GUAM MEMORIAL HOSPITAL AUTHORITY
NURSING SERVICES MANUAL
SKILLED NURSING UNIT

APPROVED	RESPONSIBILITY	ORIGINATION DATE	POLICY NO.	PAGE
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TITLE: PAIN MANAGEMENT				
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PURPOSE:

To ensure effective pain management for all residents through implementation of a multidisciplinary Pain Management Program that includes the input of the resident and family members, and recognizes the rights of residents for effective pain control.

POLICY:

All residents of GMHA Skilled Nursing Unit have a right to effective management of their pain. This includes appropriate screening and assessment for pain, care and treatment of their acute and/or chronic pain, and education as to how to manage their pain on an ongoing basis, as well as attention to any needs related to their continuum of care

DEFINITIONS:

- Pain: An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.
- Acute Pain: Pain, most often, a clear cause, relatively brief in duration that subsides as healing takes place. Acute pain has many causes—surgery, sprains, fractures, and burns. Acute pain if often accompanied by observable signs of pain—such as increased pulse rate, increase in blood pressure, nonverbal signs and symptoms such as facial expressions, and tension muscles.
- Chronic Pain: Pain that is constant or recurs. When pain persists it serves no useful purpose and may dramatically decrease the quality of life and function. Chronic pain is perceived by those who suffer it as irreversible and meaningless. Chronic pain rarely has any observable or behavioral signs although persons may appear anxious or depressed.

PRINCIPLES OF PAIN MANAGEMENT:

- Believe the resident and family in their reports of pain and what relieves it
- Ask about pain on admission and regularly. Assess pain systematically.
- Choose pain control options appropriate for the resident, family and setting.
- Deliver interventions in a timely, logical, and coordinated fashion.

- Empower residents and their families. Allow choices whenever possible. Enable them to control their course to the greatest extent as possible.

- When using a pain scale tool, always use the same tool unless the resident condition warrants a change.

- The goal of pain management is complete pain relief, or a pain level which is tolerable to the resident, as stated during reassessment, enabling resident to return to his/her basic activities. This level will be identified as the resident's comfort goal

RESPONSIBILITIES:

- All staff providing direct patient care is responsible for performing pain management activities as outlined in this policy.

- Unit supervisors are responsible for ensuring that all direct patient care staff have completed the pain management competency requirement.

- Unit supervisors are responsible for participating in Performance Improvement activities in order to monitor and improve processes associated with pain management.

PROCEDURE:

I. INPATIENT ASSESSMENT

A. **ALL residents** will be screened for pain during the initial general admission process. For residents who cannot verbalize their pain (such as newborns, infants, children, or the cognitively impaired), the use of behavioral pain tools (CRIES, NIPS, or FLACC) shall be utilized.

B. Initial Pain Assessment shall be performed for all residents who screen positive for having pain during the general admission process, or when the resident first reports of pain during his/her admission. This assessment will include

1. Description of pain

2. Intensity of pain (pain scale tools)

3. Location of pain

4. Duration of pain

5. Aggravating/Alleviating Factors

6. Type of pain (acute/post-op) vs. chronic pain

7. Effects of pain on daily life

8. Any other symptoms with pain

C. For those residents who are unable to verbalize their pain, wherein the behavioral pain tools will be utilized, documentation shall include which pain scale tool was used, along

with observable behaviors (facial expressions, body movement, crying) and physiological measures (vital signs).

D. Frequent assessment of the presence of pain shall be done at minimum every four hours, along with every set of vital signs.

II. PAIN SCALE TOOLS

(*see* Attachment for various tools)

A. When using a pain scale, use the same scale every time with the same patient. Only change scales when the patient's cognitive ability changes. Also use what makes sense to the patient

B. The following pain scale tools will be utilized at GMHA and SNU.

1. Visual Analog Scale (VAS): a numerical scale (0-10), to be used for patients >10 years of age
2. Wong-Baker FACES: a scale of 0-10; used primarily for pediatric patients (ages 3-10). Can also be used for the non-English speaking population
3. FLACC: a scale of 0-10, used primarily in the pediatric population up to 7 years old
4. The Critical-Care Pain Observation Tool: a scale of 0-7, the higher the score, the greater the pain, used primarily in the intensive care setting, for intubated patients
5. NIPS: a scale of 0-7, wherein a score of three indicates pain; used primarily in the neonatal population

C. Interpretation of Numerical Scoring:

1. For scales of 0-10, in general:
   a. Scores of 0-4 indicate minimal to no pain
   b. Score of 5-6 indicate moderate pain
   c. Scores of 7-10 indicate moderate to severe pain
2. For scales of 0-7, in general
   a. Scores of 0-2 indicate minimal pain to no pain
   b. Scores of 3-4 indicate moderate pain
   c. Scores of 5-7 indicate moderate to severe pain

III. INTERVENTION

Pain management treatment plan will be based on individual resident assessment, pain severity, and multidisciplinary evaluation and input.

A. Pharmacological Inverventions

1. **As needed "prn" pain medication:** Most pain medications are administered, as needed (prn), per physician orders. The following guidelines will be used to determine which pain medication (non-opiod vs. opiod) shall be administered based on the resident's reported intensity level:

   a. Minimal pain may be treated with a non-opiod

   b. Moderate pain may be treated with a non-opiod and opiod combination

   c. Severe pain may be treated with an opiod first, then a non-opiod combination

2. **Post operative pain medication:** Post-operative pain management intervention may occur frequently as every hour for the first 24 hours after surgery. Timely interventions should be performed based on physician's orders, and should be reassessed appropriately. During post-operative stage, pharmacological and nonpharmacological interventions should be used concurrently.

3. **Guidelines to pain medication administration**

   a. Oral is the route of choice when indicated and tolerated by the patient. Rectal and transdermal routes should be considered before intramuscular injection

   b. Avoid intramuscular administration for pain medication, as it may increase the presence of pain.

   c. Post-operative patient should be administered pain medication around the clock for at least 24 hours, with additional as needed doses.

   d. Merperidine (Demerol) should not be considered as a first choice of opiods in the treatment of pain especially when needed for 48 hours or more. This is due to the build-up of the toxic metabolite normeperidene, which can cause seizures and dysphoria.

   e. Merperidine is contraindicated in residents with impaired renal function.

   f. Administer pain medication before any activity which may enhance the resident's pain perceptions, such as positioning, or deep breathing and coughing exercises.

   g. Anticipate common side effects of analgesics by early intervention (anti-emetics to prevent nausea/vomiting, or laxatives to prevent constipation

B. Non-pharmacological Interventions

Non-pharmacological management techniques may be used alone or in conjunction with pharmacological management. These interventions include, but are not limited to:

a. Heat

b. Cold/ice pack

c. Distraction

d. Environmental control

e. Imagery

f. Massage

g. Music

h. Positioning

i. Relaxation

IV. PAIN REASSESSMENT

A. Pain reassessment shall occur every four hours on all residents, as the fifth vital sign

B. A detailed pain reassessment shall occur based on the pain management intervention. This assessment shall include

a. Assessment/Response

b. Pain Intensity

c. Sedation

d. Side effects

e. Any other significant observation

C. Sedation Assessment: shall indicate whether the resident is:

a. Alert, awake

b. Slightly drowsy, easily arousable

c. Frequently drowsy, arousable yet drifts off to sleep during conversation; or

d. Sommolent, minimal to no response to physical stimulation

D. Reassessment for Post-operative Pain

Post operative pain medication administration may occur around the clock for at least 24 hours. Therefore, the detailed pain reassessment shall be done within 30 to 60 minutes after any intervention.

E. "as needed" (PRN) Pain Interventions & Non-pharmacological Interventions

A detailed reassessment of pain should occur within 30-60 minutes after an "as needed" pain intervention.

F. Pain Intervention via Continuous Analgesic Intravenous Infusion (Cancer pain)

1. Pain intervention may occur via continuous analgesic intravenous infusion, such as a Morphine drip. Therefore, a detailed reassessment of pain shall be every

hour for the first four hours, then every four (4) hours thereafter. If the resident is on a continuous analgesic from home and his/her pain is well-managed, then reassessment shall occur every four (4) hours.

2. Residents managed in this category may have "as needed" pain medication, therefore a reassessment for "as needed" pain interventions shall apply.

V. PHYSICIAN NOTIFICATION

Physician notification shall be based on the professional judgment of the licensed personnel. Notify the admitting physician immediately if the following occurs: hypotension, tachycardia (compared to baseline heart rate); respiratory depression, elevated temperature, or pain not relieved with current pharmacological and non-pharmacological intervention.

VI. RESIDENT EDUCATION

A. All residents will be instructed on the following:

1. Their right to effective pain management and their right to participate in decision

2. Importance of reporting any new pain

B. Residents who are to undergo any surgery (preoperative patient education), or who reports pain will be provided the following instructions:

1. The plan of care in regards to pain, and any changes

2. Type of pain medication prescribed and common side effects

3. Informing staff of increase in pain intensity

4. Safety issues, such as asking for assistance before getting out of bed, side rails up, and bed placed to the lowest position

5. Reporting any side effects of pain medication administration

VII. DOCUMENTATION

A. Pain management shall be documented appropriately

B. All pain medication that has been administered should be signed by the licensed personnel, with the date and time of administration in the Medication Administration Record (MAR).

C. All IV analgesics infusion shall be documented in the Intravenous Parenteral Form.

VIII. STAFF EDUCATION

A. All nursing staff shall be educated on GMHA and SNU Pain Management Policy annually.

B. Education on Pain management shall provide opportunities for the nurses to demonstrate effective practices in pain assessment and management.

C. Pain Management shall be included in the orientation program for nursing staff.

IX. MULTIDISCIPLINARY APPROACH:

Licensed personnel understand that effective pain management is a multidisciplinary approach, to include and not be limited to Pharmacy and Rehabilitative Services. All assessments and recommendations by other disciplines will be part of the plan of care for pain management.

X. MEASUREMENT OF OUTCOMES:

Organizational performance in pain management will be measured using subjective and objective parameters that quantify how effective the patient's pain is being managed. Efforts will focus on:

1. Improving timely assessment, intervention, and reassessment
2. Educating residents and family members in their role in pain management
3. Initiating a pain management care plan once the presence of pain has been identified.

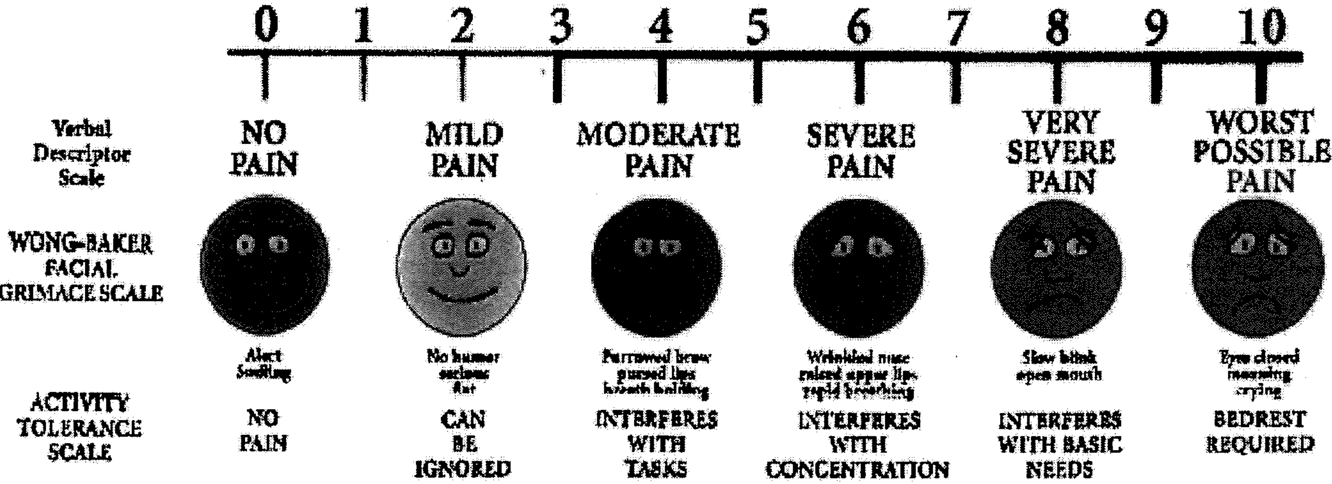
ATTACHMENT
PAIN SCALE TOOLS

VERBAL ANALOG SCALE

- Ask the resident to rate his/her pain from a scale of 0 to 10.

WONG-BAKER FACES SCALE

- Ask the resident to point at which face does he/she feel like



FLACC (FACE, LEGS, ACTIVITY, CRY, CONSOLABILITY)

- Observe the resident in each criterion and select the point beside which best describes the resident's behavior. The pain score is the total of each criterion.

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 comliant
2	Crying steadily, screams or sobs, frequent complaints
CONSOLABILITY	
0	Content, relaxed
1	Reassured by occasional touching, hugging or talking to, distractable
2	Difficult to console or comfort

NIPS

- Observe the resident in each criterion and select the point beside which best describes the resident's behavior. The pain score is the total of each criterion.

FACIAL EXPRESSIONS		
0	RELAXED MUSCLES	Restful face, neutral expression
1	Grimace	Tight facial muscles; furrowed brow, chin, jaw (negative facial expression—nose mouth, and brow)
CRY		
0	No Cry	Quiet, not crying
1	Whimper	Mild moaning, intermittent
2	Vigorous cry	Loud scream, rising, shrill, continuous
BREATHING PATTERNS		
0	Relaxed	Usual pattern for the child
1	Changed in Breathing	Indrawing, irregular, faster than usual; gagging; breath holder
ARMS		
0	Relaxed/Restrained	No muscular rigidity; occasional random movement of legs
1	Flexed/Extended	Tense, straight arms; rigid and/or rapid extension, flexion
LEGS		
0	Relaxed/Restrained	No muscular rigidity, occasional random movement of legs
1	Flexed/Extended	Tense, straight legs; rigid and/or rapid extension, flexion
STATE OF AROUSAL		
0	Sleep/awake	Quiet, peaceful sleeping or alert random leg movements
1	Fussy	Alert, restless, and thrashing

THE CRITICAL CARE PAIN OBSERVATION TOOL

- This tool is to be used for intubated and recently extubated patients
- Observe the patient in each criterion and select the point beside which best describes the patient's behavior. The pain score is the total of each criterion.

FACIAL EXPRESSION	
0	Relaxed, Neutral
1	Tense
2	Grimace
BODY MOVEMENT	
0	Absence of movement
1	Protection-slow, cautious movement, seeking attention through movements
2	Restless—Pulling at tube, uncooperative
MUSCLE TENSION (evaluated by passive range of motion)	
0	Relaxed-no resistance to passive movement
1	Tense, rigid-resistant to passive movement
2	Very tense, rigid-strong resistance
COMPLIANCE WITH VENTILATOR (FOR INTUBATED PATIENT	
0	Tolerating ventilator
1	Coughing but tolerating ventilator
2	Fighting ventilator
OR	
VOCALIZATION (for extubated patients)	
0	Talking in normal tone or no sound
1	Sighing, moaning
2	Crying out, sobbing

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

☐ Bylaws	Submitted by Department/Committee:	Nursing Services
☐ Rules & Regulations	Policy No.:	6580–D1 thru D38; 6580–D39 thru D63
☐ Policies & Procedures	Title:	SNU Unit Specific Policy & Procedures Section D – Standard of Nursing

	Date	Signature
Reviewed/Endorsed	12.22.2015	[signature]
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***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.**