LOS ANGELES GENERAL MEDICAL CENTER POLICY

Subject:	Original Issue Date: 4/09/02	Policy # 803
PAIN MANAGEMENT	Supersedes: 4/17/20	Effective Date: 9/8/23

Policy Owner(s): Chief Nursing Officer
Executive Sponsor(s): Chief Executive Officer

Departments Consulted:	Reviewed & approved by:	Approved by:
Nursing Services Department of Anesthesiology Department of Emergency Medicine Department of Internal Medicine Department of Neurosurgery Department of Obstetrics/Gynecology Department of Orthopedics Department of Pediatrics Department of Pharmacy Department of Surgery Ethics Resource Committee	Attending Staff Association Executive Committee Senior Executive Officer	Chief Executive Officer Chief Executive Officer

PURPOSE

To describe a Medical Center-wide interdisciplinary approach to pain management consistent with State laws and guidelines issued by the Joint Commission.

POLICY

Los Angeles General Medical Center assures that every patient seen in its ambulatory care settings or admitted to the hospital is assessed and treated effectively for pain and other related symptoms. This also includes evaluation of the efficacy of interventions with written documentation of all elements in the patient's health/medical record.

DEFINITIONS

The following four pain rating scales are approved for use within the Medical Center.

- **Wong-Baker FACES Scale:**
  A visual pain assessment tool featuring images of facial expressions to help the patient describe the intensity or severity of pain. Each facial expression consists of a numerical score which correlates to a pain intensity/severity on a scale of 0 to 10, with zero (0) being no pain and ten (10) being the worst possible pain. The scale is used for populations greater than 5 years of age.

- **Face, Legs, Activity, Cry, and CONSOL ability (FLACC Scale):**
  A behavioral scale used to quantify pain by using five categories: Face, Legs, Activity, Cry, and CONSOL ability. 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 NRS and/or Wong-Baker faces Scale who are greater than 5 years of age, and patients who may not be able to verbalize the presence/severity of pain or are non-communicative.

- **N-PASS (Neonatal Pain Agitation and Sedation Scale):**
  Used to evaluate the presence of pain 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 paint and eleven (11) being the worst possible pain.

- **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 and ten (10) being the worst possible pain. The NRS is used for patients greater than 5 years of age.

- **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.

- **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." (Quinn, 2006). 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.

PROCEDURE

Goals of Pain Management

In-patient Care

- Obtain a pain score at admission that is acceptable to the patient/guardian and is based on the patient's acuity.
- Manage pain at the patient's/guardian's acceptable score or better throughout hospitalization.

Ambulatory Care

- Assess for the presence of pain upon initial contact with the patient. When pain is identified, the patient is treated based on care setting and scope of services available or is referred for treatment.

Use of the Pain Scales

- The patient's self-report of pain shall be considered the single most valuable indicator of pain.
- As appropriate, each patient and/or family member, upon admission to the Medical Center, will be educated on the use of the appropriate scale in reporting pain intensity.
- One of the Medical Center approved scales will be used as a measure of the intensity of pain. The scale shall be appropriate to the age and development of the patient. The same scale will be used throughout the 24-hour day unless warranted by patient condition.

Initial Assessment of Pain

- All patients will be screened for the presence or absence of pain upon admission or initial contact in an ambulatory setting. The resulting numerical score or behavioral and physiologic indicators will be documented on the appropriate form.
- In the in-patient setting, the nurse will initiate the "Pain Management Clinical Nursing Standard" for any patient reporting pain during the assessment/reassessment.

Ongoing Assessment of Pain/Intervention

- The appropriate pain rating scale or behavioral and physiologic indicators will be utilized for the documentation of pain assessment and reassessment.
- The physician should be notified if the patient's pain score remains unacceptable to the patient/guardian and is based on the patient's acuity after the prescribed analgesic therapy has been maximized.
- In the ambulatory care setting, a reassessment is conducted when warranted by the patient's condition at clinic visit.

Patient Education

In-patient Care

- Each patient and/or family member, as appropriate, will be taught that the goal of pain management is prevention (when possible) and that early intervention in the course of pain is important. Patients/guardians will be encouraged to ask for analgesic interventions early, rather than waiting until the pain is severe.
- Each patient and/or family member will be taught the use of the appropriate rating scale to report his or her pain score.
- Patients will be informed that they will be regularly assessed throughout their stay regarding their level of pain.

Ambulatory Care

- Preoperative clinics will instruct patients and/or family members regarding pain management.

Pain Management at Discharge

- Patients will be provided with instructions for follow-up should pain continue to be an issue.

PROCEDURE DOCUMENTATION

Nursing Service Policy Manual
Nursing Service Clinical Protocol, "Pain Management"

REFERENCES

California Health and Safety Code, Section 1254.7
Joint Commission Standards (Ethics, Rights, and Responsibilities; Provision of Care, Treatment, and Services)
Los Angeles County Department of Health Services Policy# 311.102 "DHS Pain Assessment Tool Policy"

ATTACHMENTS

Attachment A: Wong-Baker FACES Pain Rating Scale
Attachment B: FLACC Behavioral Pain Rating Scale
Attachment C: Neonatal Pain, Agitation, & Sedation Scale (N-PASS)
Attachment D: Numerical Rating Scale (0-10)
Attachment E Critical Care Pain Observation Tool (CPOT):

REVISION DATES

April 19, 2005; September 8, 2008; October 14, 2008, September 13, 2011; February 11, 2014; April 11, 2017; April 17, 2020; September 8, 2023