Pain management

Pain management

Pain assessment

In standard **PC.8.10** The Joint Commission requires hospitals to assess and reassess the patient's pain. Once pain is identified, treat it appropriately based on the patient's condition and plan of care. The patient's pain must be assessed at the patient's point of entry, which may include the following locations:

- Emergency department
- Ambulatory surgery center
- Nursing unit
- Outpatient clinics
  - Rehab unit
  - Physician or ambulatory clinics surveyed by the The Joint Commission under the hospital standards

  (*Note: Other standard manuals may apply; however, this text focuses only on the hospital standards manual.*)

Population-related assessments

There are several components involved in assessing the patient's pain. First, the assessment must be appropriate to the patient's age and must accommodate any special circumstances, such as patients who are deaf, mute, or non-English speaking. Also remember that neonatal, infant, pediatric, and adult patients have different ways of expressing pain. The caregiver assessing the pain must be competent and knowledgeable about these age and special-needs populations.

Figure 1

Pain Rating Scale (Adult and Pediatric)

PREMATURE INFANT PAIN PROFILE (PIPP)

Process	Indicator	0	1	2	3	Score
Chart	Gestational age (PCA) at time of observation	36 weeks or more	32 weeks to 35 weeks, 6 days	28 weeks to 31 weeks, 6 days	Less than 28 weeks	
Observe infant 15 sec.	Behavioral state	Quiet/sleep Eyes closed No facial movements	Active/sleep Eyes closed Facial movements	Quiet/awake Eyes open No facial movements	Active/awake Eyes open Facial movements Crying (with eyes open or closed)	
Observe infant 30 seconds	Heart rate max _____	0–4 beats/minute increase	5–14 beats/ minute increase	15–24 beats/ minute increase	25 beats/ minute increase	
	Oxygen saturation Min. _____	0%–2.4% decrease	2.5%–4.9% decrease	5%–7.4% decrease	7.5% or more decrease	
	Brow Bulge	Non 0%–9% of time	Minimum 10–39% of time	Moderate 40–69% of time	Maximum 70% of time or more	
	Eye squeeze	None 0%–9% of time	Minimum 10–39% of time	Moderate 40–69% of time	Maximum 70% of time or more	
	Nasolabial furrow	None 0%–9% of time	Minimum 10–39% of time	Moderate 40–69% of time	Maximum 70% of time or more	
					Total	

Scoring method for the PIPP

- Familiarize yourself with each indicator and how it is to be scored.
- Score gestational age from the chart before you begin.
- Score behavioral state by observing the infant for 15 seconds.
- Assess baseline heart rate and oxygen saturation (refer to flowsheet or monitor trending).
- Observe infant for 30 seconds. You will have to look back and forth from the assessment tool to the baby's face. Score physiologic and facial action seen during that time.
- Calculate the final score.

Interpretation of score

- Each indicator is evaluated on a 4-point scale for a possible score of 21 for infants of lesser gestational ages and a total score of 18 for infants of greater gestational age.
- For all age groups:
- Total score of 6 or less generally indicates minimal or no pain.
- Total score of 7–12 generally indicates minimal to moderate pain.
- Total score greater than 12 indicates moderate to severe pain.

Source: Stevens, B., Johnston, C.C, Petryshen, P et al. 1996 "Premature infant pain profile: Development and initial validation" Clinical Journal of Pain 12:13–22. Reprinted with permission.

Figure 1

Pain Rating Scale (Adult and Pediatric) (cont.)

Pain education for patients

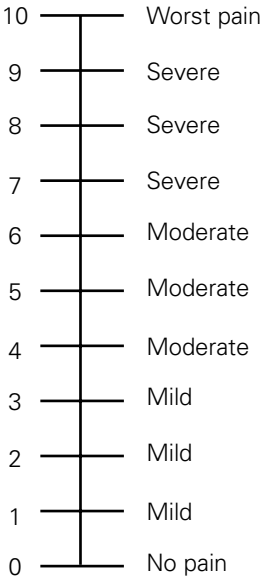
Pain is different for each person. What you think is painful may not be painful to someone else. Pain is whatever you say it is! But even the slightest pain can keep you from doing day-to-day activities. We want you to be as active as you want to be. Our goal is to control your pain.

We want you to talk to us about your pain. This helps us learn what may be causing your pain and how best to treat it. We want to treat your pain before it becomes too severe.

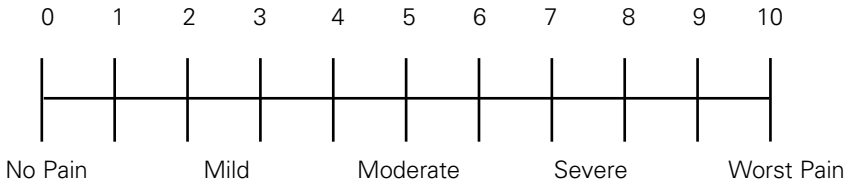
If you are an adult, we will ask you to rate your pain on a scale from 0 to 10. For pediatric patients, we use the faces scale to rate pain. By using these scales, we can better understand and treat your pain. If you are unable to tell us what your pain is, we have other ways of observing your pain.

Adult pain scale

Vertical scale:

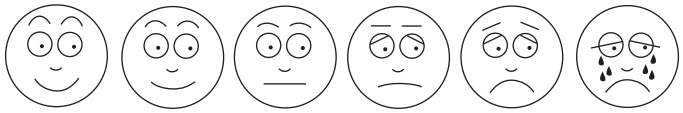


Horizontal scale:



Pediatric Pain Scale

Which face shows how much hurt you have right now?



0 No Hurt
1 Hurts Little Bit
2 Hurts Little More
3 Hurts Even More
4 Hurts Whole Lot
5 Hurts Worst

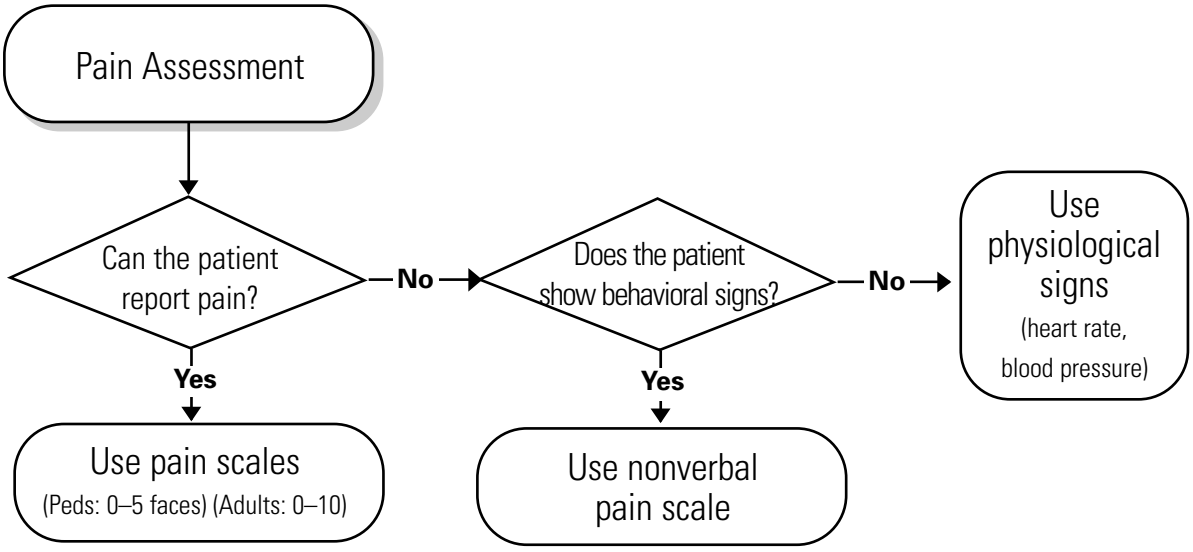
Wong-Baker Faces Scale

We often use medications as well as other treatments to control your pain. Please talk to your doctors or nurses about any concerns you may have about your pain management and/or medications. Remember, our goal is to control your pain.

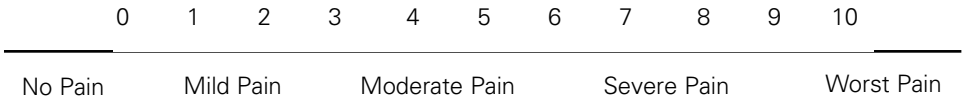
Figure 1

Pain Rating Scale (Adult and Pediatric) (cont.)

Pain assessment techniques (nursing reference)

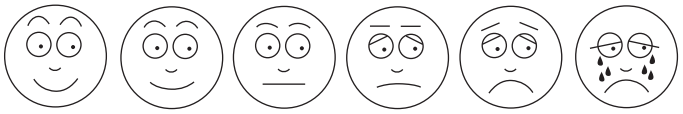


Adult pain scale



Pediatric pain scale (Wong-Baker Faces)

Which face shows how much hurt you have right now?



0 No Hurt | 1 Hurts Little Bit | 2 Hurts Little More | 3 Hurts Even More | 4 Hurts Whole Lot | 5 Hurts Worst

Nonverbal pain scale

Pain level	Patient behaviors
None (0)	Relaxed, calm expression, moves easily
Mild (1–3)	Stressed, tense expression, occasional grimace, frown, able to comfort
Moderate (4–6)	Guarded movement, grimacing, squirming, more reassurance to comfort
Severe (7–9)	Moaning, restless, rigid movement, difficult to comfort
Worst pain (10)	Crying out, unable to comfort

Figure 1

Pain Rating Scale (Adult and Pediatric) (cont.)

FLACC scale (Face, legs, activity, cry, consolability) (to be used for infants and non-verbal children)

Face	0 No particular expression, or smile	1 Occasional grimace or frown, withdrawn, disinterested	2 Frequent to constant frown, clenched jaw, quivering chin
Legs	0 Normal position or relaxed	1 Uneasy, restless, tense	2 Kicking or legs drawn up
Activity	0 Lying quietly normal position moves easily	1 Squirming shifting back/ forth tense	2 Arched, rigid, or jerking
Cry	0 No cry (awake or asleep)	1 Moans or whimpers occasional complaint	2 Crying steadily screams or sobs frequent complaints
Consolability	0 Content relaxed	1 Reassured by occasional touching, hugging, or "talking to" distractible	2 Difficult to console or comfort

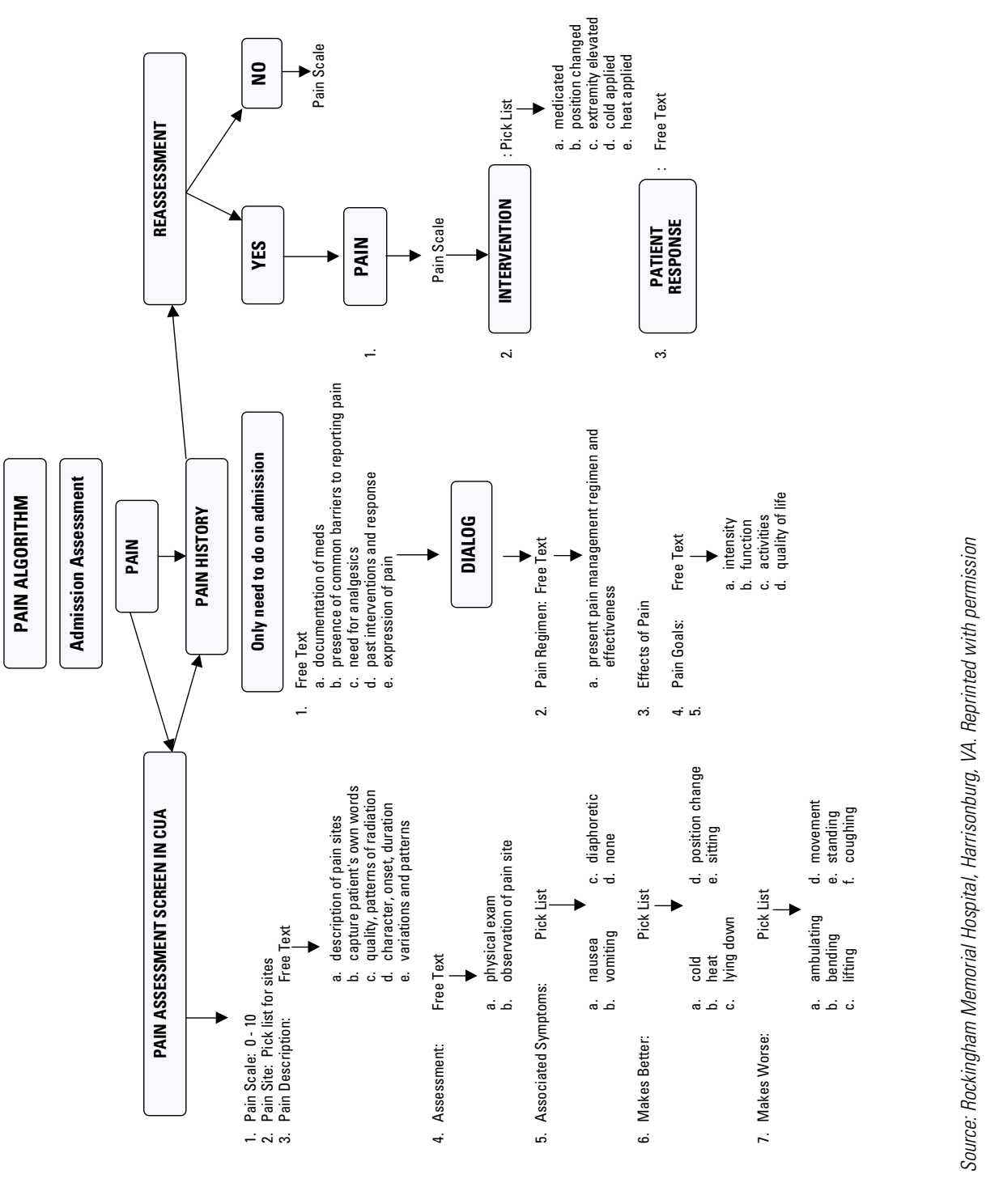
The **FLACC** is a behavior pain assessment scale for use in non-verbal patients unable to provide reports of pain.

Instructions:

1. Rate patient in each of the five measurement categories
2. Add together
3. Document total pain score

Figure 1

Pain Rating Scale (Adult and Pediatric) (cont.)



Source: Rockingham Memorial Hospital, Harrisonburg, VA. Reprinted with permission

As shown in these pain scales, the intensity of the pain is rated differently for different populations:

- Scale of 0–10 as a numeric pain rating scale.
- Wong-Baker FACES pain-rating scale.
- FLACC score for infants—Face, Leg Activity, Cry, Consolability. Each is rated numerically, and they are added together for a score.
- NIPS—Neonatal/Infant Pain Scale. Like the FLACC score, it measures facial expression, cry, breathing patterns, arms, legs, and state of arousal. Also, PIPP—Premature Infant Pain Profile.

Remember to translate your pain scales into the languages most served by your organization.

Document pain

The Joint Commission surveyors are watching closely for initial pain documentation and subsequent documentation. The more information one can get from the patient about their pain, the better. Most organizations document pain level within the scope of their initial assessment, whether electronic or on paper.

Other organizations, such as Rockingham Memorial Hospital in Harrisonburg, VA, have developed a pain flowsheet (see Figure 2). The intent of this flowsheet is to walk the nurse through the pain evaluation and re-evaluation and to provide a place to document all of the information (including initial assessment and subsequent reassessments). The flowsheet can easily be converted to an electronic format when necessary. Note that surveyors appreciate seeing graphs that represent flowsheet data. Such graphs provide quick snapshots of what is happening with the patient over a period of time.

Staff also should document the patient's description of the pain, if possible, including its:

- character
- frequency
- location and duration
- intensity

Finally, staff should document the patient's goal for his or her pain. Each patient in pain should work with an experienced staff member to set reasonable goals for reducing the pain. Such staff include nursing, rehab, and pharmacists. Collectively, they can work with the patients to identify reasonable goals that specifically address the patient's unique needs. Additionally, patients with pain should have the opportunity to tell staff what helps to alleviate the pain, whether it is pharmacologic or non-pharmacologic. Staff may ask questions such as the following:

- What have you done in the past to help your pain?
- What other kinds of techniques seem to help your pain?
- What makes your pain better?

This information is documented wherever the hospital requires pain documentation. It must be easily accessible so members of the care team can review it.

There are examples included in this chapter of ways to document pain assessments and reassessments for reference.

Don't ignore new pain

Instruct patients who are assessed with no pain to report any occurrence of pain during their care. Onset of new pain could be clinically significant and should be reported to staff immediately. Documenting the location of pain on each assessment can help identify other issues arising with the patient, especially for surgery patients, so be sure to do so. Each nursing shift will make decisions based on this information.

For example, a nurse is assigned to a new patient who is diabetic. At the time of assessment, the patient states that he has some heel pain. The nurse makes note of this pain, refers to a previous assessment, and discovers that no heel pain had ever been reported. The nurse has identified new information that is significant for a diabetic patient, and healthcare providers will need to determine whether a possible ulcer or neuromyopathy is developing. Staff must educate the patient on the importance of reporting new pain and must follow the organization's policy on reassessing the patient's pain level.

Medication and pain assessment

When medication is used to treat pain, assess pain prior to giving the medication and then reassess it to discover the patient's response to the medication. Best practice would be to begin with the least intervention (i.e., start with PO medication) and then move to other choices—IM or IV. If the reported pain score consistently increases without relief, the physician will be notified so treatment decisions can be made. Be sure that policies are not so broad that your staff assess pain at too long of an interval.

Remember to document pain assessments and reassessments and response to medication in the same area of the medical record to make it easy for other staff to reference this information (i.e. pain graph, flowsheet, etc.).

Keep next shift informed

When reporting to the next shift, nurses should prepare to communicate how the patient's pain progressed. In this chronicle, the outgoing staff members should discuss the following:

- What type of pain was assessed
- How the pain was addressed
- What non-pharmacologic methods worked best to alleviate pain, if any
- What pharmacologic methods worked best for relief, if any
- Patient's response to pain medication
- Confirmation that all pertinent information was documented

Reassessments

Surveyors find that initial assessments are generally thorough and easy to find in the medical record. Most organizations document the first pain assessments on the initial nursing assessment.

Figure 2

Pain assessment flow sheet

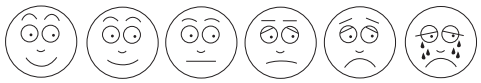
Time / Date	Reassess Y / N	Intensity/ Pain level	Site	Pain type	Quality/ frequency	Interventions	Education	Comments

Intensity/Pain level

Pain (0 – 10)

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mderate Pain — Worst Possible Pain



Patient ID label

Site

1. Abdomen
2. Ankle
3. Arm
4. Back
5. Breast
6. Chest
7. Ear
8. Elbow
9. Eye
10. Flank
11. Foot
12. Groin
13. Hand
14. Headache
15. Heel
16. Hip
17. Knee
18. Leg
19. Neck
20. Nose
21. Perineum
22. Rectal
23. Scrotum
24. Shoulder
25. Throat
26. Wrist
27. Other (See Comments)

Pain type

1. Acute
2. Chronic
3. Cancer

Quality/frequency

S–Sharp
D–Dull
A–Achy
C–Crampy
B–Burning
T–Tight
P–Pressure
Th–Throbbing
I–Intermittent
Co–Constant
So–Soreness
R–Radiating
Sp –Spasm

Interventions

A. Medicated with PRN—See MAR
B. Has PCA (See Form #670)
C. Has epidural (See Manual MAR)
D. Position changed
E. Extremity elevated
F. Cold applied
G. Heat applied
H. MD paged
I. Other (see comments)

Education

1. Educated patient about PCA use.
2. Educated family about PCA use.
3. Educated about medication indication and effects.
4. Educated about use of interventions.

Source: Rockingham Memorial Hospital, Harrisonburg, VA. Reprinted with permission

The difficult part, however, is tracing reassessment, medications given, and response to pain medication. Therefore, surveyors are drilling down on pain reassessments and timeliness. Consistent charting and location of pain is important, especially for surgery patients. Charting pain management information in the medical record will help other caregivers identify whether other issues arise.

Some computer charting systems can graph pain assessments. If you use such systems, be sure to note on the graph the mechanisms patients use to describe their pain levels. For example, if a patient rates his pain at an 8 upon initial assessment, is medicated, and then on reassessment rates pain at a level of 4, the graph will show the pain score, location, time, and intervention taken to alleviate the pain. If your organization does not have the mechanisms in place to graph the reassessment of pain, consider developing a pain flowsheet. Be sure to include interventions on the flowsheet as well—denote a corresponding code for the interventions, and code it on the manual flowsheet.

Reassessment of inpatients should occur often enough that staff can quickly address patients' pain needs. For example, reassess physician office patients and outpatients at least every visit, and reassess ED patients at least every hour. Although reassessments shouldn't be less frequent than that, they may be more frequent. The reassessment frequency for all patients in all settings may be greater when indicated by patient response or when the condition of the patient changes.

What the surveyors look for

The Joint Commission will survey and score a hospital against the hospital's policies. Therefore, make your policies specific as to how often you expect staff to reassess the patient. Surveyors seem to focus more on the reassessments and the timeliness of the reassessments than on the original pain assessments. Many hospitals reassess every shift—eight to 12 hours—but that may not be often enough. Surveyors want to ensure that healthcare providers assess the patients' pain levels often enough to manage their pain effectively, so hospitals may want to consider modifying their policies to require staff members to assess pain every four hours and when the condition of the patient changes.

Figure 3

Sample Policies

Surgical center	Date effective		Number
Applicable to: Medication/emergency procedure	Title: Pain management and assessment of patients		
Revision dates: Review dates:			

Purpose:

All patients have the right to appropriate assessment and management of pain. All patients are provided the best level of pain control that can be safely managed.

I. Education of patient

A. Pre-procedure

Patients and their families are instructed by facility staff on

1. pain management being an important part of their care
2. pain relief measures will be provided quickly in response to reports of pain
3. the pain rating tools that will be used during their stay for evaluating levels of pain
4. identifying pain rating (tolerance level) acceptable to patient to perform allowable activities after discharge.

B. Post-procedure

Patients and their families are instructed by facility staff on

1. managing pain at home, noting frequency of pain, occurrences, intensity, times of medication and relief
2. preventative measures to control pain and specific management options
3. use of drugs and controlling their common side effects
4. when to contact their physician for further assistance

II. Assessment

A. All patients will be initially assessed for pain upon admission

B. Patients identified with pain will be further assessed for location, intensity, and character of pain

C. Regular assessments take place until the problem is resolved

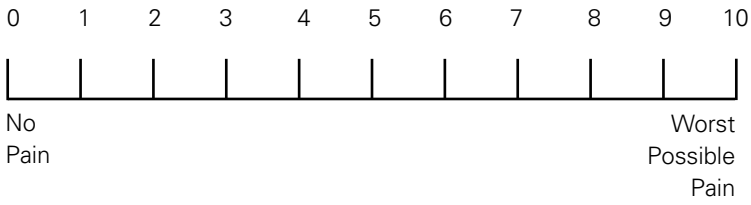
D. To facilitate rating pain intensity

Figure 3

Sample Policies (cont.)

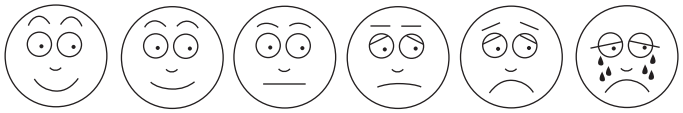
- The numerical 0–10 scale will be used to select pain with 0 as "no pain" and 10 as "worst possible pain."

Numerical scale:



- The Wong-Baker FACES pain rating scale (smile-frown) will be used for the population unable or unwilling to use the numerical scale.

WONG-BAKER FACES:



- Infants and preverbal children will be assessed via behavioral observation (FLACC scale)

FLACC:

Category	Scoring		
	0	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid or jerked
Cry	No cry (awake or asleep)	Moans or whimpers; occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractible	Difficult to console or comfort

Figure 3

Sample Policies (cont.)

III. Intervention

A. If pain is rated >4 or is unacceptable to the patient (causing them to desire pain relief measures, regardless of the rating), there will be an intervention to reduce the pain.
B. Patient is assessed for drug allergies and physician orders are reviewed for appropriate medication orders and appropriate time of dose administration prior to giving.
C. Evaluate effectiveness of pain medication with the same pain intensity scale used prior to intervention.
D. Continue interventions as prescribed and applicable to the patient's needs for relief. When interventions ordered prove unsuccessful, the anesthesiologist is notified for PACU patients, and the surgeon for patients in RCC.

IV. Documentation

A. The initial pain assessment is documented on the appropriate record pre-procedure.
B. Subsequent assessments of pain post-procedure, the interventions, and patient response to treatment are documented on the appropriate record, usually the post-op record. Pain should also be assessed prior to discharge.
C. Post-procedure pain management instructions are provided on the discharge instructions.
D. Post-op call will reflect patient response on pain assessment questions during the follow-up after discharge.

V. Staff education

A. A yearly inservice will be provided for nursing staff on pain assessment and management, including psychosocial, cultural, and spiritual diversity, and if indicated, need for referral for unresolved pain or continued pain treatment.

VI. Patient satisfaction

A. During the post-op call, the staff will collect data from the patient on the effectiveness of their pain management.
B. The patient has the opportunity to respond on a mailed patient satisfaction survey with any comments regarding their pain management

VII. Performance improvement

The surgical center will monitor the way pain is managed through the performance improvement program.

Source: Rockingham Memorial Hospital, Harrisonburg, VA. Reprinted with permission

Remember that surveyors won't scrutinize pain management more closely in any particular department. Your program must be consistent throughout the organization.

Universal goals of pain management

When patients experience pain, staff must work diligently to manage it and to perform reassessments, review patients' records, and discuss a plan with the physician. Patients heal better and develop less anxiety if their pain can be relieved. Therefore, the healthcare team needs to do whatever they can to address the patient's pain. Staff should be encouraged to use all resources available to them, including the expertise of other staff.

For example, consult your organization's rehabilitation staff, who are familiar with treating regular pain in patients. They can provide advice on alternatives for patients who experience break-through pain (i.e., pain that returns before another dose of medication can be administered). For example, if a patient is on a PCA pump and still experiences pain before the next dose, some physicians may order a PRN medication to be given.

You also could schedule a pharmacist to consult with the patient's treatment team. Pharmacists have the expertise needed to make recommendations to physicians regarding the patient's pain medication regimen. They have resources available to them about the most effective methods of pain control and how different methods interact with one another. Staff must feel comfortable talking to physicians and other disciplines about patients who are in pain, and physicians must be open to staff's suggestions.

The treatment team must consider the patient's mental status as well and decide whether a consult by a behavioral health specialist may be appropriate.

Non-pharmacologic methods of pain control

Also use non-pharmacologic methods to assist patients with their pain. Some examples may include

- massage
- repositioning
- music therapy
- support from a loved one
- holding a young child and rocking

Consider a holistic approach to pain management, too, especially for those patients with chronic pain. Approach complete pain management with an inter-disciplinary team effort, starting with the patient and including the nurse, physician, pharmacist, rehab staff, and other members of the treatment team. Include in patients' pain goals a plan for post discharge, especially for chronic pain. The plan may include a referral to a pain clinic or other therapies. Be sure that discharge instructions include pain management techniques that can be used in the home setting.

For example, a patient was admitted to the hospital to receive IV antibiotics for cellulites related to ulcers on his hands from the use of his wheelchair. This patient is permanently in a wheelchair and has multiple hand, arm, and leg deformities from birth. Because of his condition, the patient has chronic pain and has been on multiple pain medications. When admitted to the hospital, the patient continually complained of pain with no relief and wanted to leave against medical advice (AMA) before his treatment was finished. On one occasion, the nurse told the patient that they were doing more for him at the hospital than he could do at home. The patient replied to her that he could do more for his pain at home than they were doing in the hospital.

This nurse asked him what he could do differently (or better) at home. He stated that he has a softer bed at home and that he is more mobile, does puzzles, and plays video games. He generally does things that would distract him from the pain. Based on this conversation, the nurse made arrangements for him to be discharged to home with home IV antibiotics.

Review your program

Review the plan periodically to ensure that it is working effectively. An ideal way to review your processes is to include the patient in the review, and hospital surveys often include a question about pain management for that reason. Additionally, include the users in various settings to help identify barriers in the process, such as staff's timeliness in referrals. If nursing requests that a physician write an order for a rehab consult, the physician waits 24 hours to do so, and then it takes rehab another 24 hours to conduct the consult, the referral is probably not timely enough.

Organizations must develop meaningful monitors to measure the effectiveness of their pain management program. First, begin with the patient's response to hospital survey questions. Second, complete ongoing chart reviews to determine the quality of staff's assessments and reassessments. Concurrent chart review is a good way to ensure that staff are consistently documenting reassessments. By keeping up with chart reviews, you can make immediate interventions to correct or educate staff about your pain management program. In addition, by doing concurrent chart review, the organization will be continually prepared for a THE JOINT COMMISSION survey.

Additional figures

Figure 4

Patient care policy

Patient care policy **Title: Pain management**	Policy number: Origination date: Effective date:

Policy statement

It shall be the policy of this medical center to provide effective pain management for patients by

1. informing patients of the importance of effective pain management in their care
2. assessing for pain
3. intervening when pain is identified

Purpose of policy

To provide guidelines for pain assessment, management, reassessment, and documentation

Entities to which this policy applies

This medical center

Definition of terms

***Assessment*—the collection and analysis of subjective and objective data about the patient's health problem.**

***Pain*—whatever the patient says it is, existing wherever he or she says it does. For those patients who cannot verbally express pain, pain is defined by behaviors/physiologic parameters assessed by the healthcare team/family.**

***Reassessment*—a reevaluation of the analysis of subjective and objective data about the patient's health problem.**

Figure 4

Patient care policy (cont.)

Procedure

A. Plan of care

1. Based upon the initial and ongoing patient assessment, the physician, registered nurse, pharmacist, and therapist, as appropriate, in collaboration with the interdisciplinary care team, ensures that pain management interventions are incorporated into the individualized plan of care.

2. Response to medication/therapies is assessed and the plan is revised as necessary to provide effective pain management.

3. Whenever pain is anticipated (e.g., post-surgical/post-procedural/post-trauma), measures will be initiated to reduce the patient's pain and discomfort.

4. Pain management includes both pharmacological and nonpharmacological interventions. Nonpharmacological interventions may include the following:

    a. Repositioning
    b. Massage
    c. Feeding
    d. Guided imagery
    e. Verbal support
    f. Music therapy
    g. Holding/rocking
    h. Hot application
    i. Toileting/diapering
    j. Cold application
    k. Distraction
    l. Significant other present
    m. Adjustment of environment
    n. Meditation
    o. Emotional support
    p. Prayer
    q. Play
    r. Hypnotherapy

Figure 4

Patient care policy (cont.)

B. Assessment

1. Pain assessment shall be done using age-appropriate pain scales.

    a. Adult patients will be assessed using the 1–10 numeric pain scale.
    b. Pediatric patients will be assessed using the Wong-Baker FACES scale.
    c. Infants and nonverbal pediatric patients will be assessed using the FLACC scale.
    d. Neonates and premature pediatric patients will be assessed using the Premature Infant Pain Profile (PIPP) scale.

2. The patient's diagnosis, behavior, and physiological factors contributing to pain will be considered. Behavioral assessment includes the following:

    a. Body positioning, such as
        – guarding
        – cradling of limb
        – clenching of hands
    b. Muscle rigidity
    c. Restlessness
    d. Facial expressions, such as
        – grimacing
        – tightening of jaw
    e. Sweating
    f. Pallor
    g. Dilated pupils
    h. Moaning, crying, or screaming

3. Assessment and documentation of the presence or absence of pain specific to the growth and development of the patient is done upon admission/visit to this medical center and, when pain is present, shall include

    a. location
    b. quality
    c. intensity
    d. duration

Figure 4

Patient care policy (cont.)

4. Pain assessment will also consider

    a. patient's pain history
    b. patient's coping patterns
    c. cultural beliefs about pain

5. Ongoing nursing assessment for presence or absence of pain is done at least once per shift/visit—more frequently according to physician orders or guidelines, or if pain is poorly controlled or patient condition changes.

6. Patients shall be educated to report pain or discomfort as soon as it occurs.

7. The physician shall be notified of patient pain requiring intervention and of inadequate pain control.

C. Interventions

1. Specific pain protocols (e.g., neuropathic, acute pain, labor pain, cancer, palliative pain, end of life) shall be implemented according to a specific patient care plan or physician orders.

2. Interventions shall be tailored to age, need, preferences, and coping style of the patient.

3. Interventions shall be documented in the patient record.

4. Reassessment and documentation shall occur after each pain intervention or according to specific patient care plan or physician orders.

5. Where patient receives a prescription for pain medication, instruct the patient/family on

    a. how to take or administer medication
    b. effects the medication may have
    c. possible side effects
    d. restrictions or precautions (i.e. driving, operating machinery)

D. Reassessment

1. Pain shall be reassessed within one hour after each intervention and documented

2. Additional reassessments shall follow steps 1–6 in Assessment section of policy

Figure 4

Patient care policy (cont.)

E. Pharmacologic management of pain policies

1. Patient-controlled analgesia

2. Epidural narcotic infusion

F. Documentation

1. Document pain assessment, interventions, patient's response, and instructions/education as indicated

2. Document any medications administered for pain control, include drug name, dose, route, and time administered

3. For specific documentation related to PCA medications or epidural/CADD pump medications, please refer to applicable policy in the Patient Care (PC) section of Patient Care Services P&P manual

G. Education

1. Educate patients and family that pain management is an important aspect of their individual treatment and encourage them to discuss pain with their caregivers and physicians. Patient's education may include

    a. pain relief (pharmacological and nonpharmacological) measures
    b. decision on the duration and intensity of pain they are willing to endure or tolerate

1. Educate patients on the need for effective pain management based on the patient's assessed pain management needs at the time of discharge.

H. Outcomes

1. In order to improve patient care and identify opportunities for improvement, the organization collects, aggregates, and analyzes data for trends on an ongoing basis

2. Based on trends and information, the organization will initiate and implement changes as needed to improve pain management outcomes continuously

Approved by:

Administrator, oncology and research Chief nursing officer	Senior vice president, medical affairs

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Figure 5

Policy: Pain management

Policy statement:

The hospital recognizes that pain can be a common part of the patient experience. Unrelieved pain has adverse physical and psychological effects. The patient's right to pain management is respected and supported. Services for patients are provided in such a way as to respect and foster their sense of dignity, autonomy, positive self-regard, civil rights, and involvement in their own care. The ethical obligation to assist with pain management and relief of suffering is at the core of a healthcare professional's commitment. Pain is to be defined by the patient.

Legal/regulatory reference: The Joint Commission

Process

1. Patients will be involved in all aspects of their care, including managing pain effectively. Patients at the hospital can expect information about pain and pain relief measures from
   1.1 staff who are concerned and committed to pain prevention and management
   1.2 health professionals who respond quickly to reports of pain
   1.3 current pain management therapies
   1.4 staff competent in pain assessment and management

2. Patient responsibilities: The following patient responsibilities will be explained to the patient:
   2.1 Ask what to expect regarding pain and pain management
   2.2 Discuss pain relief options with the healthcare team
   2.3 Ask for pain relief when pain first begins
   2.4 Help the healthcare team assess the pain
   2.5 Tell the healthcare team when pain is not relieved
   2.6 Tell the healthcare team when concerned about any pain medications being taken

3. Patients have the right to appropriate assessment and management of pain. This includes the following:
   3.1 Initial assessment and regular reassessment of pain (consider pain assessment as important as assessing vital signs)
   3.2 Reassessment after each pharmacological and nonpharmacological intervention
   3.3 Education of relevant providers in pain assessment and management
   3.4 Education of patients and families, when appropriate, regarding their roles in managing pain as well as the potential limitations and side effects of pain treatments
   3.5 After considering personal, cultural, spiritual, and/or ethnic beliefs, communication to patients and families that pain management is an important part of care

Figure 5

Policy: Pain management (cont.)

4. Pain is assessed and documented in all patients. The assessment for pain includes the following elements:
   4.1 Pain intensity
   4.2 Location
   4.3 Quality, patterns of radiation, character
   4.4 Response to medication, duration, variation and patterns
   4.5 Alleviating and aggravating factors
   4.6 Present pain management regimen and effectiveness
   4.7 Pain management history
   4.8 Physical exam/observation of pain site

5. The hospital collects outcome data to monitor the appropriateness and effectiveness of pain management.
   The following acronym will be used:
   Q—Quality
   R—Radiation
   S—Severity
   T—Temporal (Is it constant? Does the pain come and go?)

6. Assessment
   6.1 Standardized pain assessment scale of 0–10 is used to assess the patient's pain. The "0" represents a comfortable, pain-free state and a "10" represents the most horrible pain the patient has ever experienced.
   6.2 Tools to facilitate geriatric and pediatric pain assessment
      6.2.1. Neonatal Infant Pain Scale/Premature Infant Pain Profile
      6.2.2. Wong-Baker Faces Pain Rating Scale

Source: Rockingham Memorial Hospital, Harrisonburg, VA. Reprinted with permission.

Figure 6

ASC—Patient care flow sheet

ASC—Patient care flow sheet

Pre-op screening:
☐ LMP date: _____
1. Have you had a tubal ligation or hysterectomy? ☐ Yes ☐ No
2. Are your menstrual periods regular? ☐ Yes ☐ No
3. Do you regularly use birth control? ☐ Yes ☐ No
4. Is there a possibility you might be pregnant? ☐ Yes ☐ No

☐ Pregnant/gestational age _____
*MRSA/VRE
1. Have you been hospitalized or in a long term care facility within the past 8 weeks? ☐ Yes ☐ No
2. Have you received 2 or more IV antibiotics within the last 8 weeks? ☐ Yes ☐ No
3. If answer is yes to any of the above, is MRSA/VRE culture done? ☐ Yes ☐ NO

Advance directives ☐ Yes ☐ No
If yes, is there a copy on chart ☐ Yes ☐ No
If no, was copy of booklet given ☐ Yes ☐ No
* Does the patient wish a visit from the hospital chaplain? ☐ Yes ☐ No

☐ Interpreter: Name/Location_____
Person(s) with whom we can discuss your medical information.
☐ Anyone who came with you.
☐ 1. Name: _____
Relationship: _____
Phone #:_____ Location (DOS)_____
☐ 2. Name: _____
Relationship: _____
Phone #: _____ Location (DOS)_____
May we speak with them over the phone about your health? ☐ Y ☐ N

RVN entered for this patient for:
☐ Dietary assessment
☐ Physical therapy
☐ Social work
Comments: _____
_____
_____
_____
Signature of screening nurse_____

Date: _____
Time: _____

Pre-op nurse assessment
Arrival via ☐ ambulatory ☐ wheelchair ☐ stretcher Accompanied by: _____
Mental status ☐ alert ☐ oriented ☐ confused ☐ sedated ☐ combative
Lungs ☐ clear ☐ other _____
Respirations ☐ deep ☐ unlabored ☐ other _____
Skin ☐ warm ☐ dry ☐ pink ☐ other _____
IV started ☐ Yes ☐ No Time: _____
Gauge _____ Site _____ Attempts _____
IV Solution _____ Rate _____
Comments: _____
_____
_____
_____
_____
_____

Nurse signature: _____

Patient ID label

Pre-op checklist
☐ ID bracelet on (ID labels on chart)
☐ Consent on chart (signed within 30 days)
☐ Hx of anesthesia problems (see comments)
☐ Surgical site verified
☐ Pain management information given
☐ Family notified/sent to waiting room 1 North / ASC
☐ H&P/flowsheet completed (within 30 days)
☐ Allergies documented _____
_____
☐ Diagnostic studies on chart
☐ If type and cross matched consent signed
☐ NPO since date _____ time _____
☐ Medications taken by patient morning of surgery
_____
_____
_____
☐ Dentures/partials removed
☐ Contact lenses, glasses, hearing aids, artificial eyes removed
☐ Rings, watch, earrings, body piercing removed/taped
☐ Hair pins, wigs, lipstick, polish removed
☐ Chewing gum removed
☐ Bladder emptied ☐ Foley inserted ☐
☐ Isolation needed: Type _____
☐ Skin prep _____
☐ Patient and/or family verbalize understanding of surgical process.
Comments:
_____
_____
_____

Disposition of personal items
☐ Dentures/partials _____
☐ Glasses/contacts _____
☐ Jewelry/money _____
☐ Clothing _____
☐ Valuables envelope ☐ Yes ☐ No Envelope #_____

Pre-op pain assessment
Do you have any pain? ☐ Yes ☐ No
Location A _____/0-10_____
Location B _____/0-10_____
Location C _____/0-10_____
Medications/treatments used _____
_____
_____
Effectiveness _____
_____
Effects of pain: ☐ appetite ☐ mobility ☐ self-care deficit ☐ relationship ☐ sleep pattern ☐ work ability
Patients satisfactory pain rating goal: _____

Nurse signature: _____

Pre-op medications:

Medication/dose	Route	Signature/time

To OR via ☐ ambulatory ☐ wheelchair ☐ stretcher ☐ crib
Time of transfer to OR _____

Figure 6

ASC—Patient care flow sheet (cont.)

Date: _____

Procedure: _____

_____

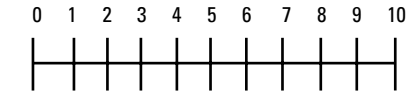
Allergies: _____

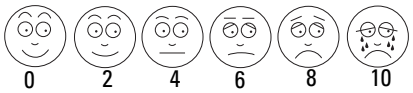
PACU time in: _____
out: _____
Adm nurse: _____
ASA class _____
☐ General ☐ MAC
☐ Spinal ☐ Epidural
☐ Local ☐ Regional
☐ Epidural/Flowsheet completed
Surgeon: _____
Anesthesiologist: _____
Comments: _____

Time													
NBP													
Temp													
Pulse													
RR													
Pain													
SaO_2													
$F10_2$													
ABP													
CVP													
Fingerstick Glucose													

SAFETY/INITIALS	PACU	ASC
ID bracelet checked		
Chart reviewed		
Alarms/limits set		
Bed locked/BSR up		
Universal precautions		
Call bell in reach		
Staff at bedside		

Pain (0–10) **Please list under RR in own row.**





Comfort Measures	Pre-Op	PACU Time INT	ASC Time INT
☐ Oriented patient to area			
☐ Warm blanket			
☐ Warm pad to: _____			
☐ Repositioned			
☐ Towel roll to: _____			
☐ Ice cap to: _____			
☐ Elevated: _____			
☐ Oral care			

☐ Family/Contact notified of patient's arrival and room assignment
☐ Floor notified
☐ Orders received and faxed

Time	Nsg Dx *See Codes	Pain 0–10	Location	Description *See codes	Tx/Int.	Reassess time	Effect	Pain 0–10	INT

1. Pain
2. High temp
3. Shiver
4. Low temp
5. Emergent
6. Cold
7. Confused
8. Apnea
9. Tachycardia
10. Dysrhythmia
11. Hypotension
12. Hypertension
13. Artificial airway
14. Anxiety
15. Nausea
16. Vomiting
17. Low SaO_2
18. _____

Pain description

S—Sharp
D—Dull
A—Achy
C—Crampy
B—Burning
T—Tight
P—Pressure
Th—Throbbing
I—Intermittent
Co—Constant
So—Soreness

Figure 6

ASC—Patient care flow sheet (cont.)

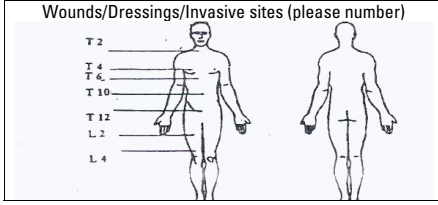
Form #174
Page 3 of 4

Nurse's initials								
Assessment use codes (N/A or for no change)	PACU Adm	15	30	45	1	D/C	ASC Adm	ASC D/C
Position **Times:**								
S – Supine; P – Prone; T – Trendenlenburg; F – Fowlers; SF – Semifowlers; Lt – Left side; Rt – Right side								
Respiratory								
Airway: N – Nasal; O – Oral; T – Trach; LMA; ET Oral/Nasal Rt/Lt								
Ext – Extubated; RT – Reintubated; CH – Chin Lift; J – Jawthrust								
☐ Patient met criteria for extubation Patient extubated by _____ @ _____								
O_2 – RA NC BH VM NRB TC-trach collar T – T-piece V- Vent								
Breath Sounds: CL – Clear D – Diminished A – Absent RUL/LUL								
Breath Sounds: R – Rales Rh – Rhonchi Wh – Wheeze RLL/LLL								
Respirations Sp-Spontaneous / Ambu / Sym-Symmetrical / D-Deep Sh-Shallow / L-Labored / UL-Unlabored								
Cardiovascular/peripheral circulation								
Heart Tones: R – Reg / I – Irregular / D – Distant / M – Murmur								
Pulses: NA +/- Dp – Doppler R – Radial Br – Brachial R / L DP – Dorsalis PT – Post Tibial R / L								
Skin: W – Warm D – Dry Pk – Pink Fl-Flushed PL – Pale CL – Cool Dp – Diaphoretic Cy – Cyanotic J – Jaundice								
Capillary Refill: Location _____ > / < 3 sec. / NA								
T: TEDS S: SCD FP – foot pumps D – Durakold IM – Ice Man								
Neurological								
LOC: A–Alert O–Oriented C–Confused D–Drowsy/Arousable E–Emergent NR-Not responding Pre-condition:_____								
Motor: 4 – Lifts & Resists 3 – Lifts & holds RUE / LUE								
2 – Lifts & falls 1 – Moves on bed 0 – No response RLE / LLE								
SAB Level Use code or FR – full return of sensory								
GI/GU								
Abd.: S – Soft F – Firm D – Distended T – Tender O – Obese								
Bowel Sounds: Absent / Active / Hypoactive								
NG Rt / Lt / LIS / C – Capped								
Urine: C–Clear CL–Cloudy A–Amber Y–Yellow P–Pink B-Bloody								
☐ Foley # _____ Fr. ☐ CBI – See GU flow sheet								

EKG **Lead:** _____ **Rhythm:** _____ **Nurse:** _____

SITE (Dressings, IV, JP, Hemovac, etc.)	Time	C/D/I	Patent	Inflt.	Red	Edema	Drainage on dressing Cm's/Color	PACU adm/int	PACU d/c/int	ASC adm/int	ASC D/c/int

Wounds/Dressings/Invasive sites (please number)



NN (PACU)

See addtnl. (N.N.) / ck. _____

Figure 6

ASC—Patient care flow sheet (cont.)

Phase I
Criteria for Fast-tracking and discharge
Postanesthesia recovery score

Consciousness
2 = Fully awake and oriented (name, place, date)
1 = Arousable on calling
0 = Not responding

Activity
2 = Moves all extremities voluntarily or on command
1 = Moves two extremities
0 = Unable to move extremities

Respiration
2 = Breathes deeply, coughs freely
1 = Dyspnea, limited breathing, or tachypnea
0 = Apneic or on mechanical ventilation

Circulation
2 = Blood pressure ± 20% of preanesthetic level
1 = Blood pressure ± 20% –49% of preanesthetic level
0 = Blood pressure ± 50% of preanesthetic level

Oxygen saturation
2 = $SpO_2 \geq 92\%$ on room air
1 = Supplemental O_2 required to maintain $SpO_2 \geq 90\%$
0 = $SpO_2 \leq 92\%$ with O_2 supplementation

10 = Total score; Score greater or equal to 9 needed for PACU discharge/bypass

Transfer summary:

Time: _____
Destination: _____
Report to: _____
PACU Staff: _____
O_2: _____

	IV solution/time	Site #	Rate	PACU total	Left up	ASC total
INTAKE						
	PO					
	Blood product					
	Autotransfusion					
			Total			

		From OR	PACU D/C	ASC D/C
OUTPUT	Urine: Void, foley, incontinent			
	NG			
	JP/Hemovac			
	T tube			
	Chest tube			
	Emesis			
	Other			
	Total:			

Score = _____ Time: _____
Nurse: _____
MD discharge: _____

Teaching goals	INT/Time	
☐ Patient/family verbalizes understanding of post-op process		
☐ Patient verbalizes understanding of pain management options		
☐ Patient verbalizes understanding of TCDB		
☐ Patient verbalizes understanding of take home RXs		
☐ Patient verbalizes understanding of how to care for, empty and record JP drain		
☐ Patient verbalizes understanding of foley catheter/leg bag/catheter care		
☐ Patient verbalizes understanding of how to care for dressings at home		
☐ Patient demonstrates use of crutches/walker prior to discharge		
☐ Smoking cessation brochure given to patient or caregiver		
☐ Other		

Phase II recovery ASC

Circulation:		
BP ± 20% of pre-anesthetic level	2	
BP ± 20%–49% of pre-anesthetic level	1	
BP ± 50% of pre-anesthetic level	0	
Pain Level:		
Pain Free	2	
Mild pain (4 or less on scale) resolved by oral meds	1	
Severe pain requiring IV or IM meds	0	
Incision or procedure site:		
Dressing/Site dry and clean	2	
Dressing moist but stationary	1	
Dressing saturated	0	
Intake:		
Able to drink and tolerate fluids	2	
Nauseated	1	
Nauseated and vomiting	0	
Output:		
Voided	2	
Unable to void, but comfortable and bladder scanner indicates ≤ 200 ml's of urine	1	
Unable to void, uncomfortable and bladder scanner ≥ 400 ml of urine	0	
10 = Total score. Patient must score ≥9 for discharge from ASC by criteria; otherwise, MD discharge required.		

ASC post-op notes: _____

☐ Patient/family verbalized understanding of discharge instructions ☐ Copy of instructions given
☐ Verified arrangements for safe transport home and adult care for 24 hour post-op.
Patient escorted out of hospital by ☐ Staff ☐ Self ☐ Family Transported by: ☐ Ambulated ☐ Wheelchair ☐ Stretcher

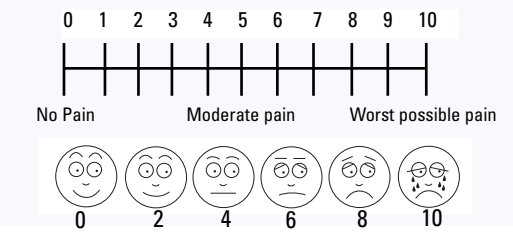
Figure 6

ASC—Patient care flow sheet (cont.)

Second page nurse's notes

Time																		
NBP																		
Temp																		
Pulse																		
RR																		
Pain																		
SaO_2																		
$F1O_2$																		
ABP																		
CVP																		
Fingerstick Glucose																		

Pain (0–10) **Please list under RR in own row.**



EKG Lead: _____ Rhythm: _____ Nurse:_____

Time	Nsg Dx *See codes	Pain 0 – 10	Location	Description *See codes	Tx/Int.	Reassess time	Effect	Pain 0 – 10	INT

Nursing Dx

1. Pain
2. High temp
3. Shiver
4. Low temp
5. Emergent
6. Cold
7. Confused
8. Apnea
9. Tachycardia
10. Dysrhythmia
11. Hypotension
12. Hypertension
13. Artificial airway
14. Anxiety
15. Nausea
16. Vomiting
17. Low SaO_2
18. _____

Pain description

S–Sharp
D–Dull
A–Achy
C–Crampy
B–Burning
T–Tight
P–Pressure
Th–Throbbing
I –Intermittent
Co–Constant
So–Soreness

Figure 6

ASC—Patient care flow sheet (cont.)

Time	**Nurse's notes**

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Figure 7

Pain rating scale

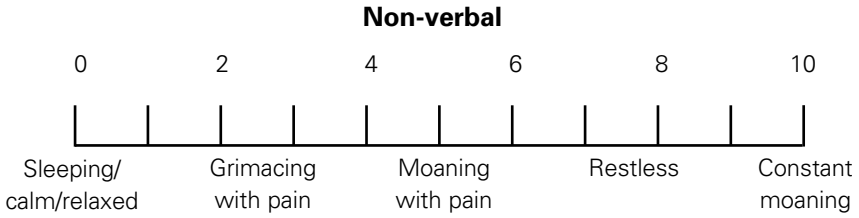

Figure 8

Pain rating scale

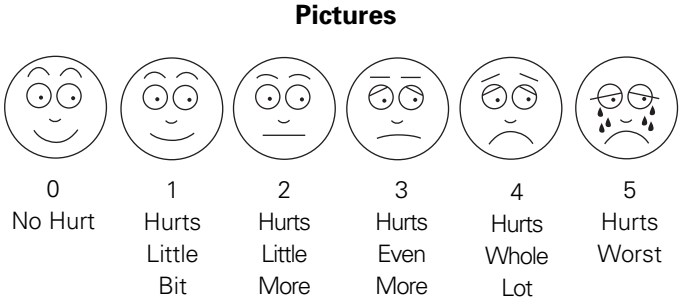

Figure 9

Spanish—Tabla de evaluacion del dolor

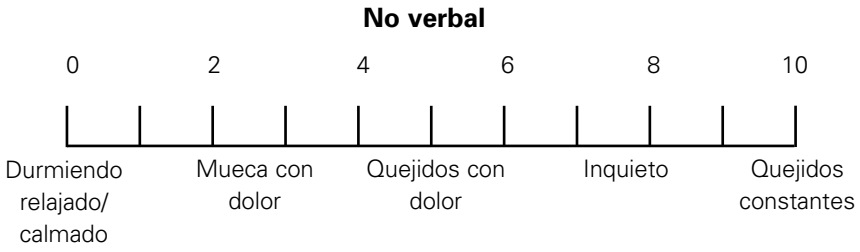

Figure 10

Pain rating scale

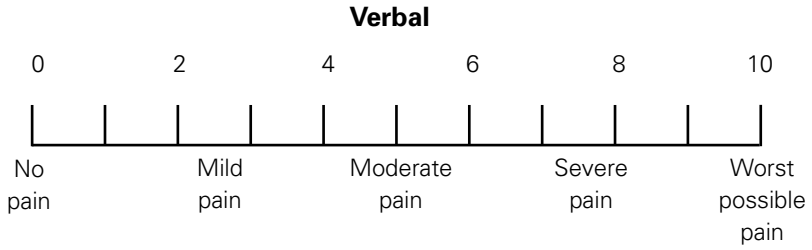

Figure 11 Nursing department/pain assessment/reassessment

Policy reference: Hospital policy

Legal/regulatory reference: The Joint Commission P.C.1.10, 2.20, 2.120–2.150; PC.4.10, 5.10, 5.50, 5.60, 6.10, 6.30, 8.10

Section reference: Assessment of patients

Goal: The patient's right to pain management is respected and supported.

Purpose: To promote effective pain management for all patients

Level of personnel: RN, LPN, MD

Equipment: Nursing admission assessment forms, department specific, clinical management system

Procedure steps/guidelines:
A. *Assessment and reassessment*

1. All patients entering the healthcare system will receive an initial nursing assessment, department specific. The initial assessment will rate pain using a 0–10 point scale or Neonatal Infant Pain Scale, Premature Infant Pain Profile, or Wong-Baker Pain Rating Scale as appropriate.

2. Initial assessment is documented on admission form.

3. *Reassessments* will be documented *on the pain assessment flow sheet*

4. Pain is assessed and documented on all patients. The assessment for pain includes the following elements:

    a. Pain intensity
    b. Location
    c. Quality, patterns of radiation, character
    d. Response to medication, duration, variation, and patterns
    e. Alleviating and aggravating factors
    f. Present pain management regimen and effectiveness
    g. Pain management history
    h. Physical exam/observation of pain site

Figure 11 Nursing department/pain assessment/reassessment (cont.)

5. Pain is reassessed on a regular basis and

    a. with each new report of pain and new procedure, when intensity is increased, and when pain is not relieved by previously effective strategies.

    b. Pain is reassessed after each intervention has reached its peak effect:

        1. 15–30 minutes after parenteral drug therapy
        2. one hour after immediate release analgesics
        3. four hours after sustained release analgesics or transdermal patch
        4. 30–60 minutes after non-pharmacological intervention

    c. Acute post-operative pain, within the first 24 hours of surgery, should be assessed

        1. at least every two to four hours based on the operation and severity of pain with each new report of pain or
        2. at any instance of unexpected pain, particularly if sudden or associated with altered vital signs such as hypotension, tachycardia, or fever
        3. after each analgesic according to peak effect time

    d. If pain is well controlled, reassessment should be conducted routinely with vital signs. Patients receiving medication via PCA for reasons other than post-operative pain will be reassessed at a minimum of every four hours

    e. Patients receiving medication via epidural catheter will be reassessed per physician order

6. Reassessment of pain will be documented on a form accessible to all clinicians. It shall include the following:

    a. Date/time of reassessment
    b. Location of pain
    c. Intensity of pain (severity)
    d. Quality of pain (the words the person uses to describe the pain)
    e. Radiation of pain (does the pain extend from the site?)
    f. Timing of pain (occasional, intermittent, constant)
    g. Strategies used to relieve pain, both pharmacological and nonpharmacological

7. Notify physician of pain that is not being relieved with current or ordered strategies.

Figure 11 Nursing department/pain assessment/reassessment (cont.)

8. Anticipate and monitor patient for common side affects:

    a. Nausea and vomiting
    b. Lethargy/sedation/respiratory depression
    c. Itching/pruritus
    d. Hypotension
    e. Urinary retention
    f. Weakness

B. *Education*

1. Provide patient and family with information about their pain and measures used to treat it, with particular attention focused on correction of myths and strategies for the prevention and treatment of side effects.

    a. Discuss goals of pain management and how these goals help the patient: comfort, quicker recovery, and fewer complications.
    b. Preventing pain is important to manage pain well. "Stay ahead of the pain."
    c. Inform patient on how pain will be assessed and how frequently.
    d. Discuss with patient how quickly pain interventions should work. Discuss pain medications, administration schedules, and non-drug measures for pain relief.
    e. Discuss prevention and treatment of side effects:

        1. Nausea and vomiting
        2. Lethargy/sedation/respiratory depression
        3. Itching/pruritus
        4. Hypotension
        5. Urinary retention
        6. Weakness

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