LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

SUBJECT: PAIN MANAGEMENT **POLICY NO.** 383A

CATEGORY: Provision of Care	**EFFECTIVE DATE:** 1/02
POLICY CONTACT: Inderjeet Julka, MD	**UPDATE/REVISION DATE:** 10/21
REVIEWED BY COMMITTEE(S): Medication Safety Committee (Pain Subcommittee)	

PURPOSE:
To provide guidelines on the Pain Management Program including assessment, treatment, and education program in accordance to State/Federal laws and regulatory requirements.

WHO MAY PERFORM:
All Harbor-UCLA Medical Center healthcare workers.

DEFINITIONS:

Pain:
- An unpleasant, sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. If untreated, pain may have negative effects on a patient's physical, emotional, and spiritual health which hinders acceptance, participation and response to medical treatment.
- Pain is highly personal and subjective and is whatever the patient says it is, existing whenever s/he says it does. Self-report of pain is considered the most reliable indicator of pain.
- Pain is often accompanied by emotional and spiritual responses, such as suffering or anguish, and effective management should include measures to address these responses.

Acute Pain: A normal, predicated physiologic response to an adverse clinical, thermal or mechanical stimulus. It is generally time-limited and is responsive to opioid and non-opioid therapy. **Note:** Acute pain episodes may be present in patients with chronic pain.

Chronic Pain: It is persistent pain that is not amenable to routine pain control methods. **Note:** Patients with chronic pain may have episodes of acute pain related to treatment, procedures, disease progression or reoccurrence.

REVISED: 8/02, 4/04, 11/04, 3/06, 8/10, 1/11, 7/17, 4/18, 10/21
REVIEWED: 1/02, 8/02, 4/04, 11/04, 3/06, 8/10, 7/17, 4/18, 10/21

APPROVED BY:
Anish Mahajan, MD
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Joy LaGrone, RN, MSN
Interim Chief Nursing Officer

Pain Management: The use of pharmacological and non-pharmacological interventions to control the patient's identified pain. Pain management extends beyond pain relief, encompassing the patient's quality of life and ability to work productively and/or, to enjoy recreation.

Pain Assessment: An evaluation of the cause of the patient's pain including, but not limited to: location, intensity, duration of pain, aggravating and relieving factors, effects on activities of daily living, sleep patterns, psychosocial aspects of the patient's life, acceptable level of pain, and effectiveness of current strategies including non-pharmacological interventions such as massage, acupuncture or guided imagery. The pain assessment includes the rating from the pain screen.

Proxy Pain Report: The patient is the preferred source of pain information. Proxy reports, during history gathering, is information taken from someone who knows a patient well, can assist staff in identifying changes in patient behavior that may indicate presence of pain in the event that the patient is unable to communicate and are severely/cognitively impaired.

HUCLA MC Pain Statement: Harbor-UCLA Medical Center supports every patient's right to have their need for pain assessment and treatment addressed. Pain is to be assessed and treated promptly and effectively as long as pain persists.

POLICY:

1. Patients receiving care at Harbor-UCLA Medical Center will be screened for pain upon initial admission/visit.
2. Patients indicating pain upon screening shall be assessed further for pain.
3. Patients shall be treated for pain and other related symptoms if they report pain interfering with function anytime during their hospital stay/visit.
4. Patients' responses to pain intervention shall be evaluated and documented in a timely manner.

PROCEDURE

I. PAIN SCREENING:

1. Any patient's report of pain will be accepted and respected as the key indicator of pain experience by the patient.
2. A report of "No" pain will be equivalent to "0" on the "0-10" score.
3. Any healthcare staff, other than a provider or a nurse, who receives a report of pain from a patient shall notify the patient's responsible care provider.
4. The Provider or RN is responsible for determining the appropriate screening tool/scale to be used, which includes:

   A. **Face, Legs, Activity, Cry, and Consolability (FLACC Scale):**
   A behavioral scale used to quantify pain by using five categories: Face, Legs, Activity, Cry, and Consolability. Each category is scored on a 0-2 scale which results in a total score of 0-10, with zero (0) being no pain and ten (10) being the worst possible pain. The tool is used for scoring pain in:
   - Children up to 5 years of age
   - Patients who are developmentally delayed

- Patients who have difficulty understanding a Numerical Rating Scale (NRS), who are greater than 5 years of age
- Patients who may not be able to verbalize the presence/severity of pain, and/or are non-communicative patients.

B. **N-PASS (Neonatal Pain Agitation and Sedation Scale):**
Used to evaluate the presence of pain in newborns to 100 day old infants. Pain should be presumed in neonates/infants in all situations that are usually painful for adults and children, and treatment should be used if there is any possibility of pain. This pain scale is documented as 0 to 10 or 11. If the patient is greater than or equal to 30 weeks gestation, pain intensity is rated on a scale of 0-10, with zero (0) being no pain and ten (10) being the worst possible plain. If the patient is less than 30 weeks gestation/corrected age, pain intensity is rated on a scale of 0-11, with zero (0) being no pain and eleven (11) being the worst possible pain.

C. **Numerical Rating Scale (NRS):**
A numeric pain assessment tool in which patients are asked to verbally rate their current pain intensity on a scale of 0 to 10, with zero (0) being in no pain, Mild pain (1-3); Moderate pain (4-6); Severe Pain (7-10) and ten (10) being the worst possible pain. The NRS is used for patients greater than 5 years of age.

D. **Critical-Care Pain Observation Tool (CPOT):**
A behavioral scale used to quantify pain by using four categories: facial expression, body movements, muscle tension, and compliance with the ventilator or vocalization of the extubated patient. Each behavior is rated from 0 to 2, which results in a total score of 0 to 8. Presence of pain is suspected when the CPOT score is greater than 2 or when the CPOT score increases by 2 or more. It is used for adult patients who are unable to communicate verbally secondary to mechanical ventilation, sedation, and changes in level of consciousness.

E. **Assumed Pain Present (APP):**
APP is the culmination of a pain assessment of a nonverbal patient, "usually when there is no appropriate behavioral assessment instrument to quantify behaviors systematically. "This includes patients who are unresponsive due to traumatic brain injury, pharmacologically induced coma or neuromuscular blockage. Pain is assumed to be present in these patients. Analgesics will be administered when clinically indicated.

F. **Defense and Veterans Pain Rating Scale (DVPRS):**
The DVPRS is a free graphic tool clinicians can use to facilitate self-reported pain diagnoses from patients. While it includes a numerical scale, it also includes functional word descriptors, color coding and pictures of facial expressions to describe pain levels. Green represents mild pain with a scale ranging from 0-4; yellow represents moderate pain with a scale ranging from 5-6, and red represents severe pain with a scale ranging from 7-10. The DVPRS also includes an additional visual tool: facial expressions that correspond with each number. The faces range from a full happy face representing a pain level of zero to a grimacing face representing a pain level of 10. Word descriptors are attached to each number on the DVPRS, ranging from *0 = No pain* up to *10 = As bad as pain can be, nothing else matters.*

5. **Screening of Ambulatory Patients**

A. Patients will have their pain screened as part of their intake vital signs.
B. If pain is identified, a further assessment of the patient's pain will be performed by the patient's care provider.
C. This screening will include a measure of pain intensity using the numeric rating scale or other appropriate pain assessment tool (e.g. PEG 3-item scale), as well as a description of other pain characteristics (i.e., location, quality, aggravating and alleviating factors, associated signs and symptoms, acceptable level of pain, and impact on functional ability).
D. Rescreening will be performed at subsequent clinic visits as appropriate.
E. Pain assessment will be performed in Ambulatory Care Clinics in relevant areas.

6. **Screening of Emergency Department (ED) Patients**
   A. Patients in the Adult and Pediatric ED will be assessed for pain during triage and subsequent vital sign collection.

7. **Screening of Inpatients**
   A. Patients receiving inpatient care at Harbor-UCLA Medical Center will have their pain screened upon admission and will be regularly reassessed thereafter as indicated by the persistence of pain, initiation of potentially painful procedures, or changes in medical status.
   B. This screening will include a measure of pain intensity using the numeric rating scale or other appropriate pain assessment tool as well as a description of other pain characteristics (i.e., location, quality, aggravating and alleviating factors, associated signs and symptoms, acceptable level of pain, and impact on functional ability).
      - Pain score: For chronic pain, pain score is reflective of pain on average typical day.

II. PAIN ASSESSMENT:

1. **History/Physical Examination:**
   A. A recent (<30 days) medical history and physical examination must be completed. This includes an assessment of the pain, physical and psychological function; a substance abuse history; history of prior pain treatment (pharmacological and non-pharmacological); acceptable level of pain, an assessment of underlying coexisting diseases or conditions; and documentation of the presence of a recognized medical indication for the use of a controlled substance.
   B. The complexity of the history and physical examination may vary based on the practice location. In the emergency department, the Provider and surgeon may not always be able to verify the patient's history and past medical treatment. In continuing care situations for chronic pain management, the Provider and surgeon should have a more extensive evaluation of the history, past treatment, diagnostic tests and physical exam.
2. When pain is present, a detailed assessment shall be performed to include the following parameters:
   - Pain intensity
   - Pain quality
   - Location
   - Onset, duration, variation, and patterns
   - Alleviating and aggravating factors
   - Present pain management regimen and its effectiveness
   - Use of any Complementary and Alternative Medicine (CAM) for pain management
   - Patient's pain goal (including pain intensity and goals related to function, activity, and quality

of life)
- Physical exam/observation of the pain site
- Pain management history: chronic pain only (including medication history, presence of common barriers to reporting pain and using analgesics, past interventions and responses, manner of expressing pain)
- Effects of pain: Chronic pain only, (including impact on daily life, function, sleep, appetite, relationships with others, emotions, concentration)
- Other characteristics as determined by the nature of pain: (i.e., expressions of sadness, grimacing, obvious discomfort, vital signs variations such as elevated blood pressure and tachycardia in light of absence of other causes).

3. Pain will be assessed using appropriate pain assessment tools.
   A. In the event that patient is unable to communicate with the healthcare team, input shall be sought from the patient's family or significant other(s) regarding the patient's pain and its treatment.
4. Pain assessment, appropriate to the patient's age, developmental level and medical condition, shall be documented in a way that facilitates regular reassessment and follow-up.
5. Assessment shall be performed as follows:

Initial:	As part of vital sign measurement, on admission/transfer and/or at the start of each shift
Ongoing:	As part of vital sign measurement, at intervals depending on the unit's routine assessment schedule, per patient's request, and/or as necessary

6. Reassessment will be done as indicated by persistence of pain, initiation of potentially painful procedures, changes in medical status, and/or after any interventions provided for pain management (pharmacological/non-pharmacological interventions).
   A. The following will be reported immediately to the Provider:
      - Uncontrolled pain
      - Pain intervention that do not achieve patient's pain goal in a timeframe appropriate to the intervention
      - New or worsening pain
      - Adverse effects of pain medication.

7. Assess for behaviors that are potentially indicative of pain, especially for patients who are unable to self-report pain. The following examples of behavior may be manifested singly or in combination:

Facial Expressions:	Frown; wrinkled forehead; grimace; fearful; sad
Physical Movement:	Restlessness; fidgeting; absence of movement; cautious movement; guarding; rigidity; generalized tension; trying to get attention
Vocalizing:	Groaning; moaning; crying; noisy breathing

III. PAIN MANAGEMENT

1. Pain treatment shall be based upon underlying principles of pain management and analgesic pharmacology, use of CAM, standard guidelines for opioid dosing/titration and opioid equivalency,

non-opioid treatment of chronic pain syndromes and pain management protocols for ambulatory care and inpatient services.

2. Pain Management will include any of the following:
   A. Pharmacologic – Non-opioid: There is not a minimum or maximum number of medications which can be prescribed to the patient under Federal or California law.
   B. Opioid Analgesics:
      - To prescribe controlled substances, the provider must be appropriately licensed in California, have a valid controlled substances registration and comply with federal and state regulations for issuing controlled substances prescription (e.g. checking PDMP database, naloxone co-prescribing).
      - Other providers, such as Nurse Practitioners, must only prescribe controlled substances within their scope of practice.
   C. Non-pharmacologic pain management and/or CAM may be considered which include physical interventions, acupuncture, or cognitive behavior strategies.
   D. Utilize the inpatient pain management order set embedded in the EHR to maximize non-pharmacologic and non-opioid treatment options
3. Treatment modalities shall be determined based on patient's need.
4. The treatment plan shall state objectives by which the treatment plan can be evaluated, such as pain relief and/or improved physical and psychological function, and indicate if any further diagnostic evaluations or other treatments are planned.
5. The provider shall tailor pharmacological therapy to the individual medical needs of each patient. Multiple treatment modalities and/or a rehabilitation program may be necessary if the pain is complex or is associated with physical and psychological impairment.
6. Providers may use control of pain, increase in function, and improved quality of life as criteria to evaluate the treatment plan.
7. When the patient is requesting opioid medications for their pain and inconsistencies are identified in the history, presentation, behaviors or physical findings, Providers who make clinical decision to withhold opioid medications should document the basis for their decision.
   A. The prescribing of controlled substances for pain may require referral to one or more consulting Providers.
8. When possible, provide treatment that is specific to a patient's diagnosis.
9. Placebo shall not be used for pain management unless it is as part of a clinical study approved by the hospital's Institutional Review Board.
10. Assess the results of treatment, and then adjust your therapy accordingly, until the best possible outcome is achieved.
11. Provide the patient with realistic goals and expectations. A "pain-free" hospital or healthcare experience is not always realistic, but minimization of pain and management of unavoidable induced pain are realistic goals.
12. The provider should discuss the safe use, risks and benefits of the controlled substances and other treatment modalities with the patient, family, caregiver and/or guardian.
13. A written consent or pain agreement for chronic use is not required but may make it easier for the provider and surgeon to document patient education, the treatment plan, and the informed consent. Patient, family, guardian, and/or caregiver attitudes about medicines may influence the patient's use of medications for relief from pain.

IV. STANDARD PERIODIC REVIEW:

1. Providers should periodically review the course of pain treatment of the patient and any new

information pertaining to the patient's state of health.

A. Continuation or modification of controlled substances for pain management therapy depends on the provider's evaluation of progress toward treatment objectives.

B. If the patient's progress is unsatisfactory, the provider should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

2. Patients with pain who are managed with controlled substances should be periodically assessed as required.
3. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment.

V. PAIN CONSULTATION

1. The provider should consider referring the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Complex pain problems may require consultation with a pain medicine specialist.
   A. In addition, providers should give special attention to those patients who are at risk for misusing their pain medications including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.
   B. Coordination of care in prescribing chronic analgesics is of paramount importance.
   C. In situations where there is dual diagnosis of opioid dependence and intractable pain, both of which are being treated with controlled substances, protections apply to providers who prescribe controlled substances for intractable pain complies with the requirements of the general standard of care and California Business and Professions Code section 2241.5.
      a. Consider MAT clinic referrals for assistance with patients with dual diagnosis of opioid use disorder and uncontrolled chronic pain
   D. Recommend provider consultation (for example: Anesthesia Pain Service, Palliative Care) for complex pain management needs.
2. Consult the Pain Service to assist in the management of pain when usual approaches are inadequate to meet the needs of the patient.
   A. In addition to Pain Service, consult other specialized pain specialists as appropriate such as Oncology Pain Service/Palliative Care Service.

VI. PAIN EDUCATION

1. Patients and caregivers shall be educated about pain and its treatment during hospital stay upon discharge. It must be an ongoing process throughout the patient stay.
2. Patient education may be provided verbally and/or in written instructions.
3. To ensure that patients, as well as their caregivers actively participate in pain management plans, they will be given information regarding their right to appropriate pain management, their role in pain management (including common reasons why patients hesitate to report pain) and their particular treatment plan.
   - Patient information materials will be culturally sensitive, developmentally appropriate, easily understood and available in multiple languages to accommodate the needs of our diverse patient population.

4. Patients and/or caregivers will be counseled by pharmacy personnel regarding the use of pain medication(s).
    - Instructions regarding the use of non-pharmacological interventions for pain management, and when and how to contact a healthcare professional, will also be provided.

VII. STAFF EDUCATION

1. To ensure that staff remain current regarding pain management practices, pain management education will be provided to all new hospital staff involved in patient care at their initial orientation and to all clinical staff as part of the hospital's annual reorientation program.
    - In addition, individual departments will periodically provide their staff with pain management education appropriate to their particular patient population.

VIII. DOCUMENTATION

1. Initial screening, assessment, reassessment, treatment and patient/family education regarding pain management will be entered in the electronic medical record.
2. The provider should keep accurate and complete records according to the items above, including the medical history and physical examination, other evaluations and consultations, treatment plan objectives, informed consent, treatments, medications, agreements with the patient, and periodic reviews of the treatment plan.
3. Documentation of the periodic reviews should be done at least annually or more frequently as warranted.
4. Pain levels, levels of function, and quality of life should be documented. Medical documentation should include both subjective complaints of patient and caregiver and objective findings by the provider.

IX. PATIENT DISCHARGE

1. Patient shall be assessed at the time of discharge.
2. Patient discharged with an acceptable or better pain score;
    A. A patient is considered "at risk" if his or her pain is unacceptable to the patient or guardian and is based on healthcare provider's assessment and patient acuity at the time of discharge.
    B. Patient identified as "at risk" shall be provided with instructions for follow-up and must be documented.

X. PAIN MANAGEMENT COMPLIANCE/MONITORING:

1. Monitoring and evaluation of the Pain Management Program will be conducted using performance improvement methods, tools, and techniques including, but not limited to, Patient Satisfaction Surveys and Focus Studies with objective criteria to ensure assessment and treatment strategies reflect a patient-centered approach.

Revised and Approved By:
Medical Executive Committee on 10/2021

Beverley A. Petrie, M.D.
Professional Staff Association, President