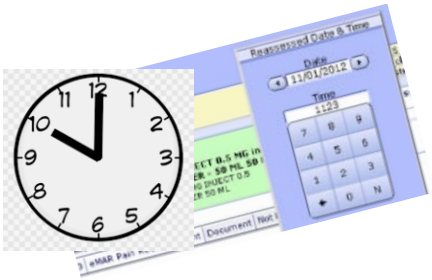
PAIN MANAGEMENT -- RESOURCE

12.21.2021

PAIN ASSESSMENT/REASSESSMENT



1. **PAIN REASSESSMENT Times**
   - **Acute Care Setting Reassessment Times**
     - ****Reassessment documented in eMAR**
       - **PO is reassessed in 30 minutes to 1 hour**
       - **SC/IM is reassessed in 30 minutes**
       - **IV is reassessed in 15 minutes**
     - ****Reassessment documented in the new PAIN Assessment Intervention**
       - **Non-pharmacologic therapies are reassessed in 60 minutes**

   - **PCA Reassessment – refer to PCA Policy & Assessment**
     - **PCA-At a minimum, the RN will assess and reassess Vital Signs, Pain Assessment, and Sedation Scale (RASS)**
       - **At Baseline**
       - **Within 15 minutes of set up**
       - **Every 2 hours for 8 hours, then**
       - **Every 4 hours & as needed**
     - **PCA-Change in Dose OR Rescue dose**
       Vital Signs, Pain Assessment, and Sedation Scale (RASS)
       - **Within 15 minutes of ANY prescription change or rescue dose**
     - **PCA-Every 4 hours document in the EMR**
       - **Number of Demand doses received**
       - **Number of Attempted doses**
       - **Volume infused**
       - **Reservoir (bag) volume**

   - **Palliative Care/End-Of Life Reassessment**
     - **MD/Provider orders drug, dose, vital signs, outcome (comfort & relaxed breathing)**
     - **eMAR Cosign: Bag hang or change**
     - **Handoff @ Shift & Transfer (order verified, drug, type of infusion, LIB)**
     - **IV Spreadsheet: Dose, rate change, amount Infused**

2. **OPIOID REASSESSMENT using RASS (Richmond Agitation-Sedation Scale)**
   Following **OPIOID** administration, reassessment includes the **RASS scale.**

3. WASTE OF CONTROLLED SUBSTANCES

Tablet/Liquid/Powder

a. Tablet-split medication with pill splitter. Remove waste and place into appropriate container **(CsRx)**.
b. Liquid/Powder-pour entire medication into measuring device/syringe. Remove waste and place into appropriate container **(CsRx)**.

IV Solution (e.g., PCA/Opioid infusion/anxiolytic infusion)

a. Measure liquid then pour into the appropriate container **(CsRx)**.
b. Complete **WASTE** in ADC.

Patch [Fentanyl patch]

*OLD Patch

a. Don gloves, as appropriate.
b. Remove old patch from patient. Fold patch in two. [Assess skin integrity.]
c. Identify RN to witness waste.
d. **Bring folded patch to ADC with RN Witness**. Refer to procedure (II) below.
   i. Sign in to ADC. Select **WASTE**
   ii. Witness signs into ADC
   iii. Follow prompts
e. Place/drop WASTE patch into the appropriate container **(CsRx).**

*NEW Patch

f. Remove patch from ADC.
g. Bring medication to patient bedside. Scan according to BCMA policy.
h. **Administer new patch** to patient.
i. Enter patient body location of new patch on eMAR Assessment (Medication Profile).

4. WASTE DOCUMENTATION IN ADC/PYXIS

PROCEDURE TO DOCUMENT CONTROLLED MEDICATION WASTE IN THE ADC

A. WHEN PATCH REMOVED **AT** 72 HOURS

1. Press **WASTE**
2. Select patient's name
3. Select **ALL MED**

4. Enter **DRUG NAME** (all forms will display on screen)
   a. Select appropriate **STRENGTH** of medication

5. At bottom left of the screen, press **WASTE NOW**
6. Follow prompts
   a. For Fentanyl patch
      Select quantity: **1**
   b. **ACCEPT**
   c. A second Health Care Professional must be logged in to witness the waste.

IF YOUR NAME APPEARS AS A WITNESS, YOU MUST VISUALLY SEE THE ENTIRE PROCESS AND WASTING PROCEDURE.

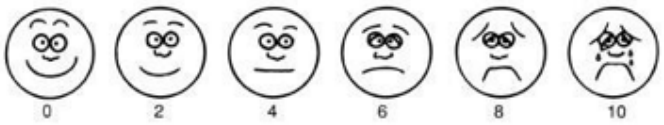
PAIN MANAGEMENT -- RESOURCE

5. PAIN MANAGEMENT SCALES

Wong-Baker Faces Pain Scale

- *Pediatrics 3 years of age and over*
- *Adults with difficulty expressing numeric values*

Using the pain rating scale is helpful for patients to communicate how much pain they are feeling.



Instructions:

- Explain to the patient that each face is for a person who feels **happy** because he/she has no pain (hurt) or **sad** because he/she has some pain or a lot of pain.

  Face 0 is very happy because he/she doesn't hurt at all.
  Face 2 hurts just a little.
  Face 4 hurts even more.
  Face 6 hurts even more.
  Face 8 hurts a whole lot more.
  Face 10 hurts as much as you can imagine, although you do not have to be crying to be feeling this bad.

- ***Ask the patient to choose the face that best describes how he/she is feeling.***

PAIN-AD Scale

Pain Assessment in Advanced Dementia (PAINAD) Pain Scale

- *Adult or patients unable to verbalize pain or express pain with numeric values or faces scales*

Pain Assessment in Advanced Dementia (PAINAD) *Adult or patients unable to verbalize pain or express pain w/ faces scale*				
SCALE	**0**	**1**	**2**	**TOTAL SCORE**
Breathing	Normal	Occasional labored breathing; Short period of hyperventilation.	Noisy labored breathing. Long periods of hyperventilation. Cheyne-Stokes respirations.	
Negative Vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated calling out. Loud moaning or groaning; crying.	
Facial Expression	Smiling or In-expressive	Sad; frightened. Frowning.	Facial grimacing.	
Body Language	Relaxed	Tense; Distressed pacing; fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract, or reassure.	

**Add ratings of each of the 5 categories and obtain the TOTAL SCORE.

PAIN MANAGEMENT -- RESOURCE

FLACC Scale

Face, Legs, Activity, Cry, Consolability (FLACC) Pain Scale

- *Pediatrics less than 3 years of age/Patients unable to communicate*

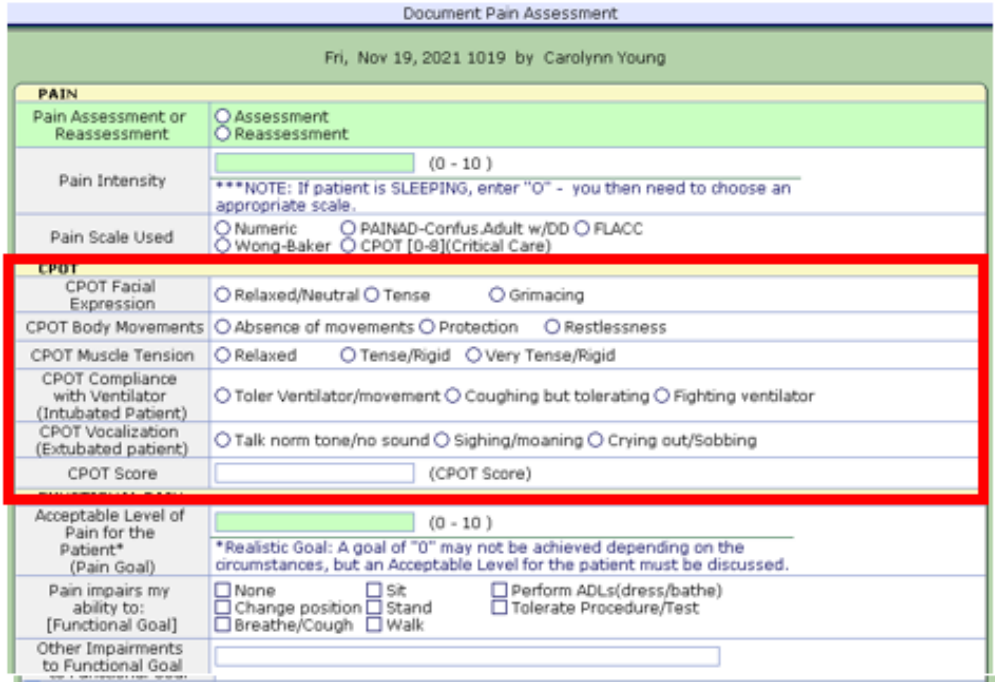
FLACC Scale (Face, Legs, Activity Cry, Consolability) *Pediatrics less than 3 years of age/Patients unable to communicate*				
SCALE	**0**	**1**	**2**	**TOTAL SCORE**
Face	No particular expression or smile.	Occasional grimace or frown, withdrawn, disinterested.	Frequent to constant frown, clenched jaw, quivering chin.	
Legs	Normal position or relaxed.	Occasional restless, shifting positions.	Kicking or legs drawn up.	
Activity	Lying quietly, normal position moves easily.	Squirming, tense, flexion of fingers and toes.	Arched, rigid, or jerking.	
Cry	No crying. (Awake or asleep).	Moans or whimpers. Occasional compliant.	Crying steadily, screams or sobs, frequent complaints.	
Consolability	Content, relaxed.	Reassured by touching, talking to, hugging, rocking, or distractible.	Difficult to console or comfort.	

**Add ratings of each of the 5 categories and obtain the TOTAL SCORE.

6. SPECIAL SITUATIONS

Critical Care Pain Observation Tool (CPOT)

CPOT is for Critical Care – Patients ONLY



Document Pain Assessment

Fri, Nov 19, 2021 1019 by Carolynn Young

PAIN	
Pain Assessment or Reassessment	○ Assessment ○ Reassessment
Pain Intensity	(0 - 10) ***NOTE: If patient is SLEEPING, enter "0" - you then need to choose an appropriate scale.
Pain Scale Used	○ Numeric ○ PAINAD-Confus.Adult w/DD ○ FLACC ○ Wong-Baker ○ CPOT [0-8](Critical Care)
CPOT	
CPOT Facial Expression	○ Relaxed/Neutral ○ Tense ○ Grimacing
CPOT Body Movements	○ Absence of movements ○ Protection ○ Restlessness
CPOT Muscle Tension	○ Relaxed ○ Tense/Rigid ○ Very Tense/Rigid
CPOT Compliance with Ventilator (Intubated Patient)	○ Toler Ventilator/movement ○ Coughing but tolerating ○ Fighting ventilator
CPOT Vocalization (Extubated patient)	○ Talk norm tone/no sound ○ Sighing/moaning ○ Crying out/Sobbing
CPOT Score	(CPOT Score)
Acceptable Level of Pain for the Patient* (Pain Goal)	(0 - 10) *Realistic Goal: A goal of "0" may not be achieved depending on the circumstances, but an Acceptable Level for the patient must be discussed.
Pain impairs my ability to: [Functional Goal]	☐ None ☐ Sit ☐ Perform ADLs(dress/bathe) ☐ Change position ☐ Stand ☐ Tolerate Procedure/Test ☐ Breathe/Cough ☐ Walk
Other Impairments to Functional Goal	

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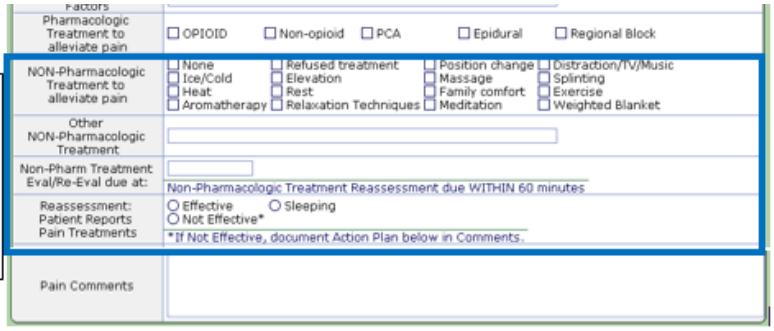
7. NON-PHARMACOLOGIC TREATMENT

"*I have a Headache*" → **Ice Pack given** ***REASSESS*** Pain#, Scale and was Non-pharm *Effective* or *Not*



8. BEDSIDE REFERENCE

Are you in pain?

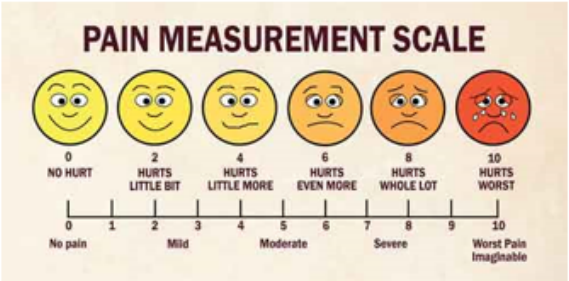
We would like to help you manage your pain.

At PHELPs, we use a 0-10 pain scale to describe pain intensity.

- 0 meaning **NO** pain and
- 10 meaning the **WORST** pain imaginable.

Use the scale below to help describe your pain.

- Choose the **number from 0-10 to rate your pain** or
- Choose the **face that best describes how you feel**



Pain Assessment In Advanced Dementia (PAINAD)

RN Assessment

	0	1	2
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying
Facial Expression	Smiling, or Inexpressive	Sad. Frightened. Frowning.	Facial grimacing.
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.
Consolability	No need to Console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.

Directions: For each of 5 rows, determine a score based on observed behavior. Add for total score (/10).
Possible interpretation of the scores. 1-3 = Mild pain; 4-6 = Moderate pain; 7-10 = Severe pain.