Subject:  Pain Management

Purpose:  To respect and support the patient’s right to appropriate assessment and management of pain. The relief of pain and suffering is integral to the mission of MMSC.

MMSC philosophy and approach to pain management is based upon and consistent with national standards derived from the body of scientific knowledge of the World Health Organization, the American Pain Society and the Agency for Health Care Policy and Research.

An interdisciplinary approach to pain assessment and management will be utilized.

Policy:  Patient Rights:
MMSC will provide appropriate pain management for all patients by staff who are knowledgeable about pain management principles and techniques. Patients will receive a prompt response to their reports of pain.

Patient Advocacy:
When a staff member has concern that the patient’s pain management needs are not being met that staff member has the obligation as a patient advocate, after thoroughly discussing the issue with the involved practitioner, to follow the normal process to resolve the conflict to their immediate supervisor, nursing administration or the Medical Chief of that service.

Responsibility:
Physicians are responsible for the medical management of pain. Registered Nurses are responsible for coordinating the interdisciplinary plan of care that includes pain management interventions and for following through with nursing interventions for pain management.

All staff with a role in pain management will be educated and competent in their appropriate responsibilities for pain assessment and management.
**Pain Assessment:**
Pain intensity and pain relief as reported by the patient will be assessed and documented.

An RN will assess all patients upon admission to the area. Patients will be reassessed twice per eight hours, and as indicated by the patient’s condition. Each patient is assessed for the existence and, if present, the nature and intensity of pain, duration, type & location, pain relief methods that have proven effective, cultural/spiritual influence, and patient’s pain relief goals. Learning needs, abilities, preferences and readiness to learn will also be assessed. For adults, the 0-10 Pain Rating Scale will be utilized based upon the Mankoski Pain Scale, the Descriptive Scale, Scale for the Cognitive Disabled, Color Scale, or Faces Scale may also be utilized. For pediatric patients or patients unable to utilize the 0-10 scale, the “Faces Scale” Descriptive Scale (mild, moderate, severe, very severe, worst possible), Wong-Baker Faces Scale, FLACC Pain Assessment Tool or the scale for the Cognitive Disabled may be utilized. The scale for the cognitively disabled/impaired and the NIPS (Neonatal Infant Pain Scale) may be utilized. Non-English versions of the 0-10 Pain Rating Scale are available.

Assessments will be documented in the medical record and will facilitate interdisciplinary assessment and reassessment of the patient.

Reassessment will be completed at least twice per eight hours and as indicated by the patient’s condition. A reassessment will be completed after a pain control intervention is employed to evaluate its effectiveness.

Other clinical department staff will perform their discipline specific pain assessment as part of their assessment and reassessment of the patient. Appropriate interventions are documented on the interdisciplinary plan of care.

**Pain Management Intervention:**
Organization-wide pain management protocols and guidelines will support the appropriate prescription and ordering of effective pain medications and the appropriate adjuvant interventions

If pain is rated > 4 (on a 0-10 scale) or more than mild or is unacceptable to the patient, there will be an intervention to reduce the pain. If pain is not improving, additional measures should be taken unless reasons for waiting longer are documented.
Prophylactic pain interventions will be considered, (E.g. – EMLA crème, lidocaine injection before IV starts, and consider a mid-line catheter or PICC for difficult or multiple IV needs).

Pain management and symptom management will be addressed in the discharge planning process utilizing an interdisciplinary process. The management plan will be communicated across care settings.

Patients and their families will receive appropriate education related to their specific pain management needs and issues at the appropriate time during their stay including:

- Patient rights to appropriate pain management and that pain relief is a primary goal of patient care;
- use of the pain rating scale and the importance of self reporting their pain;
- causes of their pain;
- pharmacologic and non-drug ways to achieve pain control;
- safe and effective use of prescribed medication and potential side-effects/interactions;
- who to contact for problems or questions.

AHCPR Guidelines for Acute Pain and for Cancer Pain are the standard of care at MMSC.

Signs are posted in patient rooms advising them to tell an MMSC employee if they are experiencing pain or discomfort. Interdisciplinary education supports this process.

The Pharmacy & Therapeutics Committee and Patient Care Evaluation Committee is responsible for conducting referred medical reviews on pain management issues.

**Special Information:**

1. The following principles of pain management will provide a framework for the pain management provided to individual patients:
   - The best indicator of the patient’s level of pain is their self report.
   - Base the initial choice of analgesic on the intensity and type of pain. Non-opioids for mild pain (rating 1-4); opioids, often in combination with a non-opioid, for moderate (rating 5-6) to severe (rating 7-10) pain. Neuropathic pain may require an antidepressant or anticonvulsant drug. (Refer to emergency department protocols for management of pain in specific patient populations in the emergency department such as migraine headache, muscle sprains/strains and low back pain.)
   - Give adequate doses according to the individual patient situation and established protocols. Dose to the maximum dose of non-opioid if side effects permit. There is no maximum dose or analgesic ceiling with most opioids.  
     Increase opioid
dose until pain relief is achieved or side effects are unmanageable before changing medications.

- Avoid using multiple opioids or multiple non-opioids (drugs from the same class at the same time) when possible.
- Nonpharmacologic interventions are intended to supplement, not substitute for pharmacologic intervention.
- Anticipate and vigorously treat side effects.
- Administer drugs orally whenever possible. Avoid intramuscular injections; intravenous is a preferable parenteral route over intramuscular. (OR cmte)
- Administer drugs on a regular basis/around the clock; scheduled as opposed to requiring the patient to request analgesics only when they have pain. Prevent pain whenever possible.
- Addiction occurs very rarely in patients who receive opioids for pain control. Drug addiction, when suspected should be investigated and ruled in or out but not implied and ‘left hanging’ because it interferes with pain management. The hallmarks of addiction include: a) compulsive use, b) loss of control, and c) use in spite of harm.
- Do not use placebos to determine if the pain is “real.”
- Teach the patient to take the pain medication in anticipation of the pain.
- Assess response to the analgesic regimen & regularly assess response to treatment. Adjust doses accordingly. Change to another drug if side effects are unmanageable.

2. Effective pain management results in faster healing, lower incidence of complications, and decreased hospital stays. Pain is psychologically detrimental to energy level, motivation and self-image.

3. In unique patient populations (i.e. Migraine headache, ankle sprains, low back pain presenting in the emergency room setting where the patient history is unknown) where patients may report severe pain, they may be treated with non-opioid pain relievers, at the physician’s discretion.

References: