

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER –
SHREVEPORT

PAIN MANAGEMENT

Policy:

The LSUHSC-S healthcare professional:

- Recognizes the right of individuals to appropriate assessment and management of pain.
- Plans, supports, and coordinates activities and resources to ensure that the pain of all individuals is recognized and addressed appropriately.
- Provides individualized care in settings responsive to specific needs.
- Provides education on pain management as part of the patient's treatment considering the patient's personal, cultural, spiritual, and/or ethnic beliefs.
- Works with the patient to set, develop and implement a plan to reach a goal for pain relief.
- Develops plan in conjunction with the patient, if on discharge the patient has pain, to address management at home.
- Monitors the performance of the pain management program.

A. Patient Rights

1. Patient Rights will be communicated to the patients. A patient at LSUHSC-S can expect:
 - a. Information about pain and pain relief measures,
 - b. A concerned staff committed to pain prevention and management,
 - c. Health professionals who respond quickly to reports of pain,
 - d. That reports of pain will be believed,
 - e. State-of-the-art pain management, and
 - f. Dedicated pain relief specialists.
2. Patient Responsibilities will be communicated to the patients. LSUHSC-S can expect a patient to:
 - a. Ask the doctor or nurse what to expect regarding pain and pain management,
 - b. Discuss pain relief options with the doctors and nurses,
 - c. Work with the doctor and nurse to develop a pain management plan,
 - d. Ask for pain relief when pain first begins,
 - e. Help the doctor and nurse assess the pain,
 - f. Tell the doctor or nurse if the pain is not relieved, and
 - g. Tell the doctor or nurse about any worries regarding taking pain medication.

B. Assessment

1. A patient's report of pain will be accepted and respected as the key indicator of the amount of pain he/she is experiencing. Additionally, Surrogate Reporting (family members, parents, caregivers) can give credible information when the reporter knows the patient well and they should be encouraged to actively participate in the assessment of pain. (Medical/nursing staff will assign the rating only if the patient is unable to report their pain.)
2. The presence of pain is assessed on admission to the hospital, at the initial clinic visit, post invasive procedure and when the patient complains of pain. The assessment is performed by: a physician, RN, LPN, Physician's Assistant, Nurse Practitioner, or other licensed healthcare staff and documented in the medical record.
3. The frequency of pain reassessment shall be dictated by the intensity of the patient's pain and the effectiveness of pain relief strategies. However, when pain is present, a pain reassessment is generally performed at least every 4 hours and more often as needed by a licensed healthcare provider. The physician is notified of the patient's pain when treatment fails to reduce the pain to a level acceptable to the patient, as ordered by the physician, or pain score ≥ 5 using the approved Pain Scales (exception: those patients not assessed by the physician, i.e. triage, for patient safety and the prevention of abandonment from the hospital or clinic). If no pain is present, the licensed healthcare provider will reassess for pain as warranted by patient condition, when the patient complains of pain and post invasive procedure.

Note: Inpatient Nursing shall follow the guidelines in Nursing Policy P-5 Pain Documentation for pain assessment and reassessment.

http://www.sh.lsuhscc.edu/policies/policy_manuals_via_ms_word/Nursing/P-05.pdf

4. Pain Scales
 - a. The Numeric Pain Intensity Scale (NPIS) will be used universally to assess pain for patients 13 years or older. Patients will be asked to rate their pain a scale of 0-10. Zero represents no pain; a rating of 5 would indicate that the patient is experiencing moderate pain, and a rating of 10 would indicate the worst imaginable pain.
 - b. The Wong-Baker Faces Pain Scale, consisting of graduated facial expressions of pain, will be used for patients, ages 5-12 and those unable to comprehend the numerical scale. Zero will represent no hurt and a rating of 10 would indicate the patient is experiencing the worst possible hurt.

- c. The FLACCr Pain Scale is used if the patient is unable to self-report pain and for ages <5 years. For the cognitively impaired child, the FLACCr has been validated in the ages 4-21.
 - d. The Neonatal Intensive Care Unit uses a pain scale appropriate to their patient population and follows their unit-specific policy.
 - e. CPOT (Critical-Care Pain Observation Tool) a behavior assessment scale for the intubated and/or unconscious patients. Facial expression, body movements, muscular tension, resistance to passive movements, compliance with ventilator settings or vocalization is assessed.
 - f. CNPI (Checklist of Nonverbal Pain Indicators) a behavior assessment tool designed for the cognitively impaired adult. The tool measures the presence or absence of observable pain behaviors commonly associated with acute/surgical pain in non verbal adults. Nonverbal vocalizations, facial grimacing, bracing, rubbing, restlessness and vocal complaints are assessed with movement and at rest.
5. If pain is present, a more comprehensive assessment is performed, which may include:
- a. Intensity (Numerical 0 -10, Wong-Baker Face Scale, FLACCr, CPOT, CNPI, Surrogate Reporting)
 - b. Quality
 - c. Location(s) (All pain locations are assessed)
 - d. Onset
 - e. Duration
 - f. Variation
 - g. Alleviating and aggravating factors
 - h. Present pain management regimen and effectiveness
 - i. Medication history
 - j. Presence of common barriers to reporting pain and using analgesics
 - k. Past interventions and response
 - l. Manner of expressing pain
 - m. Effect of pain on activities of daily living, sleep, appetite, relationships, emotions and concentration.
 - n. Pain goal, expressed as measures of intensity and function.
 - o. Physical examination:
 - 1) Mental status examination
 - 2) Motor and sensory examination
 - 3) Reflexes
 - 4) Gait
 - 5) Maneuvers targeted to pain diagnoses
6. Documentation of pain, for all patients, should include the following:
- a. Type of pain and/or location
 - b. Intensity scale

- c. Level of consciousness
- d. Respiratory rate
- e. Activity
- f. Side effects
- g. Medication
- h. Patient and family education
- i. Treatment goal

7. Staff shall be educated about pain assessment, including the availability of nonpharmacological interventions.

C. Treatment

1. Pain is managed by pharmacological treatment, nonpharmacological treatment, and interventional procedures.
 - a. Pharmacological treatment may include non-opioids, opioids, and adjuvants.
 - b. Non-pharmacological treatment may include physical interventions and cognitive behavioral strategies.
 - 1) Physical interventions may include:
 - a). Heat
 - b). Cold
 - c). Electrical stimulation (eg., TENS)
 - d). Exercise
 - e). Physical/Occupational therapy
 - f). Immobilization
 - g). Manipulation
 - h). Massage
 - i). Acupuncture
 - 2) Cognitive behavioral strategies may include:
 - a). Distraction
 - b). Relaxation
 - c). Guided imagery
 - d). Biofeedback
 - e). Hypnosis
 - f). Other coping strategies
2. LSUHSC-S provides safe medication prescription or ordering.
 - a. Pain medication shall be ordered to be given as a specific dose with a regular schedule.
 - b. PRN orders shall include specific indications for specific dosing. Example: Time ranges such as “every 2-3 hours prn” are not

acceptable. A specified interval such as “every 3 hours prn pain” is acceptable.

- c. Range orders shall be avoided unless accompanied by a sliding scale. Example: Dose ranges such as 4-10 mg. Morphine IV every 3 hours are not acceptable unless it is tied to a measurable pain severity measure (i.e. For pain rating 5-7 administer morphine 5 mg. IVP every 2 hours prn pain; For pain rating 8-10 administer morphine 10 mg IVP every 2 hours prn pain).
- d. Specific protocols shall be used for PCA and epidural analgesia.
- e. Only one long-acting agent shall be prescribed at a time.

D. Patient Education

1. Patient education may focus on fears commonly held by patients in pain, including:
 - a. Fear of drug addiction,
 - b. Fear of drug dependence,
 - c. Fear of drug tolerance,
 - d. Fear of appearing uninformed or unable to understand, and
 - e. Fear of inability to function normally.
2. Educational content may include:
 - a. Definitions of physical dependence, drug tolerance, and addiction
 - b. Explanation of pain intensity scales:
 - 1) Numerical pain scale (0-10)
 - 2) Wong-Baker Faces pain scale (0-10)
 - 3) FLACCr Pain Scale (0-10)
 - 4) CPOT (0-8)
 - 5) CNPI (0-12)
 - 6) Surrogate Reporting
 - c. Explanation of treatments:
 - 1) Pharmacological
 - 2) Procedural
 - 3) Non-pharmacological
3. Potential media for patient education may include, but is not limited to:
 - a. Educational sessions documented in chart
 - b. Written materials such as, handouts, posters and brochures.
 - c. Audio- and videotapes
 - d. Patient surveys

E. Discharge

Discharge notes shall include reference to physical needs, emotional needs, and symptom management.



Administrator

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Date

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