PURPOSE:

Effective pain assessment and management can remove the adverse psychological and physiological effects of unrelieved pain. Optimal management of the patient experiencing pain enhances healing and promotes both physical and psychological wellness. Patients need to be involved in all aspects of their care including pain management whenever possible.

DEFINITIONS:

Unrelieved pain - A pain score that remains above the patient's identified pain goal for an extended period of time.

Acute pain - pain that subsides as tissue healing takes place and has a predictable end, is transient, and is often highly localized.

Persistent pain - pain that persists three months beyond the usual course of an acute disease or three months beyond a reasonable time for tissue damage to heal, or pain that is associated with a persistent pathological process that causes continuous or recurrent pain.

Addiction - a primary, persistent, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical dependence - a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance - a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time.

Comfort Function Goal - A goal which is based upon the pain rating the patient requires to be able to perform necessary activities.

POLICY:

A. Healthcare professionals at Community Hospital respect the patient's right to pain management and to be informed of available and appropriate methods of pain relief along with possible positive and negative consequences.

B. Staff work with the patient/family & physician to set, develop, and implement a plan to reach a goal for pain relief. The patient's preferences for methods used to manage pain are considered.

C. The Emergency Department follows their own policy for pain management.

D. Pain control planning includes both pharmacologic and nonpharmacologic interventions.

E. Pain should be actively evaluated and monitored.
   1. A comprehensive initial pain assessment by an RN, consistent with the scope of care, treatment, and services, as well as the patient's condition, is provided.
   2. Ongoing evaluation and monitoring may be performed by an LPN.
   3. Methods to evaluate pain are consistent with the patient's age, condition, and ability to understand.

F. Patients with pain are reevaluated as necessary based on the plan of care, changes in condition, or upon patient's request.

G. Based upon the patient's condition and assessed needs, the education and training provided to the patient include any of the following:
   1. discussion of pain
   2. the risk for pain
   3. the importance of effective pain management
4. the pain evaluation process
5. methods for pain management

H. Pain control approaches are to be collaborated and interdisciplinary in nature and utilize input from all members of the health care team, particularly the patient and significant others.

I. Staff is oriented to the evaluation and management of pain.

J. The following treatment modalities are available for use at Community Hospital to assist patients with treatment of pain:
   1. Oral, injectable, rectal, subcutaneous, sub-lingual, topical, trans-dermal, & Patient Controlled Analgesics
   2. Implanted pain pumps or devices
   3. Epidurals
   4. Nonpharmacologic modalities, for example: distraction techniques, re-positioning, relaxation techniques, hot and cold therapy

PROCEDURE:

A. Assessment
   1. The presence of pain is assessed on admission to the hospital, at the initial clinic visit, post invasive procedure, with each RN assessment, and upon the patient's initial complaint of pain.
      a. A history of obesity and/or sleep apnea increases the risk of enhanced sedative effects and should be noted.
   2. RN's provide comprehensive patient pain assessment.
   3. LPN's collect basic health data on patients contributing to the comprehensive patient pain assessment.
   4. In home health, the presence of pain is assessed by an RN on admission to services.
   5. The RN or physician shall perform an initial assessment for acute pain and, if relevant, for persistent pain, on all patients admitted to the inpatient, or outpatient departments as applicable.
   6. Pain intensity will be quantified using one of the following pain scales:
      a. The Modified Wong-Baker Pain Intensity Scale which is a subjective, graduated scale with color, numerical values from 0-10, facial expressions from happy to crying, and words (both English and Spanish) used to describe pain from none to severe, where the patient communicates their level of pain by either stating the level or pointing to the section of the scale that most accurately describes their current level of pain. This scale is used for alert and oriented patients, such as pediatric, non-English speaking, or patients with limited communication/comprehension.
      b. The Non-Verbal Pain Scale is an objective measure that can be used for the patient who is unable to communicate. When using this scale it is important to obtain a history when possible, from the patient's caregiver or past medical records to obtain a baseline of usual behavior. It is essential to differentiate behavioral expressions of pain from otherwise normal behavior for the patient in a similar situation.
      c. For pediatric patients the Children's pain scale, the FLACC Pain Scale or the infant pain scale may be used.
   7. A patient's report of pain will be accepted and respected as the key indicator of the pain he/she is experiencing.
      a. A significant other may be asked to assign a pain scale rating when the patient is unable to respond.
      b. Medical/nursing staff may assign a pain scale rating based on the Non-Verbal Pain Scale only if the patient is unable to report their pain.
   8. If the patient reports an adverse change in pain, a more detailed evaluation of the acute and/or persistent pain will be performed and may include the following data:
      a. Location of pain. If more than one location they are evaluated separately.
      b. Duration
      c. Type, quality/description, and patterns of radiation (if applicable)
      d. Alleviating and aggravating factors
      e. Intensity Rating
      f. Patient’s acceptable rating of pain, Comfort Function Goal (CFG) and pain management history
      g. Current medications for pain and what works best
      h. Alternative methods of pain control used
      i. Vital signs and level of consciousness
      j. Patient’s physical, emotional and behavioral expressions of pain
      k. Level of influence of pain on necessary activities
   9. For the patient undergoing moderate sedation or anesthesia, pain assessment and intervention should begin when the patient shows behavioral expressions or verbal expressions of pain.

B. Pain Re-evaluation
1. Pain is monitored throughout each shift.
   a. Pain is evaluated at the onset, and throughout each shift and addressed accordingly; abnormal findings are reported by an LPN to the RN.
   b. A numerical intensity rating of pain is determined with every set of vital signs, within one hour of an intervention for pain, and if the patient spontaneously reports pain.
   c. If no pain is present, the licensed healthcare provider will monitor for pain as warranted by patient condition, throughout the shift with the pain scale, when the patient complains of pain, and post invasive procedure.
2. Interventions must be documented when the intensity rating is greater than the patient’s stated acceptable level of pain. Pain intensity rating is reevaluated and documented within 1 hour after each intervention until the intensity rating is 4 or less or the patient’s stated level of acceptable pain.
3. Pain intensity rating is obtained and CFG addressed along with appropriate interventions as needed prior to physical therapy to optimize performance.
4. When a patient experiences painful procedures and interventions, pain is treated, interventions documented, along with reevaluation within 1 hour of the intervention.
5. Prior to transfer of patient, and prior to discharge, pain is reevaluated and treated accordingly. A written or verbal report on pain will be communicated upon transfer of care.
6. Effectiveness of a pharmacologic intervention should be based upon the route and onset of action of the drug administered, but within 60 minutes after administration, or upon discharge if not a new medication.
7. The physician is notified of the patient’s pain when pharmacologic and nonpharmacologic treatment modalities have been exhausted in reducing the pain to a level acceptable to the patient.
8. In home health, pain is reevaluated at each visit by skilled nursing, PT, and OT and documented. In addition, telephone follow-up may also occur in between visits when appropriate. Patients are instructed in interventions to use prior to therapy or other painful intervention/activities and to notify home health if those interventions are not working. The physician is notified when interventions are not effective at reducing the pain to an acceptable level. With collaboration the treatment plan is modified and reevaluated for effectiveness.

C. **Documentation** of pain should include the following
   1. Type, description, location, timing of pain
   2. Intensity scale
   3. Treatment goal or CFG
   4. Level of consciousness
   5. Respiratory rate
   6. Activity
   7. Interventions: Pharmacologic & Nonpharmacologic
   8. Patient and family education

D. **Pharmacologic management** of pain is dictated by the intensity of the patient’s pain, along with RN assessment of pain, and the effectiveness of previous pain relief strategies to meet the objective of preventing:
   1. Mild pain
      a. Scheduled and/or prn nonopioid analgesics are recommended
      b. Consider adjuvant options.
   2. Moderate to severe pain: **pharmacological treatment**
      a. When continuous pain is anticipated, a long acting or fixed-dose schedule (around the clock) is recommended.
      b. A PRN order of a rapid onset analgesic may be necessary to control activity related or breakthrough pain.
      c. To ensure opioids are safely administered, **begin with a low dose (consider the patient's history of opioid use) and titrate** to comfort as ordered.
      d. Modification in analgesic administration is based upon effectiveness of the previous dose, including change in pain intensity, relief, and side effects experienced.
      e. Patients respond differently to various opioid and nonopioid analgesics; therefore if one drug is not providing adequate pain relief, another in the same class may result in better pain control.
      f. Consider adjuvant options.
   3. Safe use of opioids:
      a. Because opioid induced respiratory depression is preceded by an increasing level of sedation, sedation levels are monitored at regular intervals in patients receiving opioids.
         i. A history of sleep apnea and/or obesity increases the risk of enhanced sedative effects and those patients should be monitored more closely with pulse oximetry.
ii. Sedation should be monitored for all opioid naive patients with moderate to severe pain when opioid dosing is initiated.

iii. Sedation monitoring:
   - Sleeping and easy to arouse: acceptable
     - no action necessary; supplemental opioid may be given if necessary
   - Awake and alert: acceptable
     - no action necessary; supplemental opioid may be given if necessary
   - Slightly drowsy, easily aroused: acceptable
     - no action necessary; supplemental opioid may be given if necessary
   - Frequently drowsy, arousable, drifts off to sleep during conversation: unacceptable.
     - Discuss with physician. Consider past sleep history and pain management, then consider as applicable decreasing opioid dose.
     - Monitor sedation and respiratory status closely.
   - Somnolent, minimal or no response to physical stimulation: unacceptable.
     - Stop opioid.
     - Notify physician.
     - Slowly administer physician ordered dilute IV naloxone (0.4mg naloxone in 10 ml saline; 0.5 ml over 2 minute period) and/or call Rapid Response

E. Nonpharmacologic Pain Management
1. Utilization of non-drug strategies is encouraged to alleviate pain. These techniques have minimal adverse events and pose little safety threats to patients.

   2. Strategies include:
      - Relaxation techniques
      - Music therapy (instrumental, rhythmic, 60-80 beats per minute; duration is typically 20-30 minutes (Wells, Pasero, McCaffrey, 2008)
      - Massage- systematic manipulation of soft tissues by manual or mechanical means; duration 5-20 minutes
      - Re-positioning and/or splinting
      - Imagery
      - Transcutaneous Electrical Nerve Stimulation (TENS) unit - with physician order
      - Distraction- DVD, television, visitors, etc.
      - Heat/cold therapy- Protect skin when applying heat or cold.
        - Cold therapy has been found to improve pain, range of motion, and function in patients undergoing orthopedic surgeries (Wells, et.al, 2008)
        - Heat (over a 5 day period improved pain intensity and function for patients with low back pain (Wells, et.al., 2008))

F. Patient education
1. Patient teaching should include as applicable such topics as:
   - The patient’s right to controlled pain
   - His/her responsibility to give an accurate subjective assessment and report pain on an appropriate scale as soon as it starts, before it becomes too severe, as it is much easier to control.
   - Probable physiological causes of pain that may be specific to the patient.
   - Barriers to good pain control.
   - Address patient fears.
   - Alternative methods of pain management.
   - How to take the prescribed medication to get the optimal effect.
   - Potential limitations and side effects of pain treatments.

2. Patient teaching about pain may occur any in the following ways:
   - Individual teaching between the clinicians and patient/family
   - Printed and/or online patient education resources

G. Pain Resource Nurse (PRN)
1. PRN's are available to assist with difficult pain issues throughout the hospital
   - PRN’s are specially trained in pain management and the most current and best practices, and act as a liaison between the staff and the physicians as
well as a role model in staff and patient education regarding pain management practices.

b. The PRN's may evaluate the patient by phone or at the bedside depending on the complexity of the situation.
c. The PRN will document a note in the "Pain Resource Nurse" section of Meditech.
d. A PRN will follow up with the patient on an as needed basis.

H. **Planning for Pain Management after Discharge:** planning for the need for pain control after discharge should be a collaborative effort between the patient/family, the nurse, the physician and other members of the interdisciplinary team as relevant.

I. **Age Specific Considerations:**
   1. **Pediatrics:** Ages 0 - 17
      a. The healthcare professional must consider the age of the pediatric patient and the current stressors of the situation they are under when making the decision of which pain scale to utilize.
         i. If the pediatric patient is able to clearly communicate, the adult scale may be utilized.
      b. Care must be made with this group to ensure that the patient's subjective measure of pain is not lower than the practitioner's objective assessment.
      c. Patient education must include the parents or guardians. They need to be educated about how much pain their child will anticipate during and after major and minor procedures and what interventions will be implemented to prevent or minimize the child's pain.
      d. Efforts are made to take pediatric patients to a treatment room for any painful procedures. This allows them to continue to feel safe in their own patient room.
   2. **Geriatrics:**
      a. Many elderly individuals consider pain to be a normal part of aging.
      b. Many are reluctant to report pain due to ageist attitudes (i.e., old people complain about pain a lot).
      c. Many fear being perceived as bothersome, a hypochondriac or an addict.
      d. Pain is often under treated and under reported in this population.
      e. Polypharmacy often is an issue for many geriatric persons and therefore close monitoring for potential drug interactions with pain medication is necessary.

J. **Cultural Considerations:** Consider the cultural aspects of pain and pain management.
   1. a. Consider language barriers
      b. Identify what cultural differences and potential barriers exist.
      c. Identify decision makers and family members with healthcare backgrounds to be used as resources.
         i. Use translation services as needed.
   2. Consider the patient and family social organization, or that family structure, head of household, gender roles, status/roles of elderly, roles of children, adolescents, husbands/wives, significant others, parents, extended family, influences on decision making process, importance of social organization and network.
      a. Identify ways to achieve treatment and care outcomes for the patient while at the same time supporting and appreciating the culture.
      b. Plan for care with sensitivity to the differences that may present advantages and disadvantages.
   3. Consider the patient's health beliefs, practices, and practitioners.
      a. These provide meaning/cause of illness/health and living with a life threatening illness,
      b. They may influence expectations about treatment and the health care team
      c. They may require consideration of religious/spiritual beliefs and practices, use of traditional healers/practitioners, expectations of practitioners
      d. Consider spiritual care referral.

**RESPONSIBILITY**

Physicians, Licensed Independent Practitioners, Nurses, and other healthcare providers

**REFERENCES:**

1. American Pain Society Guidelines

Referenced Documents

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Signed by ( 03/25/2014 09:27PM PST ) Kristin M Gundt, CNO
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