POLICY ON PAIN MANAGEMENT

1.0 Policy:

It is the policy of INODAYA Hospital – Kakinada to utilize an interdisciplinary approach to the management of pain in order to eliminate or minimize the effects of pain. The patient's report of pain shall be accepted as the key indicator of the severity and extent of pain experienced. While acknowledging that all forms of pain cannot be controlled in all patients 100% of the time, every effort shall be made by the clinical team to:

- Assess the patient relative to the effect of pain during the course of his/her illness/recovery process in order to promote an efficient and comfortable recovery.
- Educate the patient and family to various forms of pain management techniques, and promote competencies within the area of pain management striving to improve or enhance methodologies to control pain.

2.0 Definitions:

2.1 Acute Pain:

Any pain of less than 6 weeks duration

2.2 Chronic Pain:

Any pain of more than 6 weeks duration

3.0 Assessment:

The scope and complexity of care shall be determined through the assessment and evaluation of patients currently experiencing or expected to experience pain symptoms.

Patients and "significant-others" shall receive easily accessible pre-therapy consultation with an anesthesiologist as requested by the Treating Physician to discuss the patients' options and to determine the appropriateness of therapy.

Assessment criteria used to establish the patient care needs may include, but are not limited to,

- clinical presentation
- diagnostic testing
- patient interview
- the patient's past experience with pain
- information obtained from "significant others"

4.0 Pain rating and pain assessment:

- <4 No Intervention
- =4 Intervention – Comfortable measures as advised by the doctor.

- >4 Intervention – Comfortable measures as advised by the doctor.

4.0.1 Principles' of intervention /patient education

4.1.1 Provide patients/family with verbal and written information about pain management.

4.1.2 Teach patients/families to use a pain rating scale that is age, condition, and language appropriate for reporting pain intensity and that the goal of pain management is prevention.

4.1.3 Teach patient/family pharmacologic and non-pharmacologic interventions.

4.1.4 Develop an individualized pain management plan which includes the patient's goal for pain management, patient preferences for treatment, age, type of pain, risk for cognitive impairment, history of chemical dependency, chronic pain and cultural beliefs and practices.

4.1.5 The physician should be notified of pain that remains at a 4 or greater or higher than the patient's comfort level.

4.1.6 A guide to pharmacologic interventions with acute pain. See diagram below.

Moderate Pain (e.g., 4-6 on 0-10 scale)	Mild pain (e.g., 1-3 on 0-10 scale)	Severe pain (e.g., 7-10/10 on 0-10 scale)
+ Low dose opioid (Tremedol, Fetanyl, Bupremorphine)	+ Non-opioid (e.g.,NSAID)- if not contraindicated for adults;acetaminophen- pediatric and adults>65 yrs	High dose opioid (eg, Fentanyl, bupremorphine, butorphenol)
Adjuvant analgesic(e.g., antidepressants: amitriptyline, desipramine, nortriptyline, anticonvulsants:gabapentin, Tegretol)		

i. +/-

2. +/- + +/-

4.1.7 Choose IV or PO routes instead of IM for administering pain medications.

4.1.8 Prevent, anticipate, and institute aggressive treatment for pain before, during, and after all painful diagnostic and/or therapeutic procedures

4.1.9 Pain management resources include Pharmacy.

The presence of pain shall be assessed on admission to the hospital, post invasive procedure and when the patient complains of pain. This assessment shall be performed by a resident physician and/or nurse and documented in the medical record.

If pain is present, a more comprehensive assessment shall be performed, including, but not limited to:

a. pain location
b. intensity
c. character
d. duration
e. what improves pain
f. what increases pain
g. pain management history

4.2 The patient's report of pain shall be accepted and respected as the key indicator of the amount of pain he/she is experiencing.

4.3 The medical/nursing staff shall assign the rating only if the patient is unable to report their pain.

4.4 The Wong-Baker FACES Pain Scale [WBF], consisting of graduated facial expressions of pain, shall be used for patient's aged above 5 years or above and for those below 5 years a FLACC scale shall be used. For comatose patients a Behavioral Pain Scale shall be used.

4.4.1 If pain is present, the physician shall be notified and pain assessment shall be performed as often as needed by a licensed physician / nurse.

4.5 If no pain is present, the physician / nurse reassesses the patient for pain as warranted by patient condition, when the patient complains of pain specifically in a post-invasive procedure situation.

4.6 All reassessments and interventions shall be documented in the medical record.

5.0 Assessment of Patient for Pain:

Inpatient Areas: A physician generally manages pain.

1. Assess patients for comfort in an ongoing manner. Screen all patients for pain on admission to the hospital. Thereafter, monitor the patient for pain:
   - At least once a day.
   - When an intervention or treatment to relieve pain is provided.
   - Post surgical situations.
   - When the patient's location of care changes.
2. If the patient confirms current or recent pain at the time of admission, record a pain scale score (0-10) on Wong Baker Faces Scale and additional information from screening data on the Admission History form. Refer Annexure 1
3. Patients unable to rate their pain will be assessed by Behavioral Pain Score
4. Additional scales may be used for pediatric patients. Refer Annexure 1

Pain can be described in terms of location, duration, intensity and etiology. Location-wise pain description may be problematic because of similar clinical presentations but different clinical needs (Referred, Visceral, Radiating pain). Based on duration is acute pain and chronic pain. Based on intensity is mild, moderate and severe pain. Lastly based on etiology is somatic pain and neuropathic pain.

Factors influencing pain are age, gender, culture, meaning of pain, attention, anxiety, fatigue, previous experience with pain, coping styles, and family and social support.

Commonly used pain descriptors by patients are:

TERM	SENSORY WORDS	AFFECTIVE WORDS
Pain	Sharp, Piercing, Shooting, Burning, Crushing, Penetrating	Unbearable, Intense, Torturing, Terrifying, Exhausting, Suffocating, Miserable
Hurt	Hurting, Pricking, Pressing, Tender	Heavy, Throbbing
Ache	Numb, Cold, Radiating, Dull, Sore, Aching, Cramp	Annoying, Nagging, Tiring, Uncomfortable, Sickening, tender

Assessing the pain - Nurses' Role:

- Accuracy in pain assessment is essential for effective pain management. Pain is important and thus is often called the fifth vital sign.

- The extent and frequency of assessment varies according to the situation.
- First important consideration is to obtain pain history to get the facts from the patient. The patient should be allowed to express in his/her own words the experience of pain. Location, intensity, quality of pain, pattern and other factors can be described by the patient.
- Secondly the nurse should observe the behavior of patient, look for signs of tissue damage and secondary physiological responses.
- Based on the observation character of pain should be described (sharp/dull/aching/burning); Acuity of pain to be identified (acute/chronic); Modifying factors to be considered (increasing/decreasing) and location of pain to be ascertained. All these elements are recorded in the Pain Assessment sheet.
- Frequency of assessment of pain is that the patient assessed for pain at least once in a shift by the nurse and once daily by the doctor.
- If the pain score is <4 the nurse has to intervene and provide comfortable position and devices and should ensure that the pain is relieved.
- If the pain score is >=4, inform the doctor and provide intervention for pain reduction after obtaining a written drug order by the doctor in drug chart. Intervention to be recorded also in the Pain Assessment Sheet by the nurse.
- Document the pain scoring after one hour of intervention. Post intervention monitoring of pain to focus on the state of pain (reduced or status-quo) and observation documented.
- Based on these observations the patient and family have to be educated on pain management and documentation made in pain assessment sheet.
- Tools for Scoring of Pain assessment are –

	○ FLACC pain Scale	○ (FLACC) For 0-5 yrs of age (discussed in Chapter 19)
	○ Visual Analog Scale	○ (VAS) For Adults

	○ Behavioral Pain Scale	○ (BPS) For critically ill, unconscious, geriatric patients

Visual Analog Scale (VAS):

Visual Analogue Scale is a measurement instrument of Pain Scoring that depicts ten subjective characteristics of faces ranging from no pain to worst pain. Nurse observes and measures the characteristics /attitude that is believed to range across a continuum of values and cannot easily be directly measured. The nurse assesses the pain intensity using this scale by matching the facial expressions of the patient with the scale and making a scoring.

Description of VAS pictures:

- **Score 0, 1 & 2** – (0) Smiling face is characterized by upturned corners of the mouth, brightening of the eyes and a look of pleasure or contentment. As the pain starts to increase the scoring is (1) or (2) namely mild pain.
- **Score 3 & 4** – (3) Inexpressive face refers to a neutral, at ease, relaxed, or blank look. When the look further worsens it is scored as (4), annoying pain.
- **Score 5 -** Sad is characterized by an unhappy, lonesome, sorrowful, or dejected look. There may be tears in the eyes. The scoring is (5)
- **Score 6** - Frightened is characterized by a look of fear, alarm or heightened anxiety. Eyes appear wide open. The patient has moderate pain but the patient is able to bear it.
- **Score 7 & 8** - (7) Frown is characterized by a downward turn of the corners of the mouth. Increased facial wrinkling in the forehead and around the mouth may appear in (8). This pain is beginning to be severe.

- **Score 9 & 10** – (9) Facial grimacing is characterized by a distorted, distressed look. The brow is more wrinkled as is the area around the mouth. Eyes may be squeezed shut.
- This is the most severe pain (10).

Behavioural Pain Scale (BPS):

This scale is used for the critically ill, unconscious, comatose patients and geriatric age group. These patients are unable to self-report the level of pain experienced by them. The elements assessed for ascertaining pain score are three namely- facial expressions, movement of upper limbs and compliance with ventilation. Every element is scored and at the end the total score is considered for assessment of pain.

Based upon the assumption that a relationship exists between each score and pain intensity, each pain indicator is scored from 1 (no response) to 4 (full response), with a maximum score of

Description of Behavioural pain scale: The total BPS score can range from 3 (no pain) to 12 (most pain). The nurse assesses the patient for the following components:

Facial expression: Score 1: Relaxed; **Score 2:** partially relaxed (brow lowering); **Score 3:** Fully tightened (eyelids closing); **Score4:** Grimacing

Upper limbs: Score 1: No movements; **Score 2:** partially bent; **Score 3:** Fully bent with finger extension; **Score4:** permanently retracted

Compliance with ventilation: Score 1: toleration movement; **Score 2:** coughing but toleration ventilation for most of the time; **Score 3:** Fighting ventilator; **Score 4:** Unable to control ventilation

Behavioral Pain score

- The total Behavioral Pain Scoring is out of 12.
- If the scoring is >= 5, pain intervention is to be done by the nurse.
- Inform the doctor and provide intervention for pain reduction after obtaining a written drug order by the doctor in drug chart.
- Intervention to be recorded also in the Pain Assessment Sheet by the nurse.
- Document the pain scoring after one hour of intervention.
- Post intervention monitoring of pain to focus on the state of pain (reduced or status-quo) and observation documented.

- The pain assessment is a very important part of nursing assessment and is to be documents as per the protocols in the Pain Assessment Sheet. Pictures of the sheets are provided so as to make process easier and clearer.

Care of Patients: Recommended Intervention

- Non-invasive methods (e.g., repositioning, massage, music, distraction) - Assess the effectiveness of pain intervention within two hours after treatment.

- **Pharmacologic Treatment:**
  Step 1: Nonopioid and adjuvant analgesics:

a. Acetaminophen and NSAIDS, including aspirin and other salicylates, are useful for acute and chronic pain due to a variety of etiologies such as surgery, trauma, arthritis, and cancer. Acetaminophen and most NSAIDS are antipyretic through inhibition of cyclooxygenase; NSAIDS, (but not Acetaminophen) also have anti-inflammatory efficacy.
b. A number of other classes of drugs may enhance the effects of conventional analgesics, have independent analgesic activity in certain situations, or counteract the side effects of opioid analgesics. All classes of medication listed below (section iii) can also be used in children, and may be considered for use at any step.
c. Tricyclic antidepressants (analgesic effects), antihistamines (analgesic, antiemetic, mild sedative), benzodiazepines (anxiety and muscle spasm), and other drugs such as caffeine, dextroamphetamines, steroids, phenothiazine, anticonvulsants, and clonidine.
d. In general, non-opioid and adjuvant analgesics have a ceiling effect and do not produce tolerance or dependence.

Step 2: Low to moderate potency opioid analgesics

a. Add low to moderate potency opioid analgesics to manage acute and chronic pain that does not respond to non-opioid and adjuvant analgesics alone.
b. Sedation, constipation, nausea/vomiting, itching, and respiratory depression are the most common side effects of opioids. Multiple pharmacologic agents may be used to treat such side effects
c. As in Step 1, consider non opioid and adjuvant analgesics, and continue if already being administered.

Step 3: Moderate to high potency opioid analgesics

a. Add moderate to high potency opioid analgesics to manage acute and chronic pain that does not respond to non-opioids and adjuvant analgesics and low to moderate potency opioids.
b. Sedation, constipation, nausea/vomiting, itching, and respiratory depression are the most common side effects of opioids. Multiple pharmacologic agents may be used to treat such side effects.
c. As in Step 1, consider non-opioids and adjuvant analgesics, and continue if already being administered.
d. Replace any low to moderate potency opioids begun in Step 2 with moderate to high potency opioids in Step 3.
    a. Assess the effectiveness of pain intervention within two hours after treatment.
    b. If pain intervention is not effective, notify the physician.

6.0 Patient/Family Education

When appropriate, patients and families are instructed by the medical/nursing staff regarding

a. Pain
b. Risk factors for pain
c. The importance of effective pain management
d. Use of the appropriate pain assessment scale and process
e. Methods for pain management when identified as part of treatment.
f. Education is documented in the medical record.

7.0 Implementation

a. Therapy shall be implemented to minimize the level of pain. The plan shall be expanded from the initial therapy consistent with the diagnosis.
b. Patients and attendant shall receive pre-therapy instruction by the appropriate staff regarding the method or therapy selected.
c. Patients shall receive pain management that is individualized based on patient feedback /objective signs, as to his/her rating.

Annexure 1

Reference: Wong Baker Faces – pain assessment scale in ICU Charts and Inpatient Record

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 jerking

Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaining	Crying steadily, screams or sobs, frequent Complaints
Consolable	Content, relaxed	Reassured by occasional, touching, hugging, or being talked to, distractible	Difficult to console or comfort