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Mid-Valley Hospital

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Author:	*Rebecca Christoph: Director of Patient Care Services*
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References:	

Pain Management

Policy:

Mid-Valley Hospital will assist the patient in maintaining an optimal level of pain relief by providing regular assessments for pain as a "vital sign" and developing a plan for its management based on these assessments.

Scope:

All patient care areas

Responsibilities:

- Nursing and Ancillary Personnel remain skilled in pain prevention
- Physicians maintain knowledge of pharmacological interventions
- Pharmacist consults as needed for effective pain management

Control:

Director of Patient Care Services, Administrator, Board of Commissioners

Definitions:

Pain is an unpleasant sensory and emotional experience arising from actual or potential tissue damage; sensation of discomfort, distress, or agony unique for that individual who is the real authority on their pain.

Procedural related pain is pain of short duration and generally related to invasive treatments or diagnostic tests, such as venipunctures and lumbar punctures.

Nociceptive pain is a pain related to disease, surgery, or side effects of treatment (i.e. mucositis) arising from bone, joint, muscle, skin or connective tissue; usually described as aching or throbbing.

Neuropathic pain is pain emanating from nerve damage or inflammation; often described as burning or piercing in nature following the path of an injured nerve such as surgical interruption of nerves (i.e. amputations, post-limb sparing procedures), chemotherapy induced (i.e. viecristine), radiation (rare).

Procedure:

A. 1. Effective management of pain (acute pain, chronic malignant pain, chronic non-malignant pain) can directly impact the patient and his significant others by:

   a. i. Improving quality of life.

   ii. Limiting physical and emotional effects of unrelieved pain.

   iii. Improving patient satisfaction.

   iv. Decreasing length of stay.

It is the duty and responsibility of all healthcare providers to recognize pain and to provide for comfort measures as applicable within their scope of practice. The patient will experience an optimal level of pain relief and can expect his report of pain to be accepted, analyzed and appropriate intervention to occur.

A. 1. All patients of developmental states are to be assessed for pain at the time of admission in conjunction with initial vital signs (pain is the 5th vital sign).

a. Utilize an assessment tool understandable by patient. Ask the patient if he/she is having pain. If the patient is unable to self-report, use the FLACC method. The nurse performs this assessment at the time of each visit, or admission and every four hours while the patient is awake.
    i. Numeric scale (0-10) is proved to be effective when assessing ages 13 – adult.
        a. 0 is no pain
        b. 10 is worst pain imaginable
b. Wong-Baker Faces Scale tool is used if patient is between the ages of 5 and 13 years.
c. CHEOPS Scale may be used if patient is a toddler between ages 1 and 3 years.
(see Attachment: Guideline for Pain Managment Flow Sheet)
d. Modified Attia Scale is to be used if patient is less than one year old.
(see attachment)
e. Verbal descriptor scale may work better with elderly in particular.
    i. no pain (0)
    ii. mild (1)
    iii. discomforting (2)
    iv. distressing (3)
    v. horrible (4)
    vi. excruciating (5)
f. FLACC (infants) : ***F***ace, ***L***egs, ***A***ctivity, ***C***ry, ***C***onsolability

Categories	Scoring		
0	1	2	
Face	smiling or relaxed	Occasional grimace	clenched jaw/quivering chin
Legs	relaxed	Restless / tense	kicking
Activity	lying quietly	Squirming / tense	arched /rigid /jerking
Cry	no cry (awake or asleep)	Moans / whimpers	crying steadily/screams/sobs
Consolability	content / relaxed	Distractible / consolable	difficult to console or comfort

    - Each of the five categories (F) face; (L) legs; (A) activity; (C) cry; (C) consolability; is scored from 0-2, resulting in a total score range of 0 to 10.
g. Other means of assessing pain, usually seen only briefly after the onset or exacerbation of pain and often returns quickly to normal are considered physiological or behavioral.
    i. **Physiologic** signs include increased heart rate, blood pressure, and respiratory rate, sweating and pallor.
    ii. **Behavioral** signs may include body positioning such as guarding, cradling limb, muscle rigidity, restlessness, clenching of hands, as well as facial expressions such as grimacing, tightening of jaw, sweating, pallor, dilated pupils, moaning, crying and screaming.
        - Behaviors often seen when pain continues are anxiety, irritability, depressed affect, fatigue, depression, and altered level of activity.

        NOTE: the absence of these symptoms does not necessarily mean the patient has no pain.

2. Document Assessments
    a. patients perception of pain (self reported)
    b. location/nature of pain
    c. time of onset
    d. duration of pain (continuous, intermittent)
    e. intensity/severity of pain (using one of above methods / scales if possible)
    f. quality of pain (sharp, dull, stabbing, aching, burning, throbbing, etc.)
    g. alleviating/ aggravating factors (what makes it better or worse)
    h. parent perception of their child re: pain
    i. record assessment method used to provide consistent reproducible results and allow for regular reassessment and follow-up.

j. sedation level using sedation scale on pain management flow sheet

Sedation Scale

0=	None
1=	Mild Occurrence, Drowsy, Easy to Arouse
2=	Moderate Frequency, Drowsy, Easy to Arouse
3=	Severe, Somnolent, Difficult to Arouse
S=	Asleep, Arousable

B. Immediately initiate non-pharmacological therapies as appropriate

1. Positioning
2. Splinting and/or Immobilization
3. Cold Treatment – Do not apply without a physician's order.
   a. Do not apply to infants/preemies where thermoregulation is a concern
   b. Do not apply on fragile skin/skin that has had frostbite.
   c. Do not apply on those with decreased or impaired sensation.
   d. 10 minute application with ice bag
   e. Observe skin for signs of tissue damage; redness, discoloration, blanching or mottling. (Stop if these signs occur.)
   f. Document treatment (time applied, to what area, action, and response)
   g. For acute invasive procedure: ice applied to opposite of invasive procedure can be effective. (e.g. for bone marrow planned for right iliac crest, place ice on left iliac crest)
4. Heat (for muscle spasm or back pain) – Do not apply without a physician's order.
   a. K-pad
   b. Hot water or warm packs from warmest water in faucet; DO NOT MICROWAVE
   c. Do not apply on fragile skin.
   d. Do not apply on those with decreased or impaired sensation.
   e. Apply for no longer than 10 minutes.
   f. Document treatment (time applied, to what area, action, and response)
   g. Check for warmth and reapply if necessary.
5. Oxygen
6. Complimentary Interventions
   a. relaxation
   b. distraction
   c. diversion
   d. guided imagery
   e. Massage (not on legs or calves)
   f. humor

C. Administer pharmaceutical therapies as soon as possible

1. Must have physician's order
2. May establish pain management protocols
3. Ascertain medication allergies prior to administration
4. Those with history of chemical dependency/ abuse or use of pain medications for reasons other than pain relief may require Pharmacist consult to establish equianalgesic dosing and to develop pain management plan of care with the physician.

D. Re-assess pain frequently (at least every 30 minutes until controlled)

1. 5-10 minutes after SL medication
2. Within 30 minutes after IV medication

3. 30-60 minutes after IM or PO medication
4. Monitor closely for signs of sedation, respiratory compromise, side effects, adverse reactions
5. Non-Pharmacologic
6. Epidurals (see protocol in OB)

E. Re-medicate as needed
1. Follow established dosing guidelines
2. Initiate patient controlled analgesia (**PCA**) management as appropriate
    a. Educate significant others about PCA use.
3. Consult pharmacist for intractable pain or other management problems as needed

F. Assess the need to establish bowel regime (stool softeners, laxatives, fiber products)for patients receiving opiates/narcotics

G. Enter "pain" to care plan/interdisciplinary plan of care and address as discharge planning criteria.

H. Educate the patient and/or significant others:
1. use of pain scales; explain pain assessment
2. causes of pain
3. medication schedule and dose, time to relief
4. when and what to report to healthcare team
    a. non-relief/ relief not as expected
    b. side effects/adverse reactions
5. side effects and treatments
6. include preprinted medication information sheets as appropriate
7. document education on pain management flow sheet

I. Management issues
1. WHO 3-step analgesic ladder
WHO 3-step analgesic ladder
2. If adequate relief is not obtained after maximizing doses of medications ordered, notify physician and/or utilize pharmacist's expertise to formulate a pain management plan to present to the physician. If physician refuses to order additional medication, utilize chain of command in attempt to resolve issue.
    a. Nursing Supervisor
    b. Nurse Manager
    c. Chief of Service
    d. Chief or Staff
    e. Administrator
3. Before switching to another drug, consider increasing dosage and/or reducing interval between doses and/or changing route of administration to prescribed maximum. If side effects outweigh benefits, select a new drug. Consult Pharmacist to assure equianalgesic effects.
    a. There is no known maximum dose of morphine sulfate, hydromorphone (Dilaudid), or oxycodone, and patients with chronic/ continuous pain may need greater doses than opiate naive patients.
    b. It may be necessary to separate components of combination products to reduce potential for toxic dosing.
        i. Acetaminophen dose should not exceed 4-grams/ day.
    c. Meperidine produces a metabolite Normeperidine, which is a CNS excitotoxin that produces anxiety, tremors, myclonus, and seizures. Do not use for periods over 48 hours, at doses > 600 mg/24 hrs./or for chronic pain. Do not use at all in-patients taking MAO inhibitors (can cause hyperpyrexic syndrome with delirium, which can be fatal).
4. Assess for and treat side effects concurrently and aggressively while you treat pain.
    a. Initiate bowel program to prevent constipation/urinary retention, notify the physician
    b. Give an antiemetic for nausea
    c. Give a stimulant for excess sedation

d. Give an antihistamine for itching

e. Give Naloxone (Narcan) in the smallest effective dose for respiratory depression

Developmental Approaches

INFANTS

Environmental	decrease noise/light; reposition; bringing infants to quiet awake state is valuable for procedures; refrain from performing all nonessential procedures; speak calmly and reassuringly; use of security objects
Distraction	music; mobiles; soothing talk; soft or novel voice; calm demeanor
Containment	holding; cuddling; swaddling; positioning; pacifier

TODDLERS/PRESCHOOLERS

Environmental	decrease noise/light; reposition; bringing infants to quiet awake state is valuable for procedures; refrain from performing all nonessential procedures; speak calmly and reassuringly; use of security objects
Distraction	pop-up books; magic circle/magic game; puppets; kaleidoscopes; counting/alphabet; music; sing along songs; doll play; drawing/painting
Breathing	pinwheel; blowing bubbles; ask the child to yawn; "meow-meow-woof"; "go limp as a rag doll"; "blow your hurt away"
Imagery	stories – use images familiar to a child
Explanations	therapeutic play before, during and after a painful procedure; provide sensory information

SCHOOL AGE/ADOLESCENTS

Environmental	decrease noise/light; reposition; refrain from performing all nonessential procedures; speak calmly and reassuringly; use of security objects
Distraction	(younger child) pop-up books; counting/alphabet; puppets; kaleidoscope (older) music with walkman; video games; books
Breathing	
Imagery	pain switch, familiar images with stories

ADULTS

Patients should be informed that effective pain relief is an important part of their treatment, communication of unrelieved pain is essential.

It is important to be aware of other influences in the patient's life (i.e. employment status, marital status, emotional stability, etc.). These factors can influence pain management.

GERIATRICS

Elderly people often suffer multiple illnesses and take multiple medications. They are at a greater risk for drug/drug and drug/disease interactions.

Pain assessment in the elderly may be difficult sue to physiologic, psychologic and cultural changes associated with aging.

Aging need not alter pain thresholds or tolerance. The similarities of pain experience between elderly and younger patients are far more common than they are different.

Cognitive impairment, delirium, and dementia are serious barriers to assessing pain in the elderly. Sensory problems such as visual and hearing changes may also make it more difficult.

Older people tend to be more sensitive to the analgesic effects of opioids. The peak opioid effect is higher and the duration of pain relief is longer.

Reassessment of pain management and appropriate changes should be made whenever the elderly patient moves (i.e. from ICU to ACU; hospital to extended care facility, etc..)

PATIENTS WITH A TERMINAL CONDITION

Pain management never stands alone, exclusive of the patient's experience. This is even truer regarding pain at the end of life. The experience of the patient involves his/her illness experience, support system, sense of satisfaction with a life lived, ability to feel in control, degree of physical well-being and many other factors. All people at the end of life may experience suffering related to the many losses they have faced and will face. Pain will be part of this suffering. It is not the pain itself that determines suffering but the meaning the pain has for the individual.

Within the context of the above description, the principles of pain management remain constant.

- Assess patient per protocol using appropriate pain scale.
- Document specific limitations of mobility and situations that exacerbate pain.
- Individualize the pain control regimen to the patient.
- The simplest dosage schedules and least invasive pain modalities should be used first.
- Administer pain medicines on a round-the-clock basis.
- Provide for breakthrough pain medication.
- Assess and document effect of medications – degree of relief of pain and duration of relief.
- Include patients & families in the pain plan. Enable them to control their course as much as possible.

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All revision dates: 08/2010, 05/2005, 08/2003

Attachments:
- Guideline for Pain Management Flow Sheet.doc
- Modified Attia Score.doc
- WHO 3-step analgesic ladder

Approver	Date
Rebecca Christoph: Director of Patient Care Services	08/2010
Lori Koby: Director Patient Care Services	08/2010
Lori Koby: Director Patient Care Services	08/2010
Mike Billing: CEO, Administration, Support Services	08/2010
Rebecca Christoph: Director of Patient Care Services	05/2013
Katie Pfitzer: HR Assistant	08/2013
Randy Coffell: HR Director/Safety/Education	08/2013