

PAIN MANAGEMENT

POLICY: All patients should be assessed for pain factors and history, initially upon presentation to the facility, then subsequently thereafter according to assessment finding. All patients should receive treatment for pain relief as warranted and monitored for effectiveness.

ASSESSMENT/REASSESSMENT:

- 1.0 The R.N. should assess the patient for pain factors and history upon presentation during the initial assessment and document findings.
- 2.0 When pain is identified, either acute or chronic, a more comprehensive assessment should be performed and pain management implemented in the patient's multidisciplinary plan of care.
- 3.0 Pain intensity should be measured with appropriate measurement tool.
 - .1 A pain scale of 0 – 10 (0 = no pain, 10 = worst pain) should be utilized for adult patient. * If they cannot understand or are unwilling to use the scale the following tools may be utilized.
 - .2 Wong Baker FACES pain scale (smile-frown).
 - .3 Behaviors and/or symptoms should be evaluated regarding presence of pain on patients who are cognitively impaired or unable to communicate.
- 4.0 Description(s) of pain, noting patients personal words, should be documented including:
 - .1 Location of pain area(s)
 - .2 Quality, and/or patterns of radiation.
 - .3 Onset, duration and/or precipitating factors
 - .4 Pain management history and effectiveness:
 - .4.1 Consider personal values, beliefs and culture.
 - .4.2 Evaluate myths about opioid analgesics regarding addiction, physical dependence and/or tolerance to this type of medication.
 - .4.3 Evaluate the type of communication the patient utilizes to report pain. (verbal or behavioral).
 - .4.4 Utilize family input if appropriate. * The patients **personal interview should always be considered first if able to communicate and not cognitively impaired.** *
 - .5 Effects of pain on daily life – level of impact
 - .6 Patients pain goal. (What level is acceptable?)
 - .7 Patient's knowledge level of disease process(s) related to pain, medications and/or alternative treatment prescribed.
- 5.0 Either a R.N. or a L.V.N. may perform the reassessment utilizing the Pain Management Flow sheet for documentation.

- 1.0 Reassessments should be performed according to type of pain and level of effectiveness regarding medication and or treatment utilized.
- The following standards should be flexible according to individual patient responses to medication and/or treatment.
- .1 Cardiac pain should be reassessed every five – (5) minutes whenever the treatment prescribed warrants the use of nitrates and/or intravenous medication, ordered on five – (5) minutes intervals, to manage pain.
- .2 Acute/chronic pain should be reassessed thirty – (30) minutes to one (1) hour after medication(s) and/or alternative treatment(s) administered.
- 2.0 The physician should be notified when **any** type of prescribed pain management regimen is not effective in relieving patient’s pain.

INTERVENTIONS:

- 1.0 Analgesics and treatments should be administered as prescribed.
- 1.0 Nurses should routinely; every 4 hours while the patient is awake, evaluate the patient for pain management.
- 2.0 PRN medications/treatments should be offered when the patients personal pain goal is exceeded or their pain is greater than four (4) on the pain scale.
- 3.0 Analgesics ordered should be administered by the least painful route, if possible.
- 4.0 Reassess the effectiveness according to the type of pain and the treatment rendered.
- 5.0 Non-pharmacological interventions should be offered and taught:
- .1 Heat/cold packs as prescribed
 - .2 Repositioning, turning and/or ambulating as tolerated.
 - .3 Relaxation exercises i.e.: deep breathing, rhythmic breathing and/or “peaceful past” memory meditation.
 - .4 Distraction
- 6.0 The physician should be notified for any type of pain management, which is not effective.

AGE RELATED CONSIDERATIONS:

- 1.0 Geriatric:
- .1 Drug metabolism is slower in the elderly due to decreased hepatic and renal function.
 - .2 At greater risk for drug-drug and drug-disease interactions due to multiple diseases and medications.
 - .3 Barriers to pain assessment include cognitive, visual, hearing and motor impairments.
 - .4 At risk for over and/or under treatment of analgesics:
 - .4.1 NSAIDS increase the risk of renal toxicity
 - .4.2 Opioids have a higher peak and last longer leading to prolonged sedation and respiratory depression.

- 1.0 Pediatric:
 - .1 More frequent assessment/reassessment and intervention are required due to a higher metabolic rate.
 - .2 Emotional distress accentuates pain.
 - .3 Children in pain may regress.
 - .4 Observation of behavior and self-report are the primary methods for assessment.

PATIENT EDUCATION:

- 1.0 Patient and/or family teaching should begin after initial pain assessment with identified knowledge deficit areas.
- 2.0 The Patient Education Record should reflect the type of teaching performed and patient/family response.
- 3.0 The Care Plan should reflect knowledge deficit areas and evaluated once a day for progress toward stated goals.
- 4.0 The Physician should be notified for multiple, different interventions that are not effective, and/or patient/family is non-compliant.

STAFF EDUCATION:

- 1.0 Direct care employees should receive education/training regarding pain assessment and management initially during new employee hospital orientation then thereafter annually through hospital orientation.
- 2.0 After receiving education/training the employee should be able to:
 - .1 Perform appropriate pain assessment and reassessments
 - .2 Render appropriate pain management regimens through multidisciplinary efforts.
 - .3 Teach patient/family appropriate pain management on individualized basis.

*Addendum's to this policy may be located in specialized areas i.e.: ACC, ER, OR, WCC, etc.