

Procedure/Guideline: Pain Management

P10395

Department: Nursing	
Audience: Nurse (Patient Care)	Last Review/Revision Date: 6/30/2024
Category: Patient Care	Classification: DNV Survey
Applies to but is not limited to: Nursing	
Location(s): Waconia campus; Arlington campus; Two Twelve campus; Le Sueur campus	

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

Definitions:

GUIDELINES/DEFINITIONS:

- 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.
- C. Pain scales are tools to assess pain in the patient who can/cannot self-report and in those who are nonverbal. Selection is based on the patient's ability to provide a self-report, age, patient preference, and ability to understand
- D. Mild pain: Generally, a pain score that is within the benchmark range of 1-3/10, unless the patient identifies it as otherwise.
 - a. Scheduled and/or PRN non-opioid analgesics are recommended
 - b. Consider adjuvant options
- E. Moderate pain: Generally, a pain score that is within the benchmark range of 4-6/10, unless the patient identifies it as otherwise.
 - a. When continuous pain is anticipated, a long acting or a fixed-dose schedule (around the clock) is recommended.
 - b. A PRN order of a rapid onset analgesic may be necessary to control activity related pain or breakthrough pain
 - c. Consider adjuvant options
- F. Severe pain: Generally, a pain score that is within the benchmark range of 7-10/10, unless the patient identifies it as otherwise.
 - a. When continuous pain is anticipated, a long acting or a fixed-dose schedule (around the clock) is recommended.
 - b. A PRN order of a rapid onset analgesic may be necessary to control activity related pain or breakthrough pain
 - c. Consider adjuvant options
- G. Pain management goal: The level or intensity of pain that allows a person to perform the activities of daily living and treatments necessary for recovery, and the ability to rest and sleep, while not necessarily being pain free
- H. Multi-model approach to pain management. This is defined as using pharmacological (opioid and non-opioid) interventions and non-pharmacological interventions together to provide comfort.
- I. Patient and family education about pain, and the importance of effective management, available treatment, will be provided throughout hospitalization and as determined by individual patient need.

- J. Therapeutic duplication- the practice of prescribing multiple medications for the same indication without a clear distinction of when one agent should be administered over another – for example, pain, nausea and vomiting, and constipation

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. If multiple medications from the same therapeutic class are ordered, each medication must include a specific indication or include criteria for which medication to administer first, second, etc. A call to the clinician is required to seek clarification.
 - D. During the postoperative period, pain management may require continuation of the medication regimen that adequately and effectively provides pain control as indicated by clinician order.
 - E. 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 severe pain.
 - i. A rating of 1-3 indicates mild pain;
 - ii. A rating of 4-6 indicates moderate pain; and
 - iii. A rating of 7-10 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 Adult Behavioral 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.

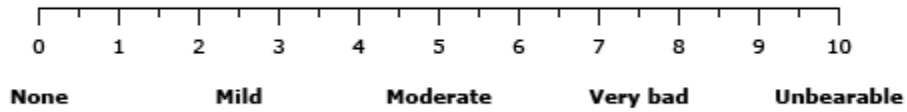
References:

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

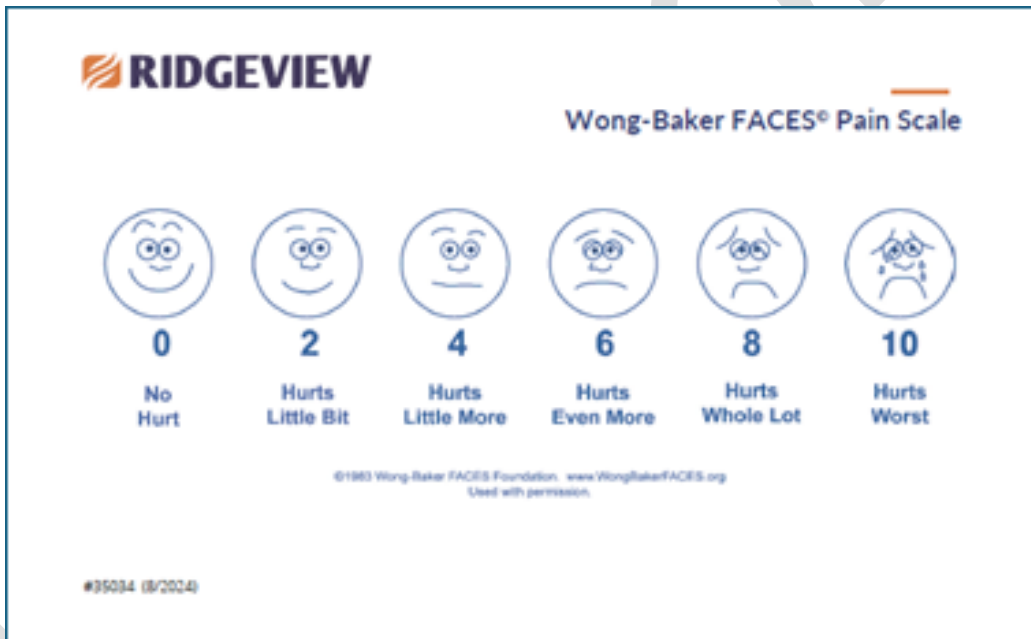
Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. *J Am Med Dir Assoc.* 2003; 4:9-15.

Appendix A

What does your pain feel like?









Date: _____



RIDGEVIEW

Wong-Baker FACES® Pain Scale

					
0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

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Revised FLACC pain score

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

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.

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Behavioral & Physiologic Pain Assessment (For the Cognitively Impaired Adult) ***

Each of the five categories have a numeric weight applied to the following assessment:

- (F) Face
- (P) Posture/Guarding
- (M) Movement
- (V) Vital Signs
- (S) Skin

Each area is scored from 0-2, which results in a total score when added between 0 and 10. Reassessment is accomplished by reevaluation after the intervention.

***To be utilized for the cognitively impaired adult. Goal is zero. If score 1 or greater consider intervention.