PAIN ASSESSMENT AND MANAGEMENT GUIDELINES

Policy: ADM808.00, **v.4** **Effective: 10/03/2024**
Category: Clinical Practice Guidelines **Origination Date:** 03/18/2014

I. PURPOSE:

All patients will be offered pain control measures to achieve the most acceptable pain control level that still maintains the safety of the patient.

II. POLICY:

It is the policy of Mary Lanning Healthcare to provide guidelines in the assessment, reassessment, treatment, and management of a patient's pain condition.

III. DEFINITIONS:

A. **Pain Scales:** Tools used to provide consistency for healthcare providers and patients to communicate the intensity of a patient's pain.

1. Numbers Pain Scale: Self-reporting 11-point scale used for patients who are able to state their pain.
2. Behavioral Pain Scale (BPS): Observational scale completed by staff, scores from 3 to 12. This scale is used to assess pain in a patient with a low level of consciousness
3. Neonatal Pain, Agitation and Sedation Scale (N-PASS): Observation scale that combines the assessment of pain, agitation and sedation levels in a critically ill infant with acute and/or ongoing pain.
4. FACES (Wong-Baker): Self-Reporting tool using 6 faces showing no pain (smiling face) to worst pain imaginable (grimace). This tool is commonly used with the pediatric population and for adults with a language barrier.
5. Critical Care Pain Observation Tool (CPOT): Observation scale of behaviors, facial expressions, body movements, and muscle tension. This scale is most commonly used on nonverbal critically ill adults.
6. Face, Legs, Activity, Cry, Consolability, scale (FLACC): Observation tool that measures the pain of a patient based on 5 criteria. This tool is usually used on the pediatric population or individuals who are unable to communicate pain.

B. **Acute pain:** Typically the result of acute trauma, illness or surgery, which is expected to resolve once the underlying condition, has been treated or improves; most commonly lasts less than three months.

C. **Chronic (non-cancer) pain:** Typically involves neurological, emotional, and behavioral features that often impact a patient's quality of life, function, and social roles; most commonly lasts longer than three months. It also includes pain that persists beyond the expected recovery time of acute trauma, illness or surgery.

D. **Multimodal approach:** Using two or more different methods or medication to manage pain.

E. **Aberrant drug-related behavior:** Unintended behaviors involving the acquisition or use of

prescribed opioids that may indicate uncontrolled pain, poor coping skills, and opioid use disorder.

IV. RESPONSIBILITIES:

A. **Nursing:** RNs & LPNs will be familiar with this policy and collaborate with pharmacy and practitioners in promoting best practice pain management.

B. **Medical Staff:** All privileged practitioners will be familiar with this policy, and collaborate with nursing staff and pharmacy in promoting best practice pain management.

C. **Pharmacy:** All pharmacy staff will be familiar with this policy and collaborate with practitioners and nursing staff in promoting best practice pain management.

V. PROCEDURE:

A. Lippincott Procedures

1. *Pain assessment*
2. *Pain assessment, physical therapy*
3. *Pain assessment, long-term care*
4. *Pain assessment, oncology*
5. *Pain assessment, neonatal*
6. *Pain assessment, pediatric*
7. *Pain assessment, psychiatric patient*
8. *Patient teaching*
9. *Pain management*
10. *Pain management, ambulatory care*
11. *Pain management, oncology*
12. *Pain management, psychiatric patient*
13. *Pain management, nonpharmacologic, neonatal*
14. *Pain management, pharmacologic, neonatal*
15. *Pain and comfort management, PACU*
16. *Pain management, physical therapy*
17. *Heat application*
18. *Heat application, superficial, physical therapy*
19. *Cold application*
20. *Cold application, physical therapy*
21. *Transcutaneous electrical nerve stimulation application and use*
22. *Transcutaneous electrical nerve stimulation removal*

23. *Electrical stimulation, physical therapy*
24. *Relaxation and stress management techniques*
25. *Aromatherapy*
26. *Therapeutic bath*
27. *Breathing and relaxation exercises, physical therapy*
28. *Breathing techniques during labor*

B. Hospital Policy Requirements

1. **Assess for presence of pain for all patients**

a) On initial assessment

- Assess effectiveness of any present pain management regimen
- Establish a pain goal with the patient

b) At regular intervals, with a minimum of once per shift (change of shift) and as needed, based on patient need and/or determined by RN.

- With each new reporting/rating of pain.
  i. Numbers pain scale 0-10 (recommended for 8 years-of-age to adult)
  ii. Behavior pain scale (recommended for 1 year-of-age to adult)
  iii. NPASS (recommended for <1 year-of-age)
  iv. FACES pain scale (recommended for 3 years-of-age to adult)
  v. CPOT pain scale (recommended for 14 years-of age to adult)
  vi. FLACC (recommended for 0-18 years-of-age)
- Established pain scale rating. Example:
  i. 0 = no pain
  ii. 1-3 = mild pain
  iii. 4-6 = moderate pain
  iv. 7-10 = severe pain

c) With initial assessment and new onset of pain, assess the following factors that may include intensity, location, description, and alleviating or aggravating factors of the pain.

d) At least once per shift, document the assessment of the patient's pain to the established pain goal.

e) For patients unable to self-report and/or unable to demonstrate pain related behaviors, assume pain present. These patients include, but are not limited to, the unresponsive patient, the intubated/sedated patient, the potential hospice patient, and patients with brain insults.

- When a patient is unable to communicate about pain and must undergo a procedure that would be painful for others, the patient should be treated

presumptively for pain.

f) Monitor for common side effects which may include over sedation, respiratory depression, nausea/vomiting, pruritus, and acute confusion.

2. Behavioral Services Department

a) Initial Assessment

- Assess whether pain is present and a factor in the patient's admission to BSU
- Establish a pain goal with the patient

b) If pain is a factor in the patient's admission to BSU

- Create a care plan problem that addresses pain
- Document at least each shift to the care plan problem of pain using the pain rating scale.

3. Ambulatory Care and Emergency Department

a) Ambulatory Setting

- Patients are asked about pain related to the current ambulatory appointment.

b) Emergency Department

- Acute pain is assessed and managed per guidelines. Chronic pain as defined above, while assessed in the ED it is not generally a medical emergency and management of chronic pain in the Emergency Department is discouraged.

4. Patient Education

a) Patients and/or family are provided with verbal and written information about pain management.

b) Teach patients/families to use pain rating scale that is age, condition, and language appropriate for the patient.

c) Teach patients/families about pharmacologic and non-pharmacologic interventions and the differences between them.

d) Communicate pain management plan on patient transfer to other nursing units or services, as well as to other care facilities on patient discharge.

e) Provide discharge instructions regarding pain management including how to take medications and what to report to the physician.

5. Intervention

a) Based on results of patient assessment, and through collaboration with the health care team and the patient, develop and implement a plan of pain management.

- For mild pain, recommended use non-opioid medications (NSAID, Acetaminophen) and non-pharmacological interventions.
- For moderate pain, recommended use low dose opioid medications (Codeine, hydrocodone, oxycodone), and/or non-opioid medications (NSAID, Acetaminophen) and non-pharmacological interventions.

- For severe pain, recommended use higher dose opioid medications (morphine, hydromorphone, and oxycodone).

b) When it is anticipated that a patient's pain will increase due to an activity (i.e. physical therapy), procedure, or dressing changes, the nurse may administer a pre-procedure/therapy pain medication that aligns with the expected pain severity, in advance.

c) Patient may request the lesser prescribed dose or the less potent prescribed pain medication regimen even when pain score is indicating the higher dose or more potent medication. The patient preference must be documented when a lesser dose or less potent dose is administered at patient request.

d) Adjuvant analgesic medications (tricyclic antidepressants, gabapentin, carbamazepine, cyclobenzaprine, topical lidocaine) may be used in addition to opioids in moderate and severe pain management.

e) Anticipate and manage opioid-induced side effects including, but not limited to; constipation, nausea/vomiting, hypotension, itching, somnolence and hypoxemia

f) All patients receiving narcotic medications who screen positive for sleep apnea (ROSA) shall be managed according to the ROSA protocol. See *Obstructive Sleep Apnea Protocol (OSA) - ADM231.10* policy.

6. **Non-pharmacologic interventions include but are not limited to:**

a) Heat/cold application

b) Massage

c) TENS unit application

d) Re-positioning

e) Exercise

f) Immobilization

g) Guided imagery

h) Relaxation

i) Meditation

j) Essential Oils (Refer to *Essential Oils - ADM512.00*)

k) Music/sound therapy

l) Slow, rhythmic breathing (e.g. “Lamaze” breathing)

m) Diversional activities

7. **For infants, provision of non-pharmacological interventions is expected.** These may include but not limited to:

a) Involve parents

b) Swaddling

c) Non-nutritive sucking

d) Decrease noise and light

e) Cover isolette

f) Speak softly to infant

g) Support with boundaries, nesting, positioning aides to promote a balance of flexion and extension postures

h) Handle infant slowly and smoothly

i) Work around sleep/wake cycles and try not to interrupt sleep. "Cluster care."

j) Promote self-regulatory behavior – holding, grasping, sucking

8. Documentation

a) Complete admission assessment.

b) Record pain rating, location, intervention, and response of intervention(s) in the EMR.

c) May include progress toward pain goals, side effects of treatment and risk factors for adverse events caused by the treatment in the plan of care.

d) All interventions and reassessments are to be documented in the Electronic Medical Record.

VI. REFERENCES

A. *Lippincott Procedures*

B. *Obstructive Sleep Apnea Protocol (OSA) - ADM231.10*

C. *Essential Oils - ADM512.00*

D. https://www.policymed.com/2017/09/joint-commission-releases-report-regarding-pain-assessment-and-management-standards.html

E. https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm?CDC_AA_refVal=https%3A%2F%

F. https://www.practicalpainmanagement.com/resource-centers/opioid-prescribing-monitoring/list-clinically-tested-validated-pain-scales

VII. COLLABORATED WITH:

A. Pharmacy & Therapeutics Committee

B. Medical Executive Committee

VIII. DISTRIBUTION:

A. Nursing staff

B. Medical staff

C. Pharmacy

D. Ambulatory Clinic

E. Emergency Department

IX. RESCISSIONS

A. Origination Date: 03/2014

1. Combine policies: ER II-7; ADM 207.10; FCCII-23 (policies retired and archived)

B. Reviews/Revisions: 03/2014, 02/2017, 07/2017, 06/2019, 05/2021, 07/2021, 10/2024

1. 07/2021 addition Behavior Services Department to Procedure. No review of policy.

X. REVIEW AND REISSUE DATE:

A. Three years (3) from Effective Date

B. 10/2027

XI. FOLLOW-UP RESPONSIBILITY:

A. Chief Nursing Officer

B. Evidence-Based Practice Committee

C. Pharmacy and Therapeutics Committee

XII. ATTACHMENTS:

A. None