	Department: PATIENT CARE Policy/Procedure: **PAIN ASSESSMENT AND DOCUMENTATION (ADULT)**

Refer to policy MC.E.48 for neonatal to pediatric pain assessment and management.

Definition:

Pain can be described as an unpleasant sensory or emotional experience associated with actual and potential tissue damage, disease, trauma, surgery or certain therapeutic procedures.

Policy:

1. Patients and their families shall be educated and informed that pain management is an important part of their care. Education should include pain assessment process, pain plan of care, and the importance of effective pain management

2. Each patient shall have the right to pain management through assessment, intervention and reassessment. Each patient has the right to expect his/her report of pain to be accepted, to have the pain assessed and reassessed, to have interventions provided and to achieve and maintain an optimal level of pain relief. The patient's self-report will be the primary means to determining pain. Torrance Memorial Medical Center (TMMC) employees shall assess and report the patients' pain across the continuum and intervene, as appropriate.

3. Ability to understand pain shall be assessed using an age or condition specific assessment tool. See Appendix B and C.

4. Pain assessments:
   a. A comprehensive pain assessment will be performed during the admission process and will include: a physical examination, patient's acceptable level of pain, pain history (including acute and chronic pain identification and assessment), medication, and non-medication pain interventions used at home or in the past.
   b. A routine pain assessment will include time, intensity of pain (level of pain) or behavior scale score, quality of pain (pain type) and location.
   c. A pain reassessment will include the time, intensity of pain (level or pain) or behavior scale score.
   d. The Pasero Opioid Sedation Scale (POSS) (Appendix D) will be assessed and documented with the pain assessment prior to administering opioids and during reassessment.
   e. The clinical assistive personnel may ask and document the patient's current pain level when taking vital signs and will report to the Registered Nurse so he/she can assess the patient and intervene, if needed.

5. Uncontrolled pain:
   When the assessed pain level is greater than the patient's documented or verbalized acceptable level of pain, a complete pain assessment shall be done following each pain medication administration or intervention including the following:
   - Assessment – time, intensity (pain level) or behavior scale score and location
   - Intervention – non-pharmacological or pharmacological
   - Measurement – time, intensity (pain level), and response or behavior and initials

6. Pain assessment frequency:
   a. Upon admission, every 4 hours when vital signs are taken or per unit's standard.
   b. Upon admission for an outpatient procedure, as appropriate and reassessed upon discharge.

7. Pain reassessment:
   Reassessment of pain will occur within one hour after administration of oral pain medication and within 15 to 30 minutes after parenteral administration.

8. Pain documentation in the medical record:
   a. An individualized pain management care plan is initiated and documented when a patient is admitted with pain or develops pain during admission.
   b. All pain assessment, patient education, non-medication pain interventions are documented.
   c. All pain medications administered, route, and time given are documented.

9. TMMC defines mild pain as 1-3, moderate pain as 4-7 and severe pain as 8-10, unless otherwise listed with a specific pain rating tool (see Appendix B).

10. For patients receiving Patient Controlled Analgesia (PCA) or Patient Controlled Epidural Analgesia (PCEA) Pain Management, refer to policy PC.E.85. If opioid administration is via Patient Controlled Analgesia (PCA), refer to policy N.E.160.

11. Patient's unable to self-report pain due to intubation or other barriers will be assessed utilizing the Behavioral Pain Scale (Appendix C). The scale is score on a 3 (no) to 12 (maximum) scale with mild pain defined as 3-6, moderate pain 6-9, and severe pain 10-12.

12. Staff shall be trained in Pain management and Opioid administration upon hire and as needed.

References:

- Assessing pain in non-untubated critically ill patients unable to self-report: an adaptation of the Behavioral Pain Scale. Intensive Care Medicine, Dec 2009. Vol 35 Issue 12, p2060-2067.
- The Joint Commission. (2015).
- American Pain Society http://www.ampainsoc.org, September 2011
- Horgas, Al. & Yoon, Sl. Pain Management: Evidence-based geriatric nursing protocols for best practices. 3rd edition. New York Springer Publishing Company, 2008. Pages 199-222.
- Registered Nurses Association of Ontario (RNAO). Assessment and management of pain: supplement. Toronto (ON): Registered Nurses Association of Ontario (RNAO); 2007.

Submitted by: Clinical Education

Initial Approvals and Major Revisions:

Nursing Policy/Procedure Committee 8/15/95
Nursing Standards Committee 8/23/95
Pharmacy and Therapeutics Committee 9/18/95
Medical Executive Committee 10/10/95
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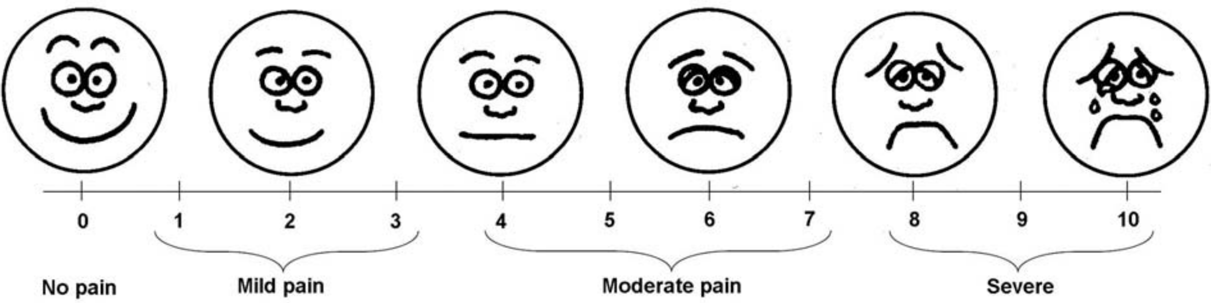
Attachments:

Appendix A. Pain Patient Teaching Tool
Appendix B. Universal Pain Assessment Tool
Appendix C. Behavioral Pain Scale for Non-Verbal & Cognitively Impaired Adults
Appendix D. Pasero Opioid Sedation Scale

Understanding Your Pain

Pain relief is an important part of the plan for your health care. At Torrance Memorial Medical Center, we promise to work hard to offer **safe and helpful treatment** when you have pain. Whether your pain is caused by disease, injury, surgery or a medical procedure, it is important to know that **most pain can be controlled.** We can work together to lesson your pain and help you get well faster.

When you feel pain, please tell your doctor or nurse about it. You are the one who can best tell us about your pain. We will ask you often to rate your pain using a **0 – 10 pain rating scale.** This tells us how much pain you are feeling and how well treatments are working. We may ask other questions to help us understand your pain.



Rate your pain on a scale off 0 – 10. 0 means "no pain", and 10 means "the worst possible pain". Moderate pain is in the middle, 4 – 6. A rating of 1 – 3 would be "mild pain". A rating of 7 or more is "severe pain". The goal is to treat pain early, before it gets worse.

There are different kinds of pain, and you can hurt anywhere in your body. It can feel like a dull ache, or it can be sharp. Pain can be throbbing, burning, cramping, pulling or tight, stabbing, tingling, or other unpleasant feelings. Please tell your doctor or nurse the type of pain you are having. Ask questions if you are not sure how to rate or tell us about your pain.

If pain gets in the way of your usual sleep, eating, energy, activity, relationships or mood, let us know. Pain can slow healing and prevent you from being active. We want you to be able to take part in your care and in the things that are important to you. There are many ways to lessen pain.

Rate your pain before and after you take your pain medicine. This helps your doctor and nurse know if your medicine or other pain treatment is working.

Tell your doctor or nurse about any side effects of the pain medicine. Some medicines may change your bowel movements, cause you to vomit, itch, feel sleepy, dizzy or weak. If we know about these, we can try to help.

Together we can make a difference. We cannot promise to make all pain go away. But we do promise to answer your questions and to work with you to find a treatment that is safe and works best for you.

872010102 (04/12)

Common Myths about Pain Management

Myth: Medications will cure all pain.
Fact: Medications can help control pain, but they rarely cure it.

Myth: I shouldn't take medications unless I'm in severe pain.
Fact: Preventing pain from developing is much easier than treating pain once it has begun. For best results, take pain medication on schedule.

Myth: Taking pain medication means I'm weak.
Fact: Feeling pain is a medical problem. Taking medication can help you get more of out of other treatments.

Myth: I'll get addicted to pain medication.
Fact: For those with no history of addictive disease, the risk is less than 1% (Joranson, Ryan, Gilson, Dahl, 2000).

Myth: Pain medications always cause heavy sedation.
Fact: Chronic pain can cause sleep deprivation and most opioids will cause initial sedation. However, once the patient catches up on lost sleep, continuing treatment…will allow them to resume normal mental alertness and orientation (Vilensky, 2002).

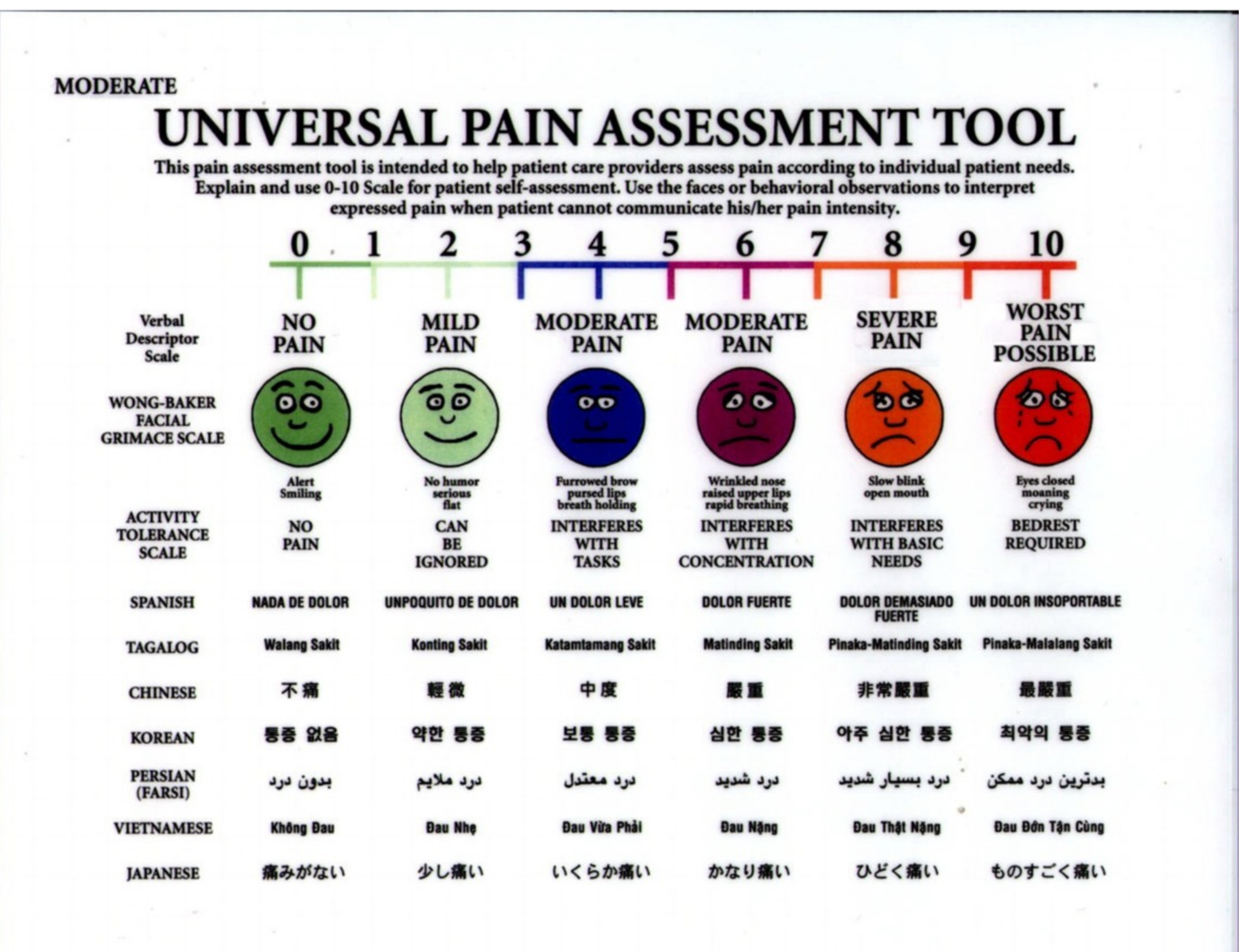
Myth: Effective pain management can be achieved on an "as needed" basis.
Fact: Medications provided "around the clock" have a much better impact on pain management with few side effects (Ead, 2005).

872010102 (04/12)

Appendix B

Universal Pain Assessment Tool

0-10 Numeric Pain Intensity Scale and Wong-Baker FACES Pain Rating Scale
In eight languages



Numeric Pain Intensity Scale (NPIS): A numeric rating of pain from 0-10, with 0 being no pain and 10 being the worst pain imaginable. Appropriate for patients greater than 8 years of age and/or who can describe pain. The NPIS will be used for all appropriate patients who are verbal and cognitively intact. The patient will be interviewed to determine the pain rating, while the patient is looking at the 0-10 pain scale

Wong-Baker Faces Scale: A visual pain rating scale for patients 3 years and older

Explain to the person that each face is for a person who feels happy because he has no pain (hurt) or sad because he has some or a lot of pain. Using language appropriate to patient and patient's age describe each fact to the patient. Face 0 is very happy because he doesn't hurt at all. Face 1-2 hurts just a little bit. Face 3-4 hurts a little more. Face 5-6 hurts even more. Face 7-8 hurts a whole lot. Face 9-10 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the person to choose the face that best describes how he is feeling.

Appendix C

Behavioral Pain Scale (BPS) Training Poster

BPS (intubated patients)

① Facial expression

1	2	3	4
Relaxed	Partially tightened = browlowering	Fully tightened = eyelid closing	Grimacing = folded cheek

② Movements of upper limbs

1	2	3	4
No movement	Partially bent	Very bent with finger flexion	Retracted, opposition to care

At rest: check the tonus by mobilisation of the limb

③ Compliance with ventilation

1	2	3	4
Tolerating ventilation	Coughing but tolerating ventilation most of the time	Fighting ventilator but ventilation possible sometimes	Unable to control ventilation

BPS-NI (non-intubated patients)

① Facial expression (=)

1	2	3	4
Relaxed	Partially tightened = browlowering	Fully tightened = eyelid closing	Grimacing = folded cheek

② Movements of upper limbs (=)

1	2	3	4
No movement	Partially bent	Very bent with finger flexion	Retracted, opposition to care

At rest: check the tonus by mobilisation of the limb

③ Vocalisation (≠)

1	2	3	4
No pain vocalization	Moaning not frequent (≤ 3/mn) and not prolonged (≤ 3 s)	Moaning frequent (> 3/mn) or prolonged (> 3 s)	Howling or verbal complaint including « Ow! , Ouch ! » or breath-holding

①+②+③ = Total BPS value

from 3 (no) to 12 (maximum) pain behavior rated using the BPS

Appendix D

Pasero Opiod-Induced Sedation Scale (POSS)

S = Sleep, easy to arouse
Acceptable; no action necessary

Recommendation: May notify prescriber to increase opioid dose if needed.

1 = Awake and alert
Acceptable; no action necessary

Recommendation: May notify prescriber to increase opioid dose if needed.

2 = Slightly drowsy, easily aroused
Acceptable; no action necessary

Recommendation: May notify prescriber to increase opioid dose if needed.

3 = Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable

Recommendation: Monitor patient, notify prescriber for order to decrease opioid dose 25% to 50%; consider administering a non-sedating, opioid-sparing non opioid, such as acetaminophen or an NSAID, if not contraindicated; ask patient to take deep breaths every 15-30 minutes.

4 = Somnolent, minimal or no response to verbal or physical stimulation
Unacceptable

Recommendation: Stop opioid, call RRT; consider naloxone; notify prescriber or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.