RMC Procedure/Guideline: Pain Management

P10395

Department: Nursing Administration Last Review/Revision Date: 7-1-2018

Distribution Departments: 7240, 7505, 7575

Accreditation/Regulatory Standard (if applicable): §482.13(b)(1) The patient has the right to participate in the development and implementation of his or her plan of care.

Purpose: To define pain management standards and provide guidelines that support a consistent level of care is provided for all patients with regard to effective pain management.

Policy: This policy provides a guideline to caregivers in how to assess, treat, and assist in managing a patient's pain.

Guidelines/Definitions:

GUIDELINES:

A. These standards apply to inpatients and outpatients with acute pain. Management of diseases that are defined as chronic are beyond the scope of these standards and may require additional evaluations and interventions through interdisciplinary effort.
B. All patients have a right to appropriate assessment and management. All patients and/or patient representatives, when possible, will be involved in the development and implementation of his/her pain management plan.

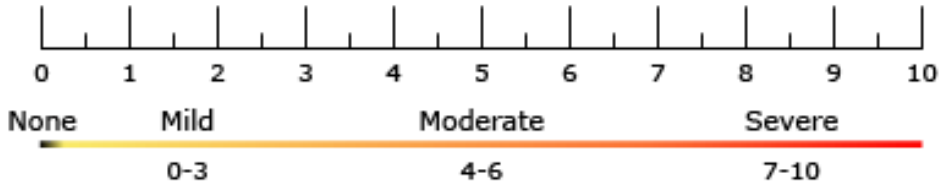
STANDARDS OF CARE FOR PAIN MANAGEMENT:

1. A comprehensive nursing assessment is conducted on all patients upon admission and as appropriate to the patient's condition, scope of care, treatment and services provided.
   A. Assess for presence of pain for all patients:
      a. During initial admission assessment;
      b. A minimum of every shift for acute and OBS patients and daily for skilled swing-bed (SSB) patients;
      c. As needed; and
      d. With each new report/rating of pain.
   B. If pain is present, the initial pain assessment will include location, intensity (pain score), onset, character, duration, intensified by, and relieved by.
   C. The appropriate pain assessment/intensity scale will be used based on the patient's age and/or abilities. See Appendix A for scales.
      a. Numeric: numeric self-rating scale 0-10 will primarily be used to evaluate pain in adults. Zero indicates no pain; 10 indicates the severe pain.
         i. A rating of 1-3 indicates mild pain;
         ii. A rating of 4-7 indicates moderate pain; and
         iii. A rating of 8-10 indicates severe pain.
      b. Faces: Wong- Baker FACES pain rating scale is recommended for pediatric patient's age three years and older. Point to each face using the words to describe the pain intensity. Ask the child to choose the face that best describes own pain and record the appropriate number.
      c. FLACC: The FLACC scale is used to assess pain in newborns, infants, children under age 5, or children unable to comprehend the numeric scale.
      d. If an adult patient is unable to report pain using above scale(s) (i.e. non-verbal, sedated, or cognitively impaired), non-verbal pain indicators may be used to assess/document pain.
      e. Patients who are cognitively impaired, non-verbal, or suffering from dementia may be assessed using the Pain Assessment in Advanced Dementia (PAINAD) scale

2. Timely reassessment (within 60 minutes) will occur after any pain management intervention. Documentation of reassessment findings is completed in the patient's medical record and will include:
    A. The patient's reported pain intensity. If a patient is unable to verbally report their pain, non-verbal signs of pain will be documented.
    B. If the patient appears to be sleeping at the time of reassessment, documentation of "patient sleeping," "resting comfortably," or "no noted nonverbal pain indicators" may be documented in lieu of a pain scale.
    C. Pain reassessment documentation **may** also include the following:
        a. Vital Signs
        b. Pain location
        c. Pain duration/distribution/character
        d. Non-verbal signs of pain
        e. What intensifies/relieves the pain
        f. Identification of adverse effects or other patient symptoms such as sedation, itching, respiratory depression, or nausea.
            i. Adverse effects of treatment will be assessed, reported to the physician as appropriate, and treated in a timely manner.

3. When clinically appropriate (not contraindicated), non-pharmacologic interventions may be utilized for all pain intensity ratings in conjunction with analgesics.
    A. Non-pharmacologic interventions include but are not limited to ice, heat, repositioning, ambulation, massage.

Numeric pain scale



The numeric pain scale allows patients to rate the pain on a scale of 0 to 10, with 10 as the worst possible pain.

Wong-Baker FACES pain rating scale

Explain to the child that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the child to choose the face that best describes how he is feeling. Rating scale is recommended for persons age three years and older. Point to each face using the words to describe the pain intensity. Ask the child to choose the face that best describes own pain and record the appropriate number.

Reproduced with permission from: Wong DL, Hockenberry-Eaton M, Wilson D, et al. Wong's Essentials of Pediatric Nursing, 6th ed. Mosby, St. Louis, 2001. p.301.

Revised FLACC pain score

Categories	Scoring		
	0	1	2
F Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested; *appears sad or worried*	Frequent to constant frown, clenched jaw, quivering chin; *distressed-looking face: expression of fright or panic*
L Legs	Normal position or relaxed	Uneasy, restless, tense; *occasional tremors*	Kicking, or legs drawn up; *marked increase in spasticity, constant tremors or jerking*
A Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense; *mildly agitated (eg, head back and forth, aggression); shallow and splinting respirations, intermittent sighs*	Arched, rigid, or jerking; *severe agitation, head banging; shivering (not rigors); breath-holding, gasping or sharp intake of breath; severe splinting*
C Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint; *occasional verbal outburst or grunt*	Crying steadily, screams or sobs, frequent complaints; *repeated outbursts, constant grunting*
C Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractable	Difficult to console or comfort; *pushing away caregiver, resisting care or comfort measures*

This pain score can be used to assess pain from burns and other etiologies for preverbal children.

- Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.
- **Patients who are awake:** Observe for at least 1-2 minutes. Observe legs and body uncovered. Reposition patient or observe activity, assess body for tenseness and tone. Initiate consoling interventions if needed.
- **Patients who are asleep:** Observe for at least 2 minutes or longer. Observe body and legs uncovered. If possible reposition the patient. Touch the body and assess for tenseness and tone.
- The revised FLACC can be used for children with cognitive disability. The additional descriptors (in italics) are included with the original FLACC. The nurse can review the descriptors within each category with parents. Ask them if there are additional behaviors that are better indicators of pain in their child. Add these behaviors to the tool in the appropriate category.

Items	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract, or reassure.	
			Total**	

*Five-item observational tool (see the description of each item below).

**Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0 = "no pain" to 10 = "severe pain").

Description: The Pain Assessment in Advanced Dementia (PAINAD) was developed to assess pain in patients who are cognitively impaired, non-communicative, or suffering from dementia and unable to use self report methods to describe pain. Observation of patients during activity records behavioral indicators of pain: breathing, negative vocalization, facial expression, body language, and consolability.

Breathing

1. *Normal breathing* is characterized by effortless, quiet, rhythmic (smooth) respirations.
2. *Occasional labored breathing* is characterized by episodic bursts of harsh, difficult, or wearing respirations.
3. *Short period of hyperventilation* is characterized by intervals of rapid, deep breaths lasting a short period of time.
4. *Noisy labored breathing* is characterized by negative-sounding respirations on inspiration or expiration. They may be loud, gurgling, wheezing. They appear strenuous or wearing.
5. *Long period of hyperventilation* is characterized by an excessive rate and depth of respirations lasting a considerable time.
6. *Cheyne-Stokes respirations* are characterized by rhythmic waxing and waning of breathing from very deep to shallow respirations with periods of apnea (cessation of breathing).

Negative Vocalization

1. *None* is characterized by speech or vocalization that has a neutral or pleasant quality.
2. *Occasional moan or groan* is characterized by mournful or murmuring sounds, wails, or laments. Groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
3. *Low level speech with a negative or disapproving quality* is characterized by muttering, mumbling, whining, grumbling, or swearing in a low volume with a complaining, sarcastic, or caustic tone.
4. *Repeated troubled calling out* is characterized by phrases or words being used over and over in a tone that suggests anxiety, uneasiness, or distress.
5. *Loud moaning or groaning* is characterized by mournful or murmuring sounds, wails, or laments in much louder than usual volume. Loud groaning is characterized by louder than usual inarticulate involuntary sounds, often abruptly beginning and ending.
6. *Crying* is characterized by an utterance of emotion accompanied by tears. There may be sobbing or quiet weeping.

Facial Expression

1. *Smiling or inexpressive*. Smiling is characterized by upturned corners of the mouth, brightening of the eyes, and a look of pleasure or contentment. Inexpressive refers to a neutral, at ease, relaxed, or blank look.
2. *Sad* is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes.
3. *Frightened* is characterized by a look of fear, alarm, or heightened anxiety. Eyes appear wide open.
4. *Frown* is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear.
5. *Facial grimacing* is characterized by a distorted, distressed look. The brow is more wrinkled, as is the area around the mouth. Eyes may be squeezed shut.

Body Language

1. *Relaxed* is characterized by a calm, restful, mellow appearance. The person seems to be taking it easy.
2. *Tense* is characterized by a strained, apprehensive, or worried appearance. The jaw may be clenched. (Exclude any contractures.)
3. *Distressed pacing* is characterized by activity that seems unsettled. There may be a fearful, worried, or disturbed element present. The rate may be faster or slower.
4. *Fidgeting* is characterized by restless movement. Squirming about or wiggling in the chair may occur. The person might be hitching a chair across the room. Repetitive touching, tugging, or rubbing body parts can also be observed.
5. *Rigid* is characterized by stiffening of the body. The arms and/or legs are tight and inflexible. The trunk may appear straight and unyielding. (Exclude any contractures.)
6. *Fists clenched* is characterized by tightly closed hands. They may be opened and closed repeatedly or held tightly shut.
7. *Knees pulled up* is characterized by flexing the legs and drawing the knees up toward the chest. An overall troubled appearance. (Exclude any contractures.)
8. *Pulling or pushing away* is characterized by resistiveness upon approach or to care. The person is trying to escape by yanking or wrenching him- or herself free or shoving you away.
9. *Striking out* is characterized by hitting, kicking, grabbing, punching, biting, or other form of personal assault.

Consolability

1. *No need to console* is characterized by a sense of well-being. The person appears content.
2. *Distracted or reassured by voice or touch* is characterized by a disruption in the behavior when the person is spoken to or touched. The behavior stops during the period of interaction, with no indication that the person is at all distressed.
3. *Unable to console, distract, or reassure* is characterized by the inability to soothe the person or stop a behavior with words or actions. No amount of comforting, verbal or physical, will alleviate the behavior.

Reference:

UpToDate. Waltham, MA: UpToDate Inc. http://www.uptodate.com (Accessed on May 24, 2018.)

Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. *J Am Med Dir Assoc*. 2003; 4:9-15.