FLOYD MEDICAL CENTER
POLICY AND PROCEDURE MANUAL
PATIENT CARE SERVICES

TITLE: Pain Assessment/Management	Policy No.: PCS-01-005
Purpose: 1. To provide effective pain assessment and management that helps remove the adverse psychological and physiological effects of unrelieved pain. 2. To provide optimal management of the patient experiencing pain that enhances healing and promotes both physical and psychological wellness. 3. To involve the patient in all aspects of their care including pain management. 4. To ensure optimal patient comfort through a proactive pain control plan which is mutually established with the patient, family, and members of the health care team across the health care system.	**Developed Date:** 12/96 **Review Date:** 10/97, 8/00 **Revised Date:** 3/03, 7/03, 4/04, 5/06, 9/08, 3/10, 4/11, 5/12, 8/12, 11/12, 3/13, 5/13, 11/15, 10/16, 3/18, 8/18 **Review Responsibility:** Executive VP Chief of Patient Services/CNO, Director of Pharmacy, Nursing Leadership, Pharmacy and Therapeutics Committee, Executive Team, Executive Committee of the Medical Staff
Reference Standards: The Joint Commission Standards: PC.01.02.07, PC.02.03.01	

DEFINITIONS:

Pain — An unpleasant sensory and emotional experience associated with actual or perceived tissue damage, or described in terms of such damage, such as non-nociceptive pain.
Pain is highly personal and subjective and is whatever the patient says it is, existing whenever he/she says it does. Self-report of pain is considered the most reliable indicator of pain.
Pain is often accompanied by emotional and spiritual responses, such as suffering or anguish, and effective management should include measures to address these responses.

Acute Pain — A normal, predicated physiologic response to an adverse clinical, thermal or mechanical stimulus. It is generally time-limited and is responsive to opioid and non-opioid therapy. ***Note:*** Acute pain episodes may be present in patients with chronic pain.

Chronic Pain — Malignant or non-malignant pain that exists beyond its expected time frame for healing or where healing may not have occurred. It is persistent pain that is not amenable to routine pain control methods. ***Note:*** Patients with chronic pain may have episodes of acute pain related to treatment, procedures, disease progression or reoccurrence.

High Risk Pain Populations
May include, but are not limited to:
Infants and children
Elderly, particularly over 70
Women presenting with labor
Patients who speak a different language or come from a different culture.
Patients with: a history of or active substance abuse; difficulty in communicating; limited financial resources, social supports or access to health care; cognitive or psychosocial impairments; metabolic alterations; analgesic allergies; and chronic pain.

Pain Assessment Generally, an evaluation of the patient's pain including but not limited to: location, intensity, duration of pain, aggravating and relieving factors, effects on activities of daily living, sleep patterns and psychosocial aspects of the patient's life, and effectiveness of current strategies. Pain assessment includes assessment of the patient's vital signs and the rating from the pain screen, as age appropriate, or pain assessment findings.

Pain Management The use of pharmacological and non-pharmacological interventions to control the patient's identified pain. Pain management extends beyond pain relief, encompassing the patient's quality of life and ability to work productively, to enjoy recreation.

Pain Screen A quantitative rating of the intensity of pain as reported by the patient utilizing a standardized instrument that has demonstrated reliability and validity.

Physical dependence Physical reliance on an opioid evidenced by withdrawal symptoms if the opioid is abruptly stopped or an antagonist is administered.

Substance Abuse Disorder
A pattern of compulsive drug and drug seeking behavior characterized by a continue craving for an opioid and the need to use the opioid for effects other than pain relief.

Tolerance A process characterized by decreasing effects of a drug at its previous dose or the need for a higher dose of drug to maintain an effect.

Policy

FLOYD and its affiliates will:

Respect and support every patient's right to optimal pain relief through education, initial and ongoing assessment, and effective and appropriate pain management.

Recognize the rights of individuals to appropriate assessment and management of pain.

Plan, support and coordinate activities and resources to ensure that the pain of all individuals is recognized and addressed appropriately. The patient's personal, cultural, spiritual, and/or ethnic beliefs will be considered while developing the goal for pain management. A patient's choice regarding an acceptable level of pain for them will be respected when intervention(s) might negatively affect a patient's perceived quality of life or functioning.

Provide individualized care in settings responsive to specific needs.

Provide education on pain management as part of the patient's treatment considering the patient's personal, cultural, spiritual, and/or ethnic beliefs.

Work with the patient to set, develop and implement a plan to reach a goal for pain relief. Patients experiencing pain, parents, and/or other family members or caretakers will be asked to participate in establishing a goal for their pain management and in a treatment plan to achieve that goal.

Develop plans in conjunction with the patient, if on discharge the patient has pain, to address management at home.

Monitor the performance of the pain management program.

Patient/Family Rights and Responsibilities

Patients can expect:

- Information about pain and pain relief measures
- A concerned staff committed to pain prevention and management
- Healthcare professionals who respond quickly to reports of pain
- Pain expression will be believed
- State of the art pain management

Patients will be expected to:

- Ask the healthcare provider what to expect regarding pain and pain management
- Discuss pain relief options with the healthcare workers
- Work with the healthcare providers to develop a pain management plan
- Ask for pain relief when pain first begins
- Help the healthcare providers assess the pain
- Tell the healthcare providers if the pain is not relieved
- Tell the healthcare provider about any worries regarding talking pain medication

Assessment/Reassessment of Pain

A. The patient's self-report of pain is the primary source of assessment.

B. On admission patient's will be screened for the presence or absence of pain using standardized pain scales for patient specific populations

C. When adults or children **are able** to self report pain severity/intensity:
   - The appropriate pain scale will be used (i.e. numeric, FLACC, etc.)
   - Assessing staff will document a numeric rating that corresponds with a number and face selected by the patient

D. When adults, young children, or infants are unable to self-report pain severity/intensity:
   - Staff will assess behavior patterns (indicators) using the age/cognitive appropriate scale.
   - When **adults are unable** to self report, the presence of pain may be evaluated using the FLACC scale
   - **For infants or young children without the ability to report** pain, the FLACC scale may be used
   - The Critical Care Pain Observation Tool (CPOT) may also be used for patients that are unable to self-report pain severity/intensity

E. If pain is identified on initial screening, a more detailed assessment of pain will be performed including:
   - The patient's perceived pain level severity using the appropriate organization pain scale
   - Onset/duration and origin
   - Severity/intensity
   - Quality and location
   - Alleviating factors
   - What provokes or worsens pain and what relieves pain

F. Assessment/Reassessment of pain will occur:
   - Following a patient or appropriate caretaker report of pain
   - Following an intervention intended to relieve the pain, such as administration of a pain medication
   - During the post procedure period
   - If a change in patient's medical status occurs
   - On each visit in the home-care or Physician Office settings
   - Following transfer from one Floyd care setting to another
   - At discharge

G. Pain intensity will be reassessed after each pharmacological pain management intervention once a sufficient time has elapsed for the treatment to reach peak effect, but no longer than 1 ½ hours after intervention (generally IV medication is effective within: 30 minutes and PO/IM medication is effective within 60 minutes). This re-assessment will be documented in the patient medical record using the 0 – 10 pain scale. ***Note: If the patient appears to be sleeping, the nurse will document objective observations in the medical record related to apparent relief from discomfort and a pain intensity level will not be documented.***

H. If the patient's pain has increased upon reassessment, the nurse may administer additional medication as ordered. Example: (If on assessment, a patient reported a pain level of 3 with orders for Dilaudid 0.2 mg IV every 4 hours prn for pain level of 1 – 4 and Dilaudid 0.4 mg IV every 4 hours prn for pain level 5 – 10, the nurse administers the Dilaudid 0.2 mg and then reassesses the patient in 30 minutes. Upon reassessment of pain, the patient reports a pain level of 6. The nurse may administer the other 0.2 mg of Dilaudid, but must wait 4 hours from this time to administer the next dose of Dilaudid.

I. The physician will be contacted for additional orders if the patient experiences ineffective pain relief, or pain intensity greater than mutually established goal, once available orders/resources have been maximized.

Pain Scale Definitions:

Pain scale definitions when using the **Numeric Scale, Happy Face/Sad Face and FLACC:**

- Mild Pain 1 – 3 on pain scale
- Moderate Pain 4 – 6 on pain scale
- Severe Pain ≥ 7 on pain scale

Pain scale definitions when using the **Critical Care Pain Observation Tool (CPOT)**

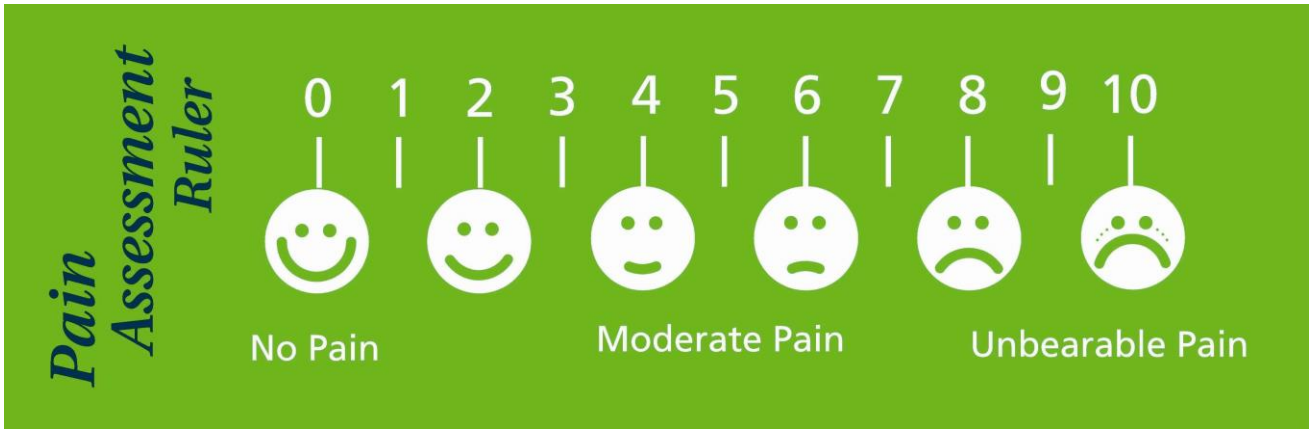
- Mild Pain 2 – 4 on pain scale
- Moderate Pain 5 – 6 on pain scale
- Severe Pain 7 – 8 on pain scale

Numeric Pain Intensity Scale

The Numeric Pain Intensity Scale is a subjective scale where the patient communicates their current level of pain. 0 = no pain and 10 = the most severe pain imaginable. In order to use this scale, the patient must be alert, oriented, and cognitively able to understand the rating scale.

Happy Face/Sad Face Scale

This is a subjective, graduated facial expression of pain scale where the patient communicates their level of pain by pointing to the picture that most accurately describes their current level of pain. This scale is used for alert and oriented patients, such as predicative, non-English speaking, or patient with limited communication/comprehension of the numerical scale. A happy face represents no pain; a sad face indicates the patient is experiencing pain.



FLACC Scale

The FLACC 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, form 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. This scale may be used for neonates, infants and children up to age 7 or with a child of any age who have communication deficits. It may also be used for older children or adult patients who are non-verbal or who do not communicate in English.

Category	Scoring		
	0	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerking
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort
		TOTAL SCORE	

Critical Care Pain Observation Tool (CPOT)

The CPOT is a validated tool the nurse can use to assess the pain of a critical care patient that is unable to self- report. An example is: The patient that is on mechanical ventilation and sedated.

Indicator	Description	Score	
Facial Expression	♦ No muscular tension observed ♦ Presence of frowning, brow lowering, orbit tightening, and levator contraction ♦ All of the above facial movements plus eyelid tightly closed	Relaxed Tense Grimacing	0 1 2
Body Movements	♦ Does not move at all (does not necessarily mean absence of pain) ♦ Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements ♦ Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed	Absence of movements Protection Restlessness	0 1 2
Muscle Tension (Evaluation by passive flexion and extension of upper extremities)	♦ No resistance to passive movements ♦ Resistance to passive movements ♦ Strong resistance to passive movements, inability to complete them	Relaxed Tense, Rigid Very tense or rigid	0 1 2
Compliance with the Ventilator (intubated patients) OR **Vocalization** (extubated patients)	♦ Alarms not activated, easy ventilation ♦ Alarms stop spontaneously ♦ Asynchrony: blocking ventilation, alarms frequently activated ♦ Talking in normal tone or no sound ♦ Sighing, moaning ♦ Crying out, sobbing	Tolerating ventilation or movement Coughing but tolerating Fighting ventilator Talking in normal tone or no sound Sighing, moaning Crying out, sobbing	0 1 2 0 1 2
		TOTAL RANGE (0 – 8)	

Treatment

A. Treatment strategies for pain may include pharmacological and non-pharmacological approaches. Strategies should reflect a patient-centered approach and consider the patient's current presentation, the LIP Clinical Judgment, and the risk and benefits associated with the strategies.

B. When used in combination with opioids, non-opioids treatments may reduce the dose of opioids required to effectively manage pain. Consider the following guidelines:
   - ♦ Schedule non-opioid analgesics first, adding opioids for moderate to severe pain.
   - ♦ Step 1 Mild Pain — Acetaminophen, COXIBs, or NSAIDs and local or regional anesthesia
   - ♦ Step 2 Moderate Pain — Step 1 plus low doses of opioids
   - ♦ Step 3 Severe Pain — Steps 1 and 2 plus higher doses of opioids

C. Specific policies and guidelines will be followed for the use of patient controlled analgesia (PCA) and epidural/intrathecal analgesia (see specific policies).

D. Equianalgesic charts will be available in areas where orders are written for converting between analgesic routes and doses to assure that conversions are accurate and appropriate.

E. Upon initiation of a chronic opioid regimen, a laxative protocol and/or bowel management plan should be initiated.

F. General Guidelines from American Pain Society
   - ♦ Individualize the route, dosage, and schedule:
     - IV is the route providing the most rapid onset of effect.
     - Oral is the route of choice when indicated and tolerated by the patient. It is usually the preferred route for chronic treatment of pain.
     - Intramuscular (IM). Although commonly used, IM administration has the disadvantages of painful administration, wide fluctuations in absorption from muscle, a 30 – 60 minute lag to peak effect, and rapid fall off of action compared to oral administration. Chronic IM injections sometimes cause sterile abscesses and fibrosis of muscle and soft tissue.
     - Rectal, transdermal, epidural, and intrathecal routes may also be considered.
   - ♦ Medications for persistent pain should be administered on around-the-clock basis, with additional "as needed" doses, in order to maintain a constant level of drug in the body and help prevent recurrence of pain.
   - ♦ Use adjuvants to enhance analgesic efficacy, provide independent analgesic activity in certain situations, or treat concurrent symptoms that exacerbate pain.
   - ♦ Follow patients closely, particularly when beginning or changing analgesic regimens.
   - ♦ Anticipate common side effects of analgesics by early intervention, e.g., laxative to prevent constipation.
   - ♦ Recognize the difference in the strength of Morphine versus Dilaudid to prevent over medication. ***Dilaudid is a much stronger analgesic than Morphine. (2 mg of Dilaudid is the same as 13 mg of Morphine)***
   - ♦ Do not use placebos to assess the nature of pain.
   - ♦ Distinguish between tolerance, physical dependence, and addiction (psychological dependence) and treat appropriately.

- ♦ Be aware that the optimal analgesic dose varies widely among patients and all patient populations.
- ♦ Give each analgesic an adequate trial by increasing the dose up to the appearance of limiting side effects before switching to another drug.

Nonpharmacological Pain Management Techniques for Children

Age Group	Techniques
Neonates	✓ Pacifier ✓ Music ✓ Swaddling, blanket nests ✓ Speaking in soft, quiet tones ✓ Minimizing noxious stimuli: frequent handling, noise, bright lights
Infants	✓ Visual stimuli ✓ Speaking in quiet tones ✓ Pacifiers ✓ Rocking ✓ Swaddling ✓ Music ✓ Cutaneous stimulation: heat, cold, massage
Toddlers	✓ Magic wands ✓ Kaleidoscopes ✓ Pop-up books ✓ Music ✓ Controlled breathing: blowing bubbles ✓ Cutaneous stimulation
Pre-schoolers	✓ Magic wands ✓ Kaleidoscopes ✓ Pop-up books ✓ Controlled breathing: blowing bubbles ✓ Cutaneous stimulation ✓ Listening to music through a headset ✓ Watching videos
School Age	✓ Cutaneous stimulation ✓ Listening to music through a headset ✓ Watching videos ✓ Imagery
Adolescents	✓ Cutaneous stimulation ✓ Listening to music ✓ Watching videos ✓ Imagery ✓ Controlled breathing

Non-Pharmacological Interventions for Adult Patients

Physical Interventions

- Positioning
- Massage
    - Heat/Cold
- Immobilization

Cognitive Behavior Interventions

- Distraction/relaxation
- Guided imagery
- Patient education

Patient/Family Education

Patient education may 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 a numerical or happy face scale
- Probable physiological causes of pain that may be specific to the patient
- Barriers to good pain control
- Patient fears
- Alternative methods of pain management
- Pain intensity scales and patient's responsibility to report pain as soon as it starts before it gets severe because it is much easier to control
- How to take the prescribed medication to get the optimal effect
- Potential limitations and side effects of pain treatments

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. On discharge, the patient will receive written instructions, when indicated, regarding individual treatment plan of care for pain, side effects of pain management treatment, activities of daily living that may exacerbate or reduce effectiveness of plan, safe storage, use and disposal of medications and notifying the physician if pain is not relieved or if undesirable side effects occur.

Documentation

A. Initial assessment and reassessment for pain is completed/documented in the electronic medical record or designated site-specific forms using population-appropriate rating scales.

B. Pain relief strategies and their effectiveness will be documented on an ongoing basis in the electronic medical record or on designated site-specific forms.

In the **Primary Care/Urgent Care locations**, a pain screen/assessment should be performed as warranted by the patient's presenting condition. If the patient's pain requires an intervention, reassessment should occur prior to the patient leaving the practice location.

When pain is identified, the individual is assessed based on his or her clinical presentation and in accordance with the care, treatment and services provided by the organization, or referred to an appropriate clinic and/or provider.

In the **Willowbrooke at Floyd Outpatient Program**, participants are screened/assessed for pain, upon admission and then daily. For patient's complaining of pain, the program nurse will work with the patient on comfort measures that are acceptable to the patient and will include non-invasive interventions that the program is able to provide (example: ice, heat, pillows for support). The provider will be notified when a patient reports pain levels greater than their tolerance or desire. The provider will provide guidance to the staff on acceptable pain management interventions or provide appropriate referrals. All interventions provided by the staff will be documented in the medical record.

The below is a guide, as pain scale numbers and interventions are subjective based on patient preference, tolerance, care plan, and desire:

- Participant self-administering non opioid analgesics or other medication prescribed for the participant ~ for Pain Level of 1 – 3 ~ Mild Pain
- Non Pharmacological therapy such as repositioning, heat, cold, etc. ~ for Pain Level of a 1 – 3 ~ Mild Pain
- Referral to Primary Care Physician ~ for Pain Level of 1 – 6 ~ Mild to Moderate Pain
- Referral to Urgent Care or ECC ~ for Pain Level of 7 – 10 ~ Severe Pain
- Referral to Pain Management Clinic ~ for Chronic Pain over 5

Age Specific and Cultural Considerations

Infants

The approach to infant pain assessment is made on the basis of the following assumptions or beliefs:

- Infants are capable of feeling pain. Infants have the anatomic and functional requirements to process pain from mid to late gestation
- Infants are as sensitive to pain as older children and adults. Term neonates have the same sensitivity to pain as older infants and children. Pre-term neonates may have a greater sensitivity to pain.
- Infants are capable of expressing pain. Although infants cannot verbalize pain, they respond with behavioral cues and physiologic indicators that can be observed by the family and healthcare professionals.
- Pain requires no prior experience; it need not be learned from earlier experience. Pain is present from the first insult.
- Pain can be accurately assessed in infants. Assessment of behavioral cues (facial expressions, cry, body movements)
- Infants are capable of remembering pain. Early exposure to painful stimuli may have an effect on the infant's future responses to pain.
- Analgesics and anesthetics can be safely given to infants and neonates. Infants older than one month of age can metabolize drugs in the same manner as older infants and children. Careful selection of the agent, dose, route and time, monitoring for desired effects, drug titration and weaning can minimize the adverse effects of medication used in the pain management of neonates.

Pediatrics ((up to age 17)

- The healthcare professional should 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.
- 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.
- 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 their child's pain
- 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.

Geriatrics

- Many elderly individuals consider pain to be a normal part of aging
- Many are reluctant to report pain due to ageist attitudes (i.e. old people complain about pain a lot)
- Many fear being perceived as bothersome, a hypochondriac, or an addict
- Pain is often under treated and under reported in this population
- Polypharmacy often is an issue for many geriatric persons and therefore need close monitoring for potential drug interactions with pain medication.

Cultural Considerations

- Consider language barriers, use interpreters or translators, as necessary
- Consider the patient and family social organization, or that family structure, head of household, gender roles, status/roles of elderly, roles of children, adolescents, husband/wives, patents, extended family, influences on decision making process, importance of social organization and network
- Consider the patient's health beliefs, practices, and practitioners
- Consider religion and spirituality

Staff Education/Ongoing monitoring and evaluation

Evaluation of the organization's performance in pain management will be conducted periodically through patient satisfaction surveys, focused pain audits, and during system Medical Record review.

A. Results will be reported through site-specific, nursing and Medical Staff Committees with recommendations/actions as indicated.

B. Staff, including new employees, are educated in:
   - patient rights and responsibilities concerning pain management,
   - organization-wide policy for providing effective strategies for assessing pain
   - organization-wide age, population-appropriate rating scales
   - about pain assessment and treatment including the barriers to reporting pain
   - non-Pharmacological Interventions
   - analgesics use

C. Staff competency in appropriate management of pain is evaluated annually using department specific competency.