
		Time:	
Choose one: Crying/agitated 25%-50% of interval Crying/agitated >50% of interval	 2 3		
Choose one: Sleeps ≤25% of interval Sleeps 26%-75% of interval Sleeps >75% of interval	 3 2 1		
Choose one: Hyperactive Moro Markedly hyperactive Moro	 2 3		
Choose one: Mild tremors, disturbed Moderate/severe tremors, disturbed	 1 2		
Increased muscle tone	2		
Temperature 37.2°-38.4°C	1		
Temperature >38.4°C	2		
Respiratory rate >60 (extubated)	2		
Suction >twice/interval (intubated)	2		
Sweating	1		
Frequent yawning (>3-4/interval)	1		
Sneezing (>3-4/interval)	1		
Nasal stuffiness	1		
Emesis	2		
Projectile vomiting	3		
Loose stools	2		
Watery stools	3		
TOTAL SCORE			
ADJUSTED SCORE			
INITIALS OF PERSON SCORING			

Directions: Score every 2-4 hours per guideline
Score greater than 8-12 may indicate withdrawal

Guidelines for use of the flow sheet

Use of form

Use the flowsheet for all infants who have received continuous or around-the-clock opioid medication for 3 days or more, or more than 3 doses per day for more than 5 days. This patient population will most often include postoperative patients, agitated intubated infants, and all post-ECMO patients.

Instructions

1. Write drug, dose, and frequency of analgesics and sedatives ordered.
2. Enter date, name of drug (abbreviated MS=morphine sulfate or FENT=fentanyl), and administration time of drugs given in the appropriate boxes; indicate if dose frequency given is an increase or decrease from the ordered dose.
3. Scoring must be performed every 4 hours during weaning of opioids, every 2 hours if score is 8 or greater. The score for each item indicates the presence of the sign during the previous 2-4 hours (depending on the scoring interval). Every 4-hour scoring should continue until the patient is off all opioids for 48-72 hours. Place a "0" in the column after the sign if it is not seen during the scoring period.

Central nervous system

Crying behavior: Score 2 points if patient exhibits crying or cry behavior for a duration of ≤50% of the scoring interval. Score 3 points if cumulative crying behavior totals >50% of the scoring interval.
NOTE: Crying behavior is accompanied by the facial expressions associated with crying, but without audible sounds because of endotracheal intubation.
Sleeping: Score 3 points if patient sleeps for ≤25% of the scoring interval. Score 2 points if patient sleeps for 26%-75% of the scoring interval. Score 1 point if patient sleeps for >75% of the scoring interval.
Moro (startle) reflex: Score 2 points if patient has some arm and/or leg extension when touched or when disturbed by loud noises. Score 3 points if patient has marked arm and/or leg extension that is accompanied by crying behavior, hyperalert state, or continued arm and/or leg tremors after being startled.
Tremors—disturbed: Score 1 point if patient has mild tremors when disturbed. Score 2 points if patient has moderate to severe tremors when disturbed. NOTE: Tremors are alternating movements that are rhythmic, of equal rate and amplitude, and can usually be stopped by flexion of the limb.
Increased muscle tone: Score 2 points if patient exhibits fisting or tight flexion of extremities that are difficult to extend.

Metabolic

Temperature: Score 1 point if patient's temperature is 37.2°-38.4°C. Score 2 points if patient's temperature is >38.4°C.
Respiratory rate: Score 1 point if patient's spontaneous respiratory rate is >60/minute. Score 2 points if patient's spontaneous respiratory rate is >60/minute and accompanied by retractions.
Suction: Score 2 points if patient is suctioned more than twice during a 4-hour period.
Sweating: Score 1 point if patient exhibits any type of sweating, including beads of sweat, or if skin is moist to touch.
Yawning: Score 1 point if patient yawns >3-4 times in succession or yawns 1-2 times often during a 4-hour period.
Sneezing: Score 1 point if patient sneezes >3-4 times in succession or sneezes 1-2 times during a 4-hour period.
Nasal stuffiness: Score 1 point for nasal stuffiness.

Gastrointestinal

Emesis of formula/stomach contents: Score 2 points if patient has 1 or more episodes of emesis during a 4-hour period.
Projectile vomiting: Score 3 points if patient has 1 or more episodes of projectile vomiting.
Loose stools: Score 2 points if patient has loose stools characterized by a water ring around some solid stool. The stools will often be frequent. NOTE: Do not score for "breast milk" stools: frequent, small, seedy, yellow stools.
Watery stools: Score 3 points if patient has stools that consist of only liquid. The stools will often be frequent.

Total score: Add up all the scores in the column and place the total score in this box. Clinical signs that appear continuously, such as respiratory rate >60 or regular poor feeding, should be included in the total score.
Adjusted score: The adjusted score is used when a sign is detected that is expected to occur independently of withdrawal, due to a preexisting condition (high respiratory rate in infant with bronchopulmonary dysplasia). The decision to adjust the score should be made after discussion with the healthcare team during rounds, and the rationale should be recorded in a problem-oriented note. Circle the signs to be excluded and deduct the points from the total score to obtain the adjusted score.
Initials of person scoring: The person scoring should write his/her initials in this space.

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