



Current Status: Active

PolicyStat ID: 2265257



Ascension

Origination: 2/8/2016
Last Reviewed: 3/15/2016
Last Revised: 3/15/2016
Next Review: 3/15/2019
Owner: Peggy Lutz: Srvc Line Pain Mgmt Dir
Policy Area: Provision of Care, Treatment and Services
Reference Tags:
Applicability: Ministry Health Care Systemwide

Pain Management

Scope:

Hospital and skilled nursing facility based inpatient and hospital outpatient services. Management of specialty populations including NICU, Newborn Nursery, the laboring patient, Palliative Care, and Behavioral Health departments are outside the scope of this policy. Clinic based services are outside the scope of this policy.

Purpose:

The identification and management of pain is an important component of person centered care. A patient's right to have pain managed will be respected and supported. Staff will communicate with patients and families that pain management is an important part of their overall care.

Policy Statement:

Pain is defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (American Pain Society, 2006, p. 1). Unrelieved pain has adverse physical and psychological effects. It is presumed throughout this standard that pain affects the whole being and is best measured by the subjective report of pain.

Definitions:

Mild pain: Generally a pain score that is within the bench mark range of 1-3/10, unless the patient identifies it as otherwise

Moderate pain: Generally a pain score that is within the bench mark range of 4-6/10, unless the patient identifies it as otherwise

Severe pain: Generally a pain score that is within the bench mark range of 7-10/10, unless the patient identifies it as otherwise

Pain management goal: The level or intensity of pain that allows a person to perform the activities of daily living and treatments necessary for recovery, and the ability to rest and sleep, while not necessarily being pain free

Licensed Independent Practitioner (LIP): Any individual permitted by both state law and hospital policy, within the scope of their licensure and consistent with granted privileges to independently order pain intervention and assessments: Physician, Physician Assistant, Licensed Resident or Nurse Practitioner who is responsible for the care of the patient.

Policy:

Hospital-based Outpatient Care Departments (Cardiac Rehab, Infusion Services, Wound Clinic, Therapies, etc.):

I. Assessment:

- A. The Registered Nurse (RN) will complete a screening assessment during the initial visit by the outpatient department. When the patient reports pain, an assessment will be done consistent with the scope of care, treatment and services provided by the Licensed Independent Practitioner (LIP) and the patient's medical condition. At subsequent visits, pain assessment would be needed only as appropriate to the reason the patient is presenting for care or services (Joint Commission, 2008).
- B. There are some services that do not require a pain screening e.g., patient presenting for imaging services or lab, etc. However, if the patient is experiencing pain, appropriate care will be made available (Joint Commission, 2015).

II. Urgent Care and Emergency Department:

- A. Patients will be screened for pain. If the patient reports pain, an assessment is done consistent with the scope of care, treatment and services, and the patient's medical condition.
- B. If a pain problem is ongoing and not associated with the presenting problem, the treatment plan will take into consideration the impact of chronic pain or use of pain medications will have on the acute condition.
- C. Pain treatment may include pharmacologic and nonpharmacologic approaches.
- D. Pain is reassessed after pharmacologic interventions once a sufficient time has elapsed for the treatment to reach peak effect (See Attachment A – Time to Peak Effect Analgesics).
- E. Pain management is included in the discharge evaluation as appropriate for visit.

Inpatient Care Units:

I. Assessment Guidelines

- A. **Admission Screening:** All patients will be screened for the presence, absence, or history of pain during the admission process.
 - 1. A comprehensive pain assessment, consistent with the patient's medical condition, the scope of care, treatment, and services, is completed for patients currently experiencing pain or reporting a history of ongoing pain.
 - 2. The comprehensive assessment may include, but is not limited to: onset, location, duration, intensity, quality, aggravating and alleviating factors, associated symptoms, past treatments including medications and efficacy, and impact of pain

on patient's life.

- B. Pain management goals:** Pain management goals will be determined by the patient and documented for any patient currently experiencing pain.
1. Patients able to communicate and understand will define a "manageable" level of pain which is indicated as the level or intensity of pain that allows a person to perform the activities of daily living and treatments necessary for recovery, and the ability to rest and sleep, while not necessarily being pain free.
 2. Pain goals are not limited to pain intensity ratings but may include functional goals.
 3. For the patient experiencing pain, pain goals are assessed upon admission and as needed with any change in patient condition or by patient preference.
- C. Pain Assessment Scales:** Pain is assessed using organization approved, evidence-based, validated scales appropriate for the patient's age, medical condition, and ability to understand. See Attachment B - Pain Assessment Scales
- D. Routine Pain Assessment:** Patients will be assessed using the appropriate pain assessment tools a minimum of twice on both the day and evening shift and at least once during the night shift and PRN in acute care areas.
1. Routine pain assessment includes pain intensity (as reported by the patient); for patients receiving pharmacologic interventions, level of sedation and presence of adverse effects are also assessed.
 2. Pain assessments should be completed per LIP order
 3. Patients receiving intravenous (IV), spinal, or regional analgesia will be assessed according to the corresponding LIP order set and applicable local policy.
- E. Reassessment:** Reassess and document pain intensity, level of sedation, and presence of adverse effects following ***PRN pharmacologic interventions:***
1. Once a sufficient time has elapsed for the treatment to reach peak effect, but not to exceed two hours.
 2. See Attachment A – Time to Peak Effect Analgesics
- F. Respiratory Assessment:**
1. If indicated by local policy and LIP order, respiratory assessment will be included with pain assessments/reassessments. At minimum, this includes respiratory rate and quality (depth and regularity).
 2. Use of pulse oximetry and capnography are based on local policy and LIP order.
- G. Sedation Assessment:**
1. Sedation assessment is completed using an evidence-based sedation scale according to local policy. (See Attachment C – Sedation Assessment Scales)
 2. To properly assess sedation related to pain control:
 - a. Respiratory rate and quality (depth and regularity) must be assessed prior to arousing a patient.
 - b. A sleeping patient needs to be gently awakened/aroused for assessment.

Rational: Sedation is a measure of level of consciousness and cannot be assessed while asleep. Patients who are sleeping normally and have well controlled pain will fall back to sleep after being aroused for the sedation assessment. Those that do not fall back to sleep require further evaluation as they may be experiencing pain and need additional intervention.

H. **Assessment when the patient appears to be sleeping:**

1. Important concepts: not all patients who appear to be sleeping are actually sleeping; sleep does not mean pain has been relieved (Pasero & McCaffery, 2011, p. 105)
2. Patients receiving **opioid analgesics** should be awakened to assess pain, level of sedation, and presence of adverse effects, particularly during the first 24 hours after receiving opioid analgesics (Jarzyna, et al. 2011, p. 132).
3. If the patient is receiving opioids and appears to be sleeping, the RN will: first, assess respiratory status including respiratory rate (RR) and quality; AND second, call out his or her name in a normal tone of voice.
 - a. If the patient does not arouse and the respiratory status (RR and quality) is within normal limits (WNL) for the patient, the nurse may use discretion to delay pain assessment or reassessment until the patient awakens; document sleep and respiratory status.
 - b. If the respiratory status is not WNL, the patient must be stimulated/awakened to complete a more thorough pain, level of sedation, and respiratory assessment.
 - c. Assessment of the patient who appears to be sleeping applies to the duration of hospitalization and not just the first 24 hours of opioid treatment.
4. For patients not reporting pain and not receiving opioid analgesics during their hospitalization, respiratory assessment is not indicated as part of the pain assessment.

II. **Intervention:** Incorporate patient-specific goals, outcomes and interventions for patient's individual needs.

- A. Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect a patient-centered approach and consider the patient's current presentation, the LIP clinical judgment, and the risk and benefits associated with the strategies (Joint Commission Perspectives, 2014).
- B. Patient / Family Teaching: Document on the department specific patient education record.
 1. Assess understanding of anticipated surgery, procedures, or tests and associated level of pain.
 2. Instruct on rights and responsibilities in the assessment and management of pain. Include understanding the risk of pain, the importance of effective pain management, the pain assessment process, and the methods for pain management. Take into consideration spiritual and cultural beliefs.

3. Discuss patient/family role in pain management: when and how to report pain, significant changes in pain, and identify possible barriers.
4. Instruct on pain scales and collaboratively select an appropriate pain scale based on patient age, medical condition, and ability to understand the pain rating scale. Nursing staff will continually evaluate the patient's ability to use a pain rating scale. Documentation of the patient's pain rating reflects patient's preference and ability to understand the pain rating scale at the time of assessment.
5. Instruct on treatment options for pain relief, both pharmacologic and nonpharmacologic, and identify potential limitations.
6. Discuss side effects of pain medications and means to control these.
7. Provide ongoing instruction as needed regarding disease process and rationale for interventions.

III. Discharge Planning:

- A. Assist the patient in establishing a pain management plan. Take into consideration their preferred pain rating as well as goals related to function and quality of life.
- B. Provide the patient and family with written instructions for the following:
 1. List of pain medications by name, dosage, and administration schedule.
 2. Information about each pain medication including possible adverse effects and drug-drug or drug-food interactions
 3. Who and when to call for any questions, problems with pain medications, or any changes in the patient's condition that may affect the patient's ability to adhere to the pain management regimen.
- C. Ensure the patient/guardian can verbalize an understanding of all instructions.

Related Policy:

N/A

Key Words:

Pain, pain management, pain tool, pain scale, pain assessment, sedation, care plan, respiratory status.

For More Information Contact:

Peggy Lutz

Regulations/Standards:

Joint Commission Provision of Care PC.01.02.07

Sources:

American Pain Society. (2008). *Principles of analgesic use in the treatment of acute and cancer pain (6thed)*. Glenview, IL: American Pain Society.

Fink, R. M. & Gates, R. A. (2010). Pain assessment. In B. R. Ferrell & N. Coyle (Eds.). *Oxford Textbook of Palliative Nursing (3rded.)* (137-160). Oxford, NY: Oxford University Press.

Jarzyna, D., Jungquist, C. R., Pasero, C., Willens, J. S., Nisbet, A., Oakes, L...& Polomano, R. C. (2011). American Society for Pain Management Nursing guidelines on monitoring for opioid-induced sedation and respiratory depression. *Pain Management Nursing*, 12(3), 118-145.

National Comprehensive Cancer Network. (2015). NCCN clinical practice guidelines in oncology: Adult cancer pain, version 2.2015. Retrieved from <http://www.nccn.org>

Pasero, C. (2009). Assessment of sedation during opioid administration for pain management. *Journal of PeriAnesthesia Nursing*, 24(3), 186-190.

Pasero, C. & McCaffery, M. (2011). *Pain assessment and pharmacologic management*. St. Louis, MO: Elsevier.

St. Marie, B. (Ed). (2010). *American Society for Pain Management Nursing: Core curriculum for pain management nursing, (2nded.)* Dubuque, IA: Kendall Hunt Publishing Company.

The Joint Commission. (2015). Facts about pain management. Retrieved from http://www.jointcommission.org/pain_management/

The Joint Commission. (2008). Standards FAQ details: Nutritional, functional, and pain assessments and screens. Retrieved from http://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=471

The Joint Commission. (2014). Clarification of the pain management standard. *Joint Commission Perspectives*, 34(11), 11.

The Joint Commission. (2012). The Joint Commission sentinel event alert #49: Safe use of opioids in hospitals. Retrieved from http://www.jointcommission.org/assets/1/18/SEA_49_opioids_8_2_12_final.pdf

Attachment Names:

- Attachment A: Time to Peak Effect Analgesics
- Attachment B: Pain Assessment Scales
- Attachment C: Sedation Assessment Scales
- Attachment D: Pain Assessment Tools Decision Tree

Replaces the Following Policies:

- Standards of Care for Pain Management: Acute and Ambulatory Care (MSJH)
- NS-103 Pain Management Guidelines (MSMH)

Supporting Policies:

Facility	Hyperlink
Calumet Medical Center (CMC)	N/A
Flambeau Hospital (FH)	N/A
Howard Young Medical Center (HYMC)	N/A

Mercy Medical Center (MMC)	N/A
Ministry Door County Medical Center (MDCMC)	N/A
Ministry Eagle River Memorial Hospital (MERMH)	N/A
Ministry Good Samaritan Health Center (MGSHC)	N/A
Ministry Our Lady of Victory Hospital (MOLVH)	N/A
Ministry Sacred Heart Hospital (MSHH)	N/A
Ministry Saint Clare's Hospital (MSCH)	N/A
Ministry Saint Joseph's Hospital (MSJH)	N/A
Ministry Saint Mary's Hospital (MSMaH)	N/A
Ministry Saint Michael's Hospital (MSMH)	N/A
Saint Elizabeth's Medical Center (SEMC)	N/A
St. Elizabeth Hospital (SEH)	N/A
Ministry Medical Group/Affinity Medical Group (MMG/AMG)	N/A

Attachments:

- [Attachment A - Time to Peak Effect Analgesics.docx](#)
- [Attachment B - Pain Assessment Scales](#)
- [Attachment C - Sedation Assessment Scales](#)
- [Attachment D - Pain Assessment Tools Decision Tree](#)

Approval Signatures

Approver	Date
Annette Siedschlag: Supv Pharmacy	3/15/2016
Peggy Lutz: Srvc Line Pain Mgmt Dir	3/14/2016
Rae Mead: Clinical Standards System Dir	3/14/2016