MARTIN LUTHER KING, JR.
OUTPATIENT CENTER
POLICY AND PROCEDURE

DIVISION: CLINICAL	**NUMBER**: 2.118
SUBJECT: PAIN MANAGEMENT	
SECTION: MEDICATION MANAGEMENT	**PAGE**: 1 **OF: 2**
REVIEWED BY: POLICY AND PROCEDURE COMMITTEE	**EFFECTIVE DATE**: 11/01/07
TO BE PERFORMED BY: ALL CLINICAL PERSONNEL	**REVISED DATE**: 12/15/09 **REVIEWED DATE**: 6/24/14, 12/30/15

PURPOSE

To initiate a facility-wide interdisciplinary approach to pain management that will reduce pain and suffering for our patients who experience pain associated with a wide range of illnesses, including terminal illness.

POLICY

Clinical services shall implement procedures for early recognition of pain and prompt, effective response.
Patients are evaluated and re-evaluated in a more detailed, comprehensive manner as clinically indicated.
Education about pain management is discussed between the treatment team and the patient (and family).

PROCEDURE

Initial Assessments

Patients will be screened for presence or absence of pain.

1. Initial pain screening is done by the intake staff, which may include technicians, therapists, CMAs, LVNs, and RNs.
    a. Patients are screened for the presence or absence of pain
    b. If pain is present, patient will rate their pain on a scale of 1-10
    c. Screening tools include:

    Wong-Baker FACES Scale

    Pain rating scale consisting of an ascending numerical score and facial expressions correlated to level of increased pain intensity

    FLACC (Face, Legs, Activity, Cry and Consolability) Scale for Pediatrics

    A behavioral scale used for scoring pain in young children, infant to 5 years. It consists of five categories: Face, Legs, Activity, Cry and Consolability. The scale is used to quantify pain behavior in children who may not be able to verbalize their level of pain.

2. If the intake staff member is not licensed, he/she must report a pain score ≥8 to a licensed professional. This immediate notification is documented in the medical record.

3. A more detailed and/or immediate provider assessment of pain may include:

    a. Pain Intensity
    b. Pain location
    c. Quality of Pain (i.e. sharp, dull, throbbing, shooting, aching, tearing)
    d. Onset, duration, variation and patterns
    e. Present pain management regimen and effectiveness
    f. Pain management history
    g. Effects of pain (i.e. impact of activities of daily living, sleep, appetite, relationships with others, emotions, concentration)

4. When medication is administered or an intervention is conducted to relieve pain during the visit, the effectiveness will be documented:
    a. 15 to 30 minutes after parenteral drug therapy
    b. 30 to 60 minutes after oral administration.

5. Patient pain is managed by the clinical service where they present (if possible) or the patient will be referred to a more appropriate service.

Reassessments
When clinically relevant, during subsequent visits, providers document patient response to pain treatment and management. Referrals to adjunctive or definitive services will be initiated based on patient's condition.

Patient Education
Patient and family education may include: realistic goal setting for treatment, discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management.

NOTED AND APPROVED:

_____ _____
Cynthia M. Oliver, Chief Executive Officer Date

_____ _____
Ellen Rothman, MD, Chief Medical Officer Date

_____ _____
Lessie Barber, R.N., Nursing Director Date

Signature(s) on File.

Attachment: A

FLACC Behavioral Scale

(FULL TERM NEONATE – 5 YEARS OF AGE)

The FLACC is a behavior pain assessment scale for use in non-behavioral patients unable to provide reports of pain.

Categories	Scoring		
	0	1	2
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	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Each of the five categories (F) Face; (L) Legs; (A) Activity; (C) Cry; (C) Consolability is scored from 0-2, which results in a total score between zero and ten.			

Instructions:

1. Rate the patient in each of the five measurement categories

2. Add together the score

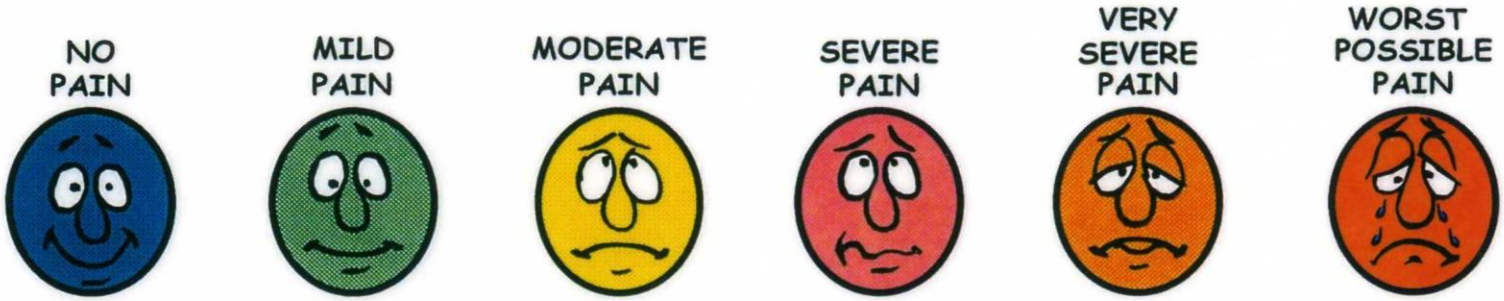
3. Document total pain score

PAIN ASSESSMENT TOOL

The pain assessment tool is intended to help patient care providers assess pain according to individual patient needs.

Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

FACIAL GRIMACE SCALE



ACTIVITY TOLERANCE SCALE

ENGLISH	NO PAIN	CAN BE IGNORED	INTERFERES WITH TASKS	INTERFERES WITH CONCENTRATION	INTERFERES WITH BASIC NEEDS	BED REST REQUIRED
SPANISH	NADA DE DOLOR	UN POQUITO DE DOLOR	UN DOLOR LEVE	DOLOR FUERTE	DOLOR DEMASIADO FUERTE	UN DOLOR INSOPORTABLE
TAGALOG	HINDI MASAKIT	MASAKIT NANG KAUNTI	KAINAMANG SAKIT	MATINDING SAKIT	NAPAKATINDING SAKIT	PINAKAMASAKIT NA POSIBLENG
VIETNAMESE	KHONG DAU	DAU NHE	DAU VUA	DAU NHIEU	DAU RAT NHIEU	DAU CUNG CUC
KOREAN	AHN APAYO	YAK GAN APAYO	BO TONG APAYO	SIMHAGAE APAYO	AJUSIMHAGAE APAYO	CHAMUISUUPSI APAYO