



**Regional Order Set**

# Administration of FentaNYL in Labour

Page 1 of 2

Last Name:		
First Name (Preferred Name):		
Encounter number:	NH Number:	Chart Created: Y/N
Date of Birth:	Gender:	Age: Encounter Type:
Responsibility for Payment:		PHN:
Primary Care Physician/Attending Physician:		

PATIENT LABEL

**Allergies:** ☐ None Known ☐ Unable to Obtain  
List with Reactions: \_\_\_\_\_

**Weight:** \_\_\_\_\_ kg  
**Height:** \_\_\_\_\_ cm

1. Appropriate counselling and reassurance of patient regarding the safety of monitored **fentaNYL** administration

2. Absolute contraindication to use **fentaNYL**:

- ☐ Allergy
- ☐ Uncorrected hypotension or hypovolemia
- ☐ Respiratory compromise: severe asthma, COPD, cystic fibrosis
- ☐ Liver or kidney disease
- ☐ Concurrent use of monoamine oxidase inhibitors (MAOI) or MAOI\* use within the previous two weeks
- ☐ Presence of fetal acidosis
- ☐ Maternal respiratory rate of less than 8/minute or O<sub>2</sub> saturation less than 94%
- ☐ Abnormal fetal heart rate tracing
- ☐ Gestation hypertension/pre-eclampsia

Caution:

- **fentaNYL** given within 1 to 2 hours of anticipated operative delivery may increase the risk of maternal and newborn respiratory depression
- Pre-pregnancy BMI greater than 35

\* Examples of MAOIs: **moclobemide**, **phenelzine**, St John's wort

3. Dosing:

- Initial dose **fentaNYL** 0.5 mcg/kg/dose = \_\_\_\_\_ mcg (maximum 100 mcg) slow IV push
- Repeat dose q5 to 10 minutes, until adequate analgesia or maximum of 4 doses in a single hour (Maximum 2 mcg/kg/h) or 6 doses total over the course of labour (Total cumulative maximum dose should not exceed 300 mcg)
- Further doses of \_\_\_\_\_ mcg (0.5 mcg/kg) may be administered every 30 minutes as required (Total cumulative maximum dose should not exceed 300 mcg)
- If satisfactory pain relief is not achieved, or administration exceeds 5 hours or a total of 2 mcg/kg/h or 300 mcg (whichever is less), anaesthesia should be consulted and consideration given to alternate pharmacological or regional methods of pain management

4. Monitoring

- Vaginal examination performed within 30 minutes prior to receiving **fentaNYL**
- Maternal vital signs q15min (see below):
  - Monitor respiratory rate and record prior to administration and for 30 minutes following each dose
  - SpO<sub>2</sub> **continuous** monitoring for at least 30 minutes following the most recent dose of **fentaNYL**
  - If desaturation occurs, no subsequent doses of **fentaNYL** should be administered to a woman with a respiratory rate less than 8 breaths a minute or an O<sub>2</sub> saturation less than 94%
    - a. Notify Primary Care Provider, consider naloxone administration
    - b. If O<sub>2</sub> saturation less than 95%, supplemental O<sub>2</sub> should be provided until the saturations remain 95% on room air
- Fetal health surveillance
  - Monitor and record fetal heart rate as per **10-111-5325 Intrapartum Admission Orders** (Note - must be completed separately)

**Prescriber signature:** \_\_\_\_\_ **College ID:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_



**Regional Order Set**

# Administration of FentaNYL in Labour

Page 2 of 2

Last Name:			
First Name (Preferred Name):			
Encounter number:	NH Number:	Chart Created: Y/N	
Date of Birth:	Gender:	Age:	Encounter Type:
Responsibility for Payment:		PHN:	
Primary Care Physician/Attending Physician:			

**PATIENT LABEL**

<b>Allergies:</b> <input type="checkbox"/> None Known <input type="checkbox"/> Unable to Obtain List with Reactions: _____	<b>Weight:</b> _____ kg <b>Height:</b> _____ cm
---	--

## Nursing Considerations

### Administration

- Follow parenteral manual for administration and dilution
- Dilute **fentaNYL** 100 mcg (2 mL) in 8 mLs NS to obtain solution concentration of 10 micrograms/mL
- Give slow IV push over 1 to 3 minutes
- Follow High Risk/High Alert Medications Requiring an Independent Double Check Procedure **1-20-6-3-260**
- **fentaNYL** is compatible at Y-site with **oxytocin** infusion
- Ensure **naloxone** is readily available on the unit, contact primary care provider for order if needed

**Prescriber signature:** \_\_\_\_\_ **College ID:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_