Banner Health

POLICY and PROCEDURE

TITLE: Pain Management			
Number: 9171		Version: 9171.2	
Type: Patient Care		Author: Pain Advisory Team	
Effective Date: 9/1/2011	Original Date: 5/27/2008	Approval Date: 8/25/2011	Deactivation Date:
Facility: System			
Population (Define): All Patients			
Replaces: #1497, #1788, #1789, #3823, 5768, #8999, + any other Pain Management Policy that is not in the P&P Database			
Approved by: Pain Advisory Team, Facility P&P Committees, Facility Medical Committees, AZ Regional Practice Council			

TITLE: *Pain Management*

I. Purpose/Expected Outcome:

A. Patient reports or exhibits behaviors that indicate an acceptable level of comfort.

II. Definitions:

A. Pain management: Alleviation of pain or a reduction of pain to a level of comfort that is acceptable to the patient.

B. Assessment: The collection, interpretation and analysis of patient care data that is used to identify the patient's problems / needs and establishes priorities for patient care. Data is compiled from the history, interview, physical examination and/or clinical/laboratory/diagnostic tests. Assessment also includes the psychosocial, emotional, and spiritual aspects of the patient. The plan of care that is mutually set with the patient is culturally and age specific to the individual patient/family. The completed patient assessment establishes the foundation for the diagnosing/ analyzing of patient problems, formulating a plan of care and determining appropriate referrals and reassessments. A discharge plan is begun with admission.

C. Reassessment: Comparing the most recent data with the data collected on the previous assessment. The results of the reassessment help to determine if a change in the plan of care is necessary and/or further assessment is warranted.

D. Screening: The identification of unrecognized occurrences or states by the application of tests, examinations, or other procedures that can be rapidly and simply applied. Screening is not intended to be diagnostic. Individuals identified by a screening process must be further assessed to establish a diagnosis.

E. Interventions:
   1. Analgesic administration: the use of pharmacologic agents to reduce or eliminate pain
   2. Cutaneous stimulation: the use of heat/cold therapy, as the patient condition warrants, may help to relax or distract patients from their pain. (NIC)
   3. Massage: stimulation of the skin and underlying tissues with varying degrees of hand pressure to decrease pain, produce relaxation, and/or improve circulation. (NIC)
   4. Guided imagery: purposeful use of imagination to achieve relaxation and/or direct attention away from undesirable sensations. (NIC)
   5. Relaxation therapy: use of techniques to encourage and elicit relaxation for the purpose of decreasing undesirable signs and symptoms such as pain, muscle tension or anxiety. (NIC)
   6. Distraction: purposeful focusing of attention away from undesirable sensations. (NIC)

7. Meditation: altering the patient's level of awareness by focusing specifically on an image or thought (NIC)
8. Music therapy: using music to help achieve a specific change in behavior or feeling. (NIC)
9. Patient Controlled Analgesia (PCA) assistance: facilitating patient control of analgesic administration and regulation (NIC)
10. Progressive muscle relaxation: facilitating the tensing and releasing of successive muscle groups while attending to the resulting differences in sensation (NIC)
11. Hypnotherapy: subconscious conditioning of the mind to empower oneself to aid in the self-treatment of pain, anxiety, phobias, etc. (NIC)

F. Placebo: Any medication or procedure, including surgery, that produces an effect in a patient because of its implicit or explicit intent and not because of its specific physical or chemical properties.
G. Numerical Rating Scale (NRS): The patient is asked to rate pain from 0 to 10 with zero equaling no pain and 10 equaling the worst possible pain. Scale may be presented visually with numbers along a vertical or horizontal line.
H. **Licensed Independent Practitioner (LIP):** Any practitioner permitted by law and by the organization to provide care and services without direction or supervision, within the scope of the practitioner license and consistent with the individually assigned clinical responsibilities (Joint Commission Perspectives November 2005, Volume 25, Issue 11.)

III. Policy:

A. The management of pain is a priority for Banner Health. A systematic assessment of patients' pain will be performed
B. Banner Health's pain management philosophy is based on the following assumptions:
   1. Pain can be relieved.
   2. The patient is the best authority on his or her pain.
   3. The patient has a valuable role in the treatment of pain.
   4. Pain management affects quality of care and consumer satisfaction.
C. A pain rating scale is to be used in order to provide a framework of care. Clinicians will assess pain with easily administered rating scales and will document the efficacy of pain relief at regular intervals after starting or changing treatment.
D. Banner Health caregivers will ask about pain and the patient's self-report will be the primary source of assessment. Self-report may include:
   1. Description of pain
   2. Location
   3. Intensity/severity (pain rating scale)
   4. Verbal rating on a 0-10 scale
   5. Wong & Whaley's faces, used for children, confused patients and when language barrier present
   6. FLACC scale – (face, legs, arms cry, consolability) used for 2 months – 7 years of age or developmental age
   7. Neonatal Pain Agitation Sedation Scale (NPASS) and PIPA for newborn pain assessment
   8. Aggravating/relieving factors
   9. ***Behavior and vital signs are not used in lieu of self-report, but will be included in the assessment for adults***
E. For the adult who is nonverbal, pain is assessed via direct observation or history from caregivers. Refer to Algorithm and Appendix A, Common Pain Behaviors in Cognitively Impaired Elderly Persons.
F. In the ICU/critical care setting, the non-verbal adult patient who is unable to self report will be assessed with a behavioral scale (CPOT – The Critical-Care Pain Observation Tool).

G. Pain is assumed to be present when painful pathologic conditions are present or the performance of a procedure done. The acronym APP (assumed pain present) is recorded instead of a pain rating in patients who are unable to self report pain.
H. Clinicians will provide information to patients and families regarding pain management.
I. Patient's level of pain will be assessed upon admission.
J. Diagnostic evaluation and modification of the treatment plan are performed when changes in pain patterns or the development of new pain occurs.
K. Placebos will not be given unless the patient is enrolled in a clinical trial and an informed consent has been obtained.
L. Clinical trials for pain management will be reviewed also by the system pain advisory committee if one arm of the protocol is a placebo and:
   1. No around the clock opioid available, or
   2. Breakthrough opioid available with a time restraint greater than 15-30 minutes for IV or 30-60 min by mouth.

IV. Procedure/Interventions:

A. Procedure:
   1. Observe, evaluate, record and **report** the patient's pain and findings as follows: (**RN, LPN**)
      a. On admission,
      b. With change of care giver,
      c. With each new report of pain.
   2. Instruct patient to report changes in their pain or any new pain so that appropriate reassessment and changes in the treatment plan can be initiated.
   3. For the patient unable to self-report, observe and document using observed behaviors or CPOT in critical care.
   4. Initiate treatment to aggressively relieve the patient's pain and lower the pain level to that which is acceptable to the patient. (**PHYSICIAN, PA, CRNA, NP, RN, LPN)**
   5. Consult with the attending physician, the patient's anesthesiologist or surgeon for interventions to assist in bringing the patient's pain scores to an acceptable level. (**RN**)
   6. Collaborate with pain specialists (such as clinical pharmacist, RN, anesthesiologist) if the patient's level of pain is not at an acceptable level or observed behaviors are not minimized after interventions are performed. The RN may ask the pain specialists to contact the attending physician to discuss treatment options.
   7. Reassess the patient after medication administration to assess the impact of the medication on pain severity and/or pain behaviors and document.
   8. When appropriate, it is recommended that clinicians teach patients and their families the following:
      a. To use assessment tools in their homes in order to promote continuity of effective pain management across all settings; and
      b. To report changes in their pain or any new pain so that appropriate reassessment and changes in the treatment plan can be initiated.

V. Procedural Documentation:

A. Document:
   1. Assessment of pain
   2. Interventions and teaching
   3. Patient/family's response to interventions and teaching

VI. Additional Information

A. Staff with expert knowledge of principles of pain management is available for consultations on complex pain patients. This includes but not limited to Physicians, Clinical Pharmacists, RNs, and complementary therapies.
B. The majority of patients with pain > 5 for 24 hours or more have problems with ADL's, sleep, nutrition and the ability to cope. An analgesic regimen consisting of (routine), around-the-clock analgesics with PRN supplemental analgesics (unless not medically indicated) is often the best way to treat continuous pain.
C. "Most clinicians will consider a patient who has used opioids regularly for approximately 7 days or more to be opioid tolerant. The clinical importance is that such individuals are assumed to have developed tolerance to most of the opioid effects." (McCaffery and Pasero, page 172).
D. Compared with opioid naïve individuals, opioid tolerant individuals are able to tolerate faster escalation in larger doses of opioid drugs without experiencing life-threatening side effects." (McCaffery and Pasero, page 172).
E. "IM administration has the disadvantages of painful administration, wide fluctuations in absorption from muscle, a 30- to 60-minute lag to peak effect, and rapid falloff of action compared to oral administration. In addition, IM injection may lead to nerve injury with persistent neuropathic pain." (APS, page 23).
F. Adults who have cognitive impairment or other communication difficulties pose assessment challenges and are at risk for under-treatment" (Pasero & McCaffery 2011).

VII. References:

American Pain Society (2003). *Principles of Analgesic Use in the Treatment of Acute and Cancer Pain.*

American Society of Pain Management Nurses (1999). *ASPMN Position Statement Use of Placebos for Pain Management.*

Gelinas, C., Fillion, L., Puntillo, K.A., et al. (2006). Validation of the Critical-Care Pain Observation Tool (CPOT) in adult patients. *Am J Crit Care, 15*(4), 420-427.

Gordon, D., et al (2004) The use of As-Needed Range Orders in the Management of Acute Pain: A Consensus Statement of the American Society of pain Management Nursing and the American Pain Society, *Pain Management Nursing, 24* (6); 808-81. W.B. Saunders.

Herr, Keela et al (2006). Pain Assessment in the Nonverbal Patient: Position Statement with Clinical Practice Recommendations, *Pain Management Nursing* 7 (2); 44-52.W.B.Saunders

McCloskey, J.C., & Bulechek, G.M. (2000). *Nursing Interventions Classification (NIC),* St. Louis: Mosby.

ONS Position Statement (1996). *ONS Position Statement on the Use of Placebos for Managing Cancer Pain.*

Pasero, C., & McCaffery, M. (2002). Pain in the critically ill. *AJN, 102*, (1), p.59.

Pasero, C., & McCaffery, M. (2011). *Pain Assessment and Pharmacological Management*. St. Louis, MO: Elsevier.

Puntillo, K. A., White, C., Morris, A. B., Perdue, S. T., Stanik-Hutt, J., Thompson, C. L., & Wild, L. R., (2001). Patients' perceptions and responses to procedural pain: Results from Thunder Project II. American Journal of Critical Care, 10, 238-251.

Shayevtiz, JR., & Malviya, S. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. Pediatric Nursing, 23, 293-297.

Wong, D.L., Hockenberry, M.J., Wilson, D. Winkelstein, M.L., Kline, N.E., Hockenberry-Eaton, M. **(2002).** Whaley & Wong's Nursing Care of Infants and Children (7th edition) St. Louis: Mosby Co.

VIII. Other Related Policies/Procedures:

A. Intraspinal Analgesia
B. Management of a Patient with a Temporary Pain Management System
C. Medication Range Orders
D. Pain Management: PCA or Continuous

IX. Keywords and Keyword Phrases:

A. Assessment of Pain

X. Appendix:

A. Appendix A: Common Pain Behaviors in Cognitively Impaired Elderly Persons

Appendix A

Adapted from AGS Panel on Persistent Pain in Older Persons, (2002). The management of persistent pain in older persons. Journal of American Geriatric Society, 50, S211-S212

COMMON PAIN BEHAVIORS IN COGNITIVELY IMPAIRED ELDERLY PERSONS

Facial expressions
- Slight frown; sad, frightened face
- Grimacing, wrinkled forehead, closed or tightened eyes
- Any distorted expression
- Rapid blinking

Verbalizations, vocalizations
- Sighing, moaning, groaning
- Grunting, chanting, calling out
- Noisy breathing
- Asking for help
- Verbally abusive

Body movements
- Rigid, tense body posture, guarding
- Fidgeting
- Increased pacing, rocking
- Restricted movement
- Gait or mobility changes

Changes in interpersonal interactions
- Aggressive, combative, resisting care
- Decreased social interactions
- Socially inappropriate, disruptive
- Withdrawn

Changes in activity patterns or routines
- Refusing food, appetite change
- Increase in rest periods
- Sleep, rest pattern changes
- Sudden cessation of common routines
- Increased wandering

Mental status changes
- Crying or tears
- Increased confusion
- Irritability or distress