COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

TITLE		POLICY
Pain Screening, Assessment and Management		**NUR-019**
MANUAL	EFFECTIVE DATE	REVIEW DATE
Nursing	**02/2020**	
DEPARTMENT	REFERENCE	
Nursing		

I. SCOPE

This policy applies to Mangum Regional Medical Center and all medical staff, nursing staff, agency staff, and other persons performing work for or at the Hospital for the assessment and management of pain including but not limited to the screening, routine assessment, reassessment, documentation, implementation of pharmacologic and non-pharmacologic interventions, and development of an individualized plan of care as appropriate to the patient's condition.

II. PURPOSE

Pain is a serious public health problem that has been linked to many physical and behavioral health conditions and contributes to rising health care costs and lost productivity (CDC, 2016). Pain is one of the most common reasons patients present to the Hospital for treatment.

Approximately 1 in 5 adults in the United States experience chronic pain. Chronic pain costs the U.S. between $560-$635 billion annually in medication expenses, disability programs and lost productivity. Patients presenting to the hospital for the treatment of pain have steadily risen over 46% and continue to grow. Despite the continued trend, pain continues to be undertreated resulting in oligoanalgesia. Inadequately treated pain can result in the development of co-morbidities such as anxiety, depression, immune system dysfunction, restricted mobility, poor perceived health, and a reduced quality of life.

The purpose of this policy is to optimize the prevention, assessment and management of pain for all patients by:

- Informing patient at the time of their initial evaluation that relief of pain is an important part of their care and respond quickly to reports of pain in an effort to maximize comfort.
- On initial evaluation and at regular intervals, assess for the presence, quality, and intensity of pain and use patients' self-report as the primary indicator of pain.
- Collaborate with the patient, responsible others, and healthcare providers to establish a goal for pain relief and develop and implement a plan of care to achieve that goal when possible.

- To provide the best pain management to include pharmacological and non-pharmacological methods.
- To provide pain management evidence-based guidelines and maintain individuality for each patient.

III. DEFINITIONS

A. **Acute Pain:** is characterized by sudden onset and short duration. The pathology and cause are often obvious (i.e. surgery, trauma, etc.)

B. **Chronic Pain:** is any pain that lasts longer than six months. Pain can become progressively worse and reoccur intermittently outlasting the usual healing process. The original condition may or may not have healed. Regardless, chronic pain is pain that has become independent of the underlying injury or illness that started it all.

C. **Pain:** "an unpleased sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage." Pain is characterized by several quantifiable features, including intensity, time, course, quality, impact, and personal meaning. "Pain is whatever the patient says it is, existing whenever the experiencing person says it does". (IASP, 2020, McCaffery & Pasero, 2011).

D. **Oligoanalgesia:** the inadequate treatment of pain, usually in patients who have difficulty communicating the amount of pain they are experiencing. At risk groups include but are not limited to, children, different cultures, language barriers, developmentally delayed, cognitively impaired, severe emotional stress, and mentally ill.

E. **Pain Assessment:** An assessment of pain that is performed with the report of pain presence.

F. **Comprehensive Pain Assessment:** an assessment process that includes evaluation of the origin/cause, location, duration, intensity, aggravating and alleviation factors, effects of pain, and the current pain regimen effectiveness that is performed if the initial pain screening indicates a history of persistent or current pain.

G. **Pain Intensity Level:** a pain rating reported by the patient that represents pain presence and intensity.

H. **Pain Scales:** 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.

I. **Pain Screening:** A process that includes the initial and ongoing evaluation of the presence of pain.

J. **Acceptable Pain Intensity:** the pain intensity, on a self-report pain scale, identified by the patient, at which the patient can perform necessary and desired activity. It should be appreciated that this often is a dynamic process and will vary depending upon the experience with interventions attempted.

K. **Assume Pain Present:** the result of nursing evaluation that may suggest pain or the identification of potential causes of pain (i.e. pathological causes, procedures,

interventions that typically result in pain) for the patient who is unable to provide a self-report.

L. **Opioid Withdrawal:** an acute preventable state resulting from abrupt withdrawal of opiates after prolonged or heavy use. Symptoms may include irritability, anxiety, apprehension, muscular/abdominal pain, chills, nausea, diarrhea, yawning, sweating, sneezing, rhinorrhea and insomnia.

M. **Opioid naïve:** an opioid naïve person has not recently taken enough opioids on a regular enough basis to become tolerant to the effects of an opioid.

N. **Opioid tolerant:** patients who are taking, for one week or longer, at least 60mg oral morphine/day, 25ug transdermal fentanyl/hour, 30mg oral oxycodone/day, 8mg oral hydromorphone/day, 25mg oral oxymorphone/day, 60 mg oral hydrocodone/day or an equianalgesic dose of any other opioid (as defined by the FDA, 2019).

O. **Sedation Assessment:** Assessment of Sedation Level for patients receiving medications that may result in unintended sedation.

P. **Sedation Level:** A level identified on a Sedation Scale to identify changes in the patient's alertness or arousability.

IV. POLICY

It is the policy of Mangum Regional Medical to provide excellence in patient care throughout the lifespan. The treatment of pain is inherent in the care of the patient and includes relief of the physical and psychosocial symptoms associated with untreated pain. All patients have the right to individualized pain assessment in addition to safe and effective pain management. Healthcare providers will respect the patient's right to pain management and to be informed of available and appropriate methods of pain relief along with possible positive and negative consequences. The prevention and relief of pain is contingent upon pain assessment and reassessment, pharmacological and non-pharmacological interventions, and the treatment of side effects that may be associated with analgesia.

Self-report is one of the most reliable indicators of pain presence and intensity. For patients who are unable to self-report staff will assume pain is present for conditions/procedures that are known to be painful, use an approved pain assessment tool and/or solicit information from caregivers/family. Pain screenings will be performed on admission, continue throughout hospitalization, with routine vital signs, and based on individual patient needs. A comprehensive pain assessment will be performed if the initial pain screening reveals current pain or a history of persistent/chronic pain. Pain will be reassessed after interventions to evaluate effectiveness and to recognize undesirable side effects and documented in the patient's medical record. Nursing staff will notify the provider if comfort is not achieved following pain management interventions for changes in pain characteristics, and/or with occurrence of advancing, unintended sedation.

The commitment of Mangum Regional Medical Center to prevent and treat pain is based on a body of scientific knowledge, evidence-based guidelines, and regulations from the following organizations:

- International Association for the Study of Pain (IASP)

- American Pain Society (APS)
- American Society for Pain Management (ASPM)
- American College of Emergency Physicians (ACEP)
- Emergency Nurses Association (ENA)
- American College of Occupational and Environmental Medicine (ACOEM)
- Centers for Disease Control and Prevention
- Oklahoma Emergency Department and Urgent Care Clinic Opioid Prescribing Guidelines
- Oklahoma Senate Bill 1446: Best Practice for an Act Regulating of Opioid Drugs.

The Hospital also endorses the American Nurses Association Code of Ethics for Nurses, and the American Nurses Association Position Statement on Pain Management and Control of Distressing Symptoms in Dying Patients.

V. PROCEDURE

A. **Screening**

1. Patients will be screened using one of the approved pain scales for the presence or absence of pain during ED visits and at the time of admission. Identify whether the patient is opioid tolerant.
2. For patients with symptoms suggestive of myocardial ischemia (MI) the goal is "No Pain".
3. Screening should be documented in the appropriate section of the patient's medical record.

B. **Assessment**

1. Initial Assessment of Patients in Pain
    - i. Initial assessment for patients in pain identified by the pain screening will include a comprehensive pain assessment. This assessment takes into consideration:
        - a. Pain assessment using the Hospital's approved pain scales appropriate for the patient's age, medical condition, and ability to understand.
        - b. Patient self-report of pain will be considered the "gold standard" and the most reliable information about the patient's pain.
        - c. Patient goals and expectations for pain relief.
        - d. The patient's medical condition, scope of care, treatment and services.
    - ii. The comprehensive pain assessment should include the following:
        - a. Origin/cause of pain
        - b. Pain intensity by patient self-report when possible.
        - c. Behavioral indicators or non-verbal signs of pain for patients not able to self-report using behavioral pain assessment tools appropriate to the patient's age and medical condition.

d. Pain quality and characteristics (onset, location, description, intensity), aggravating and relieving factors, previous treatment and effectiveness.
e. Impact of pain on functional ability and quality of life including activity, mood, appetite, sleep, social relationships, leisure and pleasure activities, etc.
f. Alternative methods of pain control used
g. Level of influence of pain on necessary activities

iii. Once pain is assessed, it will be classified for treatment purposes as follows:

On pain scales from zero to 10 – (zero indicating no pain)

- **Mild:** Pain level 1 to 3
- **Moderate:** Pain level 4 to 6
- **Severe:** Pain level 7 to 10

iv. Patient's acceptable level of pain can be used to guide treatment.

v. Prior to initiating opioid therapy patients will be assessed by a provider to determine if the patient can be treated with appropriate non-opioid alternatives. If the severity of the pain can be reasonably assumed to warrant their use, the patient's risk level for adverse outcomes related to opioid treatment will be determined by the responsible provider.

iii. Assessment information will be used to develop a plan of care based on the patient's clinical condition and pain management goals.

C. **Reassessment**

1. Emergency Department
   i. Patients in the ED experiencing pain will be assessed by nursing staff at a minimum every 4 hours or more frequently based on interventions, prescriber order, assessment or patient condition.
   ii. Nursing staff will perform a pain assessment using an approved pain scale after pain interventions as follows:
      a. 15 to 30 minutes after IV administration
      b. 60 minutes after oral administration
      c. 60 minutes after all non-pharmacological interventions
   iii. Reassess more frequently for patients experiencing severe, rapidly changing pain and patients exhibiting excess sedation.
   iv. Reassess with any new patient report of pain or following a pain-producing event
2. In-Patient and Swing-Bed
   i. Patients admitted to the Hospital or Swing-Bed status who are experiencing pain will be assessed by nursing staff at a minimum every shift or more frequently based on interventions, prescriber order, assessment or patient condition.
   ii. Nursing staff will perform a pain assessment using an approved pain scale after pain interventions as follows:
      a. 15 to 30 minutes after IV administration

b. 60 minutes after oral administration
c. 60 minutes after all non-pharmacological interventions

iii. Reassess more frequently for patients experiencing severe, rapidly changing pain and patients exhibiting excess sedation

iv. Reassess with any new patient report of pain or following a pain-producing event.

D. Assessment When Patient is Sleeping or Appears to be Sleeping

1. Patients who are receiving opioid analgesics are at increased risk of opioid induced respiratory depression during the first 24 hours of treatment. This can occur more frequently during 11:00 pm and 7:00 a.m. when most patients are sleeping (Jarzyna, et al; Pasero, 2009).
2. Nursing staff will consider a patient's need for sleep along with patient safety when determining whether or not to wake the patient for assessment.
3. The nurse may use their discretion to not wake the patient if the patient's respiratory rate (RR) and quality (depth and regularity) are within normal limits (WNL) for the patient.
4. If the patient appears to be sleeping:
   i. Assess the patient's respiratory status **PRIOR** to waking the patient, as arousing the patient will stimulate respirations.
   ii. Perform a comprehensive respiratory assessment that includes respiratory rate, depth, regularity and noisiness. RR should be counted for a full minute.
   iii. Compare RR, depth and quality to the patient's baseline status. **Shallow respirations, periods of apnea, and snoring require immediate attention and further evaluation.**
   iv. Call out the patient's name in a normal tone of voice.
      a. If the patient does not arouse and RR and quality are WNL for the patient, assessment/reassessment may be delayed until the patient wakes and "sleep" should be charted in the patient's medical record. Additionally, RR and quality should be charted.
      b. **If the patient's RR and quality are not WNL, the patient must immediately be stimulated/awakened to complete more thorough pain, sedation, and respiratory assessments.**
   v. RR alone is not sufficient enough to assess for respiratory depression. Assessing quality (regularity and depth) is necessary to determine if the patient is experiencing clinically significant respiratory depression. A patient may breathe at a rate of 8-10 breaths per minute and be well ventilated if the quality is regular and deep. On the other hand, a patient with a RR with shallow respirations may not be ventilating adequately.

E. **Pain Scales**

1. **Pediatrics 3 years of age/Patients unable to communicate:**

i. Use the Face, Legs, Activity, Cry, Consolability (FLACC) scale (See Attachment A)

2. **Pediatrics 3 years of age and over:**
   i. Use Wong-Baker Faces Pain Rating Scale (See Attachment B)
3. **Pediatrics over 6 years of age who understand concepts of rank & order:**
   i. Use Numeric Pain Rating Scale (See Attachment C)
4. **Adults:**
   i. Use the Numeric Pain Rating Scale
   ii. Consider options of the Wong-Baker or FLACC for adults with difficulty expressing numeric values for pain assessment.
5. **Geriatrics:**
   i. Use the Numeric Pain Rating Scale
   ii. Consider options of the Wong-Baker or Pain Assessment in Advance Dementia (PAINAD) (See Attachment D) for patients who have difficulty expressing numeric values for pain assessment.

F. **Sedation Assessment**

1. Sedation and respiratory depression occur on a continuum. Sedation always precedes opioid-induced respiratory depression.
2. The inability of the patient to stay awake to maintain a conversation is the hallmark of clinically significant sedation.
3. The POSS (Pasero Opioid-Induced Sedation Scale) (See Attachment E) will be used for patients receiving opioids for pain management in which advancing, unintended sedation may occur.
4. Assess sedation prior to and after opioid administration. Document assessment in the patient's medical record.
5. Reassess Sedation Level to evaluate a change in alertness or arousability and recognize unintended, advancing sedation:
   i. When using the POSS: if the patient is sleeping and pain has been well managed without occurrence of Sedation Levels 3 or 4, the RN may document "sleep, easy to arouse" if respirations are quiet, regular, deep and rate >10/minute and light touching of the patient's shoulder or gentle movement of the bed results in patient movement or change in position.
   ii. <u>WAKE</u> the patient and perform Pain and Sedation assessments if the respiratory rate is <10/minute or respirations are irregular, shallow, or noisy (even mild snoring) and/or the patient does not change position or demonstrate movement in response to light touching of the patient's shoulder or gentle moving of the bed.
6. If the patient is assessed to have respiratory depression or unintended sedation, collaborate with provider and pharmacist to identify other potentially sedating medications administered within at least the prior six hours.

G. **<u>Plan of Care</u>**

1. Patients who have pain will have their pain managed based on an individualized plan of care that is evidence-based considering the patient's clinical condition, past medical history, and pain management acceptable level of pain. The patient and/or their representative(s) should be actively involved in developing the plan of care including establishing pain management goals and strategies. This plan should be an interdisciplinary approach and include:
    i. Input from the patient and/or their representative(s);
    ii. The patient's pain intensity goal;
    iii. Development of realistic, measurable goals for the degree, duration, and reduction of pain including functional goals.
    iv. Discussion of criteria used to evaluate treatment process (for example, pain relief and improved physical and psychosocial function)
    v. The pharmacologic/non-pharmacologic interventions appropriate to the patient's condition and age, such as positioning, physical therapy, cold/heat applications, behavioral therapies, diversional activities, relaxation and imagery techniques, etc.
2. The Plan of Care should be documented in the appropriate section of the patient's medical record and revised as indicated by the patient's condition and response to treatment.
3. Anticipated Pain: patients who need to be treated for pain at a zero-pain level before participating in potentially pain provoking activities such as prior to a dressing change, procedure, or PT/Rehab should have a specific order to support the treatment for anticipated pain.

H. **Patient Education**

1. Explain that pain can be managed but not always completely relieved, the importance of reporting pain and the benefits of safe pain control.
2. Explain the importance of preventing rather than chasing pain in effective pain management. Hospital staff will teach patients and/or patient representatives to report pain as soon as it is experienced.
3. Describe to the patient and/or patient representative atypical manifestations of pain such as:
    i. Changes in function and gait;
    ii. Withdrawn or agitated behavior;
    iii. Increased behavior.
4. Teach patients and/or patient representatives to use the appropriate pain scale. Once the appropriate pain scale has been determined, continue to use that scale.
5. Teach patients and/or patient representative about the safe use of opioids when prescribed; including person risk factors for adverse events related to opioid treatment.
6. Explain common side effects of pain management medications (constipation, sedation, and nausea).
7. Teach non-pharmacological interventions and inform patient and/or patient representative that these interventions complement the plan of care.

8. Educate patients and/or patient representatives on discharge plans related to pain management including:
    i. Pain management Plan of Care
    ii. Side effects of pain management treatment
    iii. Activities of daily living, including the home environment, that might exacerbate pain or reduce the effectiveness of the pain management Plan of Care; as well as strategies to address these issues.
    iv. Safe use, storage, and disposal of opioids when prescribed.
9. Patients and/or patient representatives will also be educated regarding:
    i. Their rights to have their pain recognized and managed as part of their treatment.
    ii. Their role and participation in the overall treatment plan and management of their pain, including identifying cultural, spiritual, or personal beliefs, which should be taken into consideration in formulating an individualized pain management plan.
    iii. Other education as identified by assessment and reassessment process.
10. Education and demonstration of understanding will be documented in the appropriate section of the patient's medical record.

I. **Discharge/Follow-Up Care**

1. The discharge process provides for continuing care by referral for treatment based on the patient's assessed needs at discharge.
2. The Pain Management Plan of Care will be communicated to the next care provider, when applicable (i.e. patient, family, skilled nursing facility, home care, etc.).
3. This plan will identify the patient' plan level, the patient's goal of treatment, the scale utilized, location of pain, pharmacological interventions including last dose given and non-pharmacological strategies.
4. The plan will be documented in the discharge summary or appropriate portion of the patient's medical record so that it may be accessed by providers as necessary.
5. Discharge instructions will be provided to the patient and/or patient representative that will include but not limited to:
    i. Pain management
    ii. Symptoms which require physician notification or prompt attention by a health care provider.
    iv. Referral for treatment (if indicated)

VI. PAIN MANAGEMENT INTERVENTIONS

A. Nursing stall will administer scheduled medications "Around-the-Clock" (ATC), at the prescribed interval, to achieve and facilitate the patient's comfort. Nursing staff will collaborate with the provider to prevent nausea or constipation related to analgesics.

B. Nursing staff will collaborate with the patient to administer PRN pain medications as required to achieve the patient's desired comfort level.
C. As prescribed for the patient, nursing staff may use clinical judgement to:
    1. Determine the analgesic and dose to administer.
    2. Evaluate the patient's previous experience with the procedure, intervention or activity and response to the analgesic.
    3. Pre-emptively medicate prior to procedure/intervention or activity.
D. Collaborate with patient to identify non-pharmacologic comfort interventions including integrative therapies, positioning, music, heat/cold application and distraction.

VII. OPIOID PRESCRIBING

A. Providers will consider non-pharmacological therapies and/or non-opioid pain medications prior to prescribing opioids for the treatment of pain.
    1. Providers will consider prescribing opioids only if the expected benefits for both pain and function are anticipated to outweigh risks to the patient.
    2. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.
B. Opioids should only be used for the treatment of acute pain when the severity of pain warrants the prescribing of opioids.
C. When administering or prescribing opioids, the provider should start with the lowest possible effective dose for the management of the patient's pain.
D. When prescribing opioids for pain, the provider should prescribe no more than a short course, except in special circumstances.
    1. ED: no more than a three-day supply
    2. Inpatient: no more than a seven-day supply
E. Prior to prescribing opioids providers should query the Oklahoma Prescription Monitoring Program (PMP) for patients presenting with pain. In circumstances where a patient's pain is resulting from an objectively diagnosed disease process injury, a provider may prudently opt not to review the Oklahoma PMP.
F. For exacerbations of chronic pain, the provider should attempt to notify the patient's primary opioid prescriber that the patient is under evaluation in the ED. If the provider deems it necessary to prescribe opioids (i.e. new, acute injury or objectively diagnosed disease process/injury), Oklahoma PMP data should be reviewed, and only enough pills prescribed to last until the office of the patient's primary opioid prescriber opens.
G. Patients receiving opioid prescriptions at the time of discharge will receive information on the risk of overdose and addiction, as well as safe storage and proper disposal of unused medications.

VIII. QUALITY MONITORING

Hospital leadership including but not limited to, the Nursing Department Director are responsible for ensuring that all individuals adhere to the requirements of this policy, procedures are

implemented and followed at the Hospital and instances of non-compliance with the policy are reported to the Chief Clinical Officer and an incident report completed.

All incident reports will be forwarded to the Quality Risk Manager and reported to the QAPI, MEC, and Governing Board.

IX. REFERENCES

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VIII. ATTACHMENTS

Attachment A: Face, Legs, Activity, Cry, Consolability (FLACC) Scale
Attachment B: Wong-Baker Faces Pain Rating Scale
Attachment C: Numeric Pain Rating Scale
Attachment D: Pain Assessment in Advanced Dementia Scale (PAINAD)
Attachment E: Pasero Opioid-Induced Sedation Scale (POSS)