I. PURPOSE:

To provide guidelines to facilitate individualized, effective pain management, patient comfort/function, optimal outcomes, and patient/family satisfaction.

II. DEFINITIONS:

A. Acceptable Pain Intensity – The pain intensity, on a self-report pain scale, identified by the patient, at which the patient is able to perform necessary and desired activity. It should be appreciated that this is often a dynamic process and will vary depending upon the experience with interventions attempted, post-procedural movement, etc.

B. Assume Pain Present: The result of RN evaluation that may suggest pain or the identification of potential causes of pain (e.g. pathological conditions, procedures, interventions that typically result in pain) for the patient who is unable to provide a self-report.

C. Assume Relief: The result of RN reassessment of behaviors that decrease or resolve, or clinical judgment as a result of patient’s previous experience with pain and response to analgesics, to evaluate intervention effectiveness for the patient who is unable to provide a self-report.

D. Opioids: opium derivatives (e.g. morphine) or synthetic alternatives (e.g. fentanyl)

E. 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 pains, chills, nausea, diarrhea, yawning, sweating, sneezing, rhinorrhea and insomnia.

F. 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.
G. **Opioid tolerant:** Patients who are taking, for 1 week or longer, at least 60 mg oral morphine/day, 25 µg transdermal fentanyl/hour; 30 mg oral oxycodone/day, 8 mg oral hydromorphone/day, 25 mg oral oxymorphone/day, or an equianalgesic dose of any other opioid (as defined by the FDA).

H. **Pain:** An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Pain is whatever the individual experiencing it says it is, existing whenever the individual says it exists.

I. **Pain Assessment** – An assessment of pain that is performed with the report of pain presence.

J. **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 regime effectiveness that is performed if the initial pain screening indicates a history of persistent or current pain.

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

L. **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.

M. **Pain Screening** – A process that includes the initial and ongoing evaluation of the presence of pain at a frequency as determined by individual patient need.

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

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

**III. TEXT:**

A. All patients have the right to individualized, pain assessment in addition to safe and effective pain management.

B. Self-report is the most reliable indicator of pain presence and intensity. In patients who cannot self-report use one or more of the following to assess pain:
   1. Assume pain present for conditions or procedures that are known to be painful
   2. Use an approved pain assessment tool (see addendum)
   3. Solicit information from caregivers/family

C. Pain Screening will be conducted on admission and continue throughout hospitalization with routine vital signs as determined by unit specific guidelines of care and individual patient need.

D. A Comprehensive Pain Assessment will be performed if the initial Pain Screening reveals current pain or a history of persistent pain.
E. Pain assessment will be performed if the ongoing pain screening indicates pain.

F. Sedation assessment will be performed after the administration of opioids to identify the patient’s level of alertness and arousability. In the behavioral health and post-procedural settings, a Sedation Assessment will be performed PRIOR to and after the administration of opioids to identify the patient’s level of alertness and arousability.

G. Pain will be reassessed after interventions to evaluate effectiveness and to recognize undesirable side effects and documented in the medical record.

H. The provider will be notified if comfort is not achieved following pain management interventions, for changes in pain characteristics, and/or with occurrence of advancing, unintended sedation.

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. Patient and family will be educated about post-discharge pain management plans.

J. An individualized Pain Management Plan will be developed in collaborations with the patient/family and members of the interdisciplinary team.

K. PRN medication may be administered to facilitate effective pain management for patients with constant pain or in anticipation of painful activities/procedures.

L. Document all assessments, education and communications regarding undesired side effects or ineffectiveness of pain management plan in the medical record.

IV. PROCEDURE:

<table>
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<tr>
<th>RESPONSIBILITY</th>
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<tr>
<td>A. RN</td>
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<td>B. RN</td>
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<th>RESPONSIBILITY</th>
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<tbody>
<tr>
<td>A. RN</td>
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</tbody>
</table>

A. Perform an Initial Pain Screening on admission

1. Determine the presence of pain or history of persistent pain. Identify whether the patient is opioid tolerant.

2. For patients with symptoms suggestive of myocardial ischemia the goal is “No Pain.”

B. Perform a comprehensive Pain Assessment if the initial Pain Screening indicates chronic pain. Components may include:

1. Origin/cause of pain
2. Location of chronic pain
3. Duration of chronic pain
4. Pain intensity (acceptable, currently, at worst, at best)
TITLE: PATIENT SCREENING, ASSESSMENT AND MANAGEMENT OF PAIN

SUBJECT: Patient Care

KEYWORD(S): Pain Assessment, comprehensive pain assessment, comfort, comfort-function goal, initial screening, sedation

IV. PROCEDURE:

5. Aggravating factors
6. Alleviating factors
7. Effects of pain
8. Whether current pain regime is effective

C. Perform Pain Screening as determined by individual patient need and as minimum with:
   1. Routine vital signs per unit specific guidelines of care
   2. Interventions or procedures likely to result in pain

D. Perform Pain Assessment with any report of pain and as determined by individual patient clinical condition/need.
   Assessment Components may include:
   1. For patients able to provide a self-report:
      a. Location
      b. Pain intensity
      c. Acceptable pain intensity
      d. Time pattern
      e. Onset
      f. Duration
      g. Quality
      h. Radiation Characteristics
   2. For patients unable to provide a self-report:
      a. Patient Condition: If the patient has a pathological condition, tissue injury, or has undergone a procedure/intervention that typically results in pain, the RN may “Assume Pain Present” (APP) and implement pain management interventions, considering level of sedation.
      b. Behaviors that may suggest pain: If behavioral indicators are present using a tool to assess pain in non-verbal patients. The Critical Care Pain Observation Tool (CPOT) is used in the ICU setting and the Pain
IV. PROCEDURE:

Assessment in Advanced Dementia (PAINAD) scale is used outside of the ICU for non-verbal patients who cannot self-report. Using the score, the RN may “Assume Pain Present” (APP) and implement pain management interventions.

E. Assess Sedation Level after the administration of opioids:

1. Use the POSS (Pasero Opioid-Induced Sedation Scale), for patients receiving opioids for pain management in which advancing, unintended sedation may occur.

   a. If the patient is frequently drowsy, yet arousable, and drifts off to sleep during conversation, stop the continuous infusion/basal (if applicable), notify the physician and recommend a decrease of the dose by 25-50% and adding an opioid–sparing analgesic. (Sedation score of 3). For prn IVP and po opioids consider holding dose until sedation score is less than 3.

   b. If the patient is somnolent with minimal or no response to physical stimulation, do not administer the opioid, stop continuous infusion/basal medication, initiate Rapid Response Team or Code Blue, and notify physician. When opioid is restarted, recommend decreasing the dose by 25-50%, not restarting the continuous infusion/basal and adding an opioid–sparing analgesic (sedation score of 4). For prn IVP and po opioids consider holding dose until sedation score is less than 3.

   c. Exception: If comfort is the goal of care for patients at the end of life, sedation may be an acceptable side effect of analgesics and dosing would not necessarily be decreased.

2. Use the RASS (Richmond- Agitation- Sedation Scale) for patients receiving goal directed sedation to achieve a change in behavior, for agitation or severe anxiety, to facilitate tolerance of the hospital environment, or synchrony with mechanical ventilation and who could also be receiving opioids for pain management.

3. If patient is assessed to have respiratory depression or unintended sedation, collaborate with physician and pharmacist to identify other potentially sedating medications administered within at least the prior six hours.

F. Implement Pain Management Interventions to achieve patient comfort

1. Administer scheduled medications “Around-the-Clock (ATC), at the
IV. **PROCEDURE:**

prescribed interval, to achieve and facilitate comfort. Collaborate with physician to prevent nausea or constipation related to analgesics.

2. Collaborate with patient to administer PRN pain medications as required to achieve desired comfort level.

3. As prescribed for the patient, the RN may use clinical judgment to:
   a. Determine the analgesic and dose to administer,
   b. Evaluate the patient’s previous experience with the procedure, intervention or activity and response to the analgesic.
   c. Pre-emptively medicate prior to procedure/interventions or activity

4. Collaborate with patient to identify non-pharmacologic comfort interventions including integrative therapies, positioning, music, heat/cold application and distraction.

G. Reassess the patient within 60 minutes to evaluate the effectiveness of pain management interventions.

1. Compare post-intervention pain level to Acceptable Level of Pain to determine intervention effectiveness and/or additional interventions for patients able to provide a self-report

2. For patients unable to provide a self-report, the RN should reassess the patient using the PAINAD scale and document “Assumed Relief” if behavioral indicators decrease or resolve

H. Reassess Sedation Level to evaluate a change in alertness or arousability and recognize unintended, advancing sedation.

1. 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 greater than 10/minute and light touching of the patient’s shoulder or gentle movement of the bed results in patient movement or change in position.

2. **Wake** the patient and perform a Pain and Sedation Assessment if the respiratory rate is less than 10 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.
IV. PROCEDURE:

I. Develop an individualized pain management plan in collaboration with the patient/family and members of the interdisciplinary team and document in the Interdisciplinary Plan of Care.

J. Notify the provider if interventions are ineffective and pain level is unacceptable to patient.

K. Provide patient/family education regarding pain management throughout hospitalization as determined by individual patient need. Education may include:
   1. Risks associated with use of opioids and non-opiate analgesics.
   2. Pain Assessment Scales.
   4. Acceptable pain intensity goal.
   5. The need to establish a schedule of pain medication administration during usual hours of rest.
   6. Importance of the need to communicate pain so that assessment may be performed and interventions implemented.
   7. Relationship between effective pain management and healing
   8. Individualized Pain Management Plan including management of constipation.

L. Provide Discharge instructions on:
   1. Pain Management.
   2. Symptoms which require physician notification or prompt attention by a healthcare provider.

V. REFERENCES:

A. Health & Safety Code §1254.7 (AB 791)
D. AHCPR Practice Guideline Number 9, Management of Cancer Pain, p. 230.
TITLE: PATIENT SCREENING, ASSESSMENT AND MANAGEMENT OF PAIN

SUBJECT: Patient Care

KEYWORD(S): Pain Assessment, comprehensive pain assessment, comfort, comfort-function goal, initial screening, sedation


VI. CROSS REFERENCES: None

VII. ATTACHMENTS:
A. Pain Assessment In Advanced Dementia (PAINAD) Scale
B. The CPOT – Critical Care Pain Observation Tool
C. Pictorial Scale
D. Numeric Scale

VIII. APPROVALS:
A. Pain Assessment Taskforce – 8/23/01, 9/7/01, 12/07/01, 1/8/02
B. System Interdisciplinary Pain Management & Improvement Committee – 1/11/02, 6/03, 1/04 (defunct 2013)
C. Pharmacy & Therapeutics/Treatment & Surveillance
   a. Sharp Memorial Hospitals – 2/5/02, 8/03, 4/09; 12/13
   b. Sharp Mary Birch Hospital for Women – 4/02, 8/03, 4/09
   c. SGH – 4/02, 10/03, 3/09
   d. Sharp Coronado Hospital – 3/02, 9/03, 4/09; 11/13
   e. Sharp Chula Vista Medical Center – 3/02, 8/03, 4/09; 11/13
   f. Sharp Mesa Vista – 3/02, 7/03, 12/03, 4/09
   g. Sharp McDonald Center – 2/02, 12/03
   h. BPCC SNF QA Committee – 1/02, 8/03
   i. SCOR SNF QA Committee – 4/02, 9/03
   j. SGH TCU QI Committee – 5/01, 11/03
D. General Nursing Policy & Procedure Committee – 01/02; 01/12; 12/13
E. System Policy & Procedure Steering Committee – 02/02
F. Sharp HospiceCare Pain Management Task Force - 04/02 (n/a 2013)
G. Sharp HospiceCare Core IDT - 04/02 (n/a 2013)
H. Sharp Clinical Coordinator, Pharmacy – 2/06
I. SMV Medical Executive Committee – 06/06; 02/10; 01/14
J. Pharmacy Steering Committee – 11/09

IX. REPLACES:
X. HISTORY: System # 30327.99; originally dtd 06/02
   Reviewed/Revised: 10/03; 03/04; 02/06-added Attachment D; 07/09; 01/12;
| TITLE: | PATIENT SCREENING, ASSESSMENT AND MANAGEMENT OF PAIN |
| SUBJECT: | Patient Care |
| KEYWORD(S): | Pain Assessment, comprehensive pain assessment, comfort, comfort-function goal, initial screening, sedation |
Pain and Sedation Assessment Tools

PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD) SCALE*

*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:

<table>
<thead>
<tr>
<th>Items</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low level speech with negative or disapproving quality.</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying.</td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or inexpressive</td>
<td>Sad, frightened or frown</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td>Body language</td>
<td>Relaxed</td>
<td>Tense, distressed pacing or fidgeting</td>
<td>Rigid, fists clenched, knees pulled up. Pulling or pushing away. Striking out.</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract or reassure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>Total Score</strong></td>
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</table>

MILD pain = total score of 1-3, MODERATE pain = total score of 4-6, SEVERE pain = total score of 7 or above
The CPOT – Critical Care Pain Observation Tool

*Use for ICU patients who are unable to self-report*

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Facial Expression</strong></td>
<td></td>
<td></td>
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<tr>
<td>Relaxed, Neutral</td>
<td>0</td>
<td>No muscle tension observed</td>
</tr>
<tr>
<td>Tense</td>
<td>1</td>
<td>Presence of frowning, brow lowering, orbit tightening, and levator contraction (opening eyes, tearing during nociceptive procedure)</td>
</tr>
<tr>
<td>Grimacing</td>
<td>2</td>
<td>All of the above facial movements plus eyelid tightly closed (patient may present with mouth open or biting ETT)</td>
</tr>
<tr>
<td><strong>Body Movements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence of movements</td>
<td>0</td>
<td>Does not move at all (does not necessarily mean absence of pain) or normal position (movements not aimed toward pain site)</td>
</tr>
<tr>
<td>Protection</td>
<td>1</td>
<td>Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements</td>
</tr>
<tr>
<td>Restlessness</td>
<td>2</td>
<td>Pulling tube, attempting to sit up, moving limbs/ thrashing, not following commands, striking at staff, trying to climb out of bed</td>
</tr>
<tr>
<td><strong>Compliance with the ventilator</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intubated patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tolerating ventilator or movement</td>
<td>0</td>
<td>Alarms not activated, easy ventilation</td>
</tr>
<tr>
<td>Coughing but tolerating</td>
<td>1</td>
<td>Coughing, alarms activated, but stop spontaneously</td>
</tr>
<tr>
<td>Fighting ventilator</td>
<td>2</td>
<td>Asynchrony, blocking ventilation, alarms frequently activated</td>
</tr>
<tr>
<td><strong>Vocalization</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extubated patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talking in normal tone or no sound</td>
<td>0</td>
<td>Talking in normal tone or no sound</td>
</tr>
<tr>
<td>Sighing, moaning</td>
<td>1</td>
<td>Sighing, moaning</td>
</tr>
<tr>
<td>Crying out, sobbing</td>
<td>2</td>
<td>Crying out, sobbing</td>
</tr>
<tr>
<td>Indicator</td>
<td>Score</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Muscle Tension</td>
<td>Relaxed</td>
<td>0 No resistance to passive movements</td>
</tr>
<tr>
<td>Evaluate by passive flexion and extension of upper limbs when patient at rest</td>
<td>Tense, rigid</td>
<td>1 Resistance to passive movements</td>
</tr>
<tr>
<td></td>
<td>Very tense, rigid</td>
<td>2 Strong resistance to passive movements, inability to complete them</td>
</tr>
</tbody>
</table>

Score: __ Target Pain 0-1

*Gelinas, Fillion, Puntillo, Viens, and Fortier, 2006*
Pictorial Scale

*Use for children who are able to self-report*

**Are you in pain?**

- 0: very happy, I do not hurt at all
- 1-2: hurts just a little bit
- 3-4: hurts a little more
- 5-6: hurts even more
- 7-8: hurts a whole lot
- 9-10: hurts as much as you can imagine, you don't have to be crying to feel this bad

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**Sedation Scales**

**Richmond Agitation Sedation Scale (RASS)**

- -6: combative/molests/can't control
- -5: yells/agitated/full tubular aggressive
- -4: Agitated/amiss movement/fights vent
- -3: Restless/Aroused but not aggressive
- -2: Alert and calm
- -1: Eyes open to voice/holds eye contact >10sec
- 0: Eyes open to voice/holds eye contact <10sec
- 1: Any movement to voice/No eye contact
- 2: Movement to physical stimulation only
- 3: Unarousable to voice or physical stim

**Pain Assessment**

**Pain Assessment**

**Use to assess sedation and agitation during or post-procedure, and for ventilated patients**

**Pasero Opioid-Induced Sedation Scale (POSS)**

- 0 = Sleepy, Easy to Arouse
- 1 = Awake and alert
- 2 = Slightly drowsy, easily aroused
- 3 = Frequently drowsy, arousable, drifts off to sleep during conversation
- 4 = Sedated, minimal or no response to verbal or physical stimulation

**RASS Score**

**POSS Score**
Numeric Scale

*Use for patients able to self-report*

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<th>0</th>
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<th>4</th>
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<th>7</th>
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<td></td>
<td></td>
<td>No pain</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Worst pain</td>
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