HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: VI-108 PAIN MANAGEMENT	**POLICY #**: 1145
	VERSION: 1
APPROVED BY: Aram. Messerlian (CHIEF PHYSICIAN I ANESTHESIOLOGY), Beryl Brooks (ADMR,COMP AMB HEALTH CARE CENTER), Leila Adriano (NURSE MANAGER)	
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PURPOSE: To provide guidelines for the pain assessment, management, reassessment and documentation of patients cared for at the Ambulatory Surgical Center (ASC)

POLICY: All patients receiving care in the ASC will be screened for pain. Pain assessment and reassessment will be performed and documented throughout the perioperative Process.

PROCEDURE:

I. ASSESSMENT

A. All patients cared for in the ASC will be assessed for pain.

B. Patient and their family member will be introduced to the concept of using a pain scale, to evaluate the level of pain experienced, during the pre-anesthesia evaluation unit (PEAU) visit and, again, on admission to the ASC.

C. The following are the Pain Intensity Scales/tools used in the ASC, as appropriate for the patient's age, cognitive ability, and communication capacity:

1. *Wong- Baker Faces Rating (see attachment)*: A visual pain assessment tool for children over the age of 4, 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 pain intensity on a scale of 0 to 5. 0 being no pain and 5 being the worst pain imaginable
2. *Numeric Scale Intensity 0-10 (see attachment)*: A numeric pain assessment tool, in which patients are asked to verbally rate their current pain intensity on a scale of 0 to 10. 0 being no pain and 10 being the worst pain imaginable

HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: VI-108 PAIN MANAGEMENT	**POLICY #**: 1145
	VERSION: 1

3. *Faces Pain Intensity Scale 0-10 (see attachment):* A visual pain assessment tool featuring images of facial expressions to help the patient describe the intensity or severity of pain. 0 being no pain and 10 being the worst pain imaginable
4. *Riley Infant Pain Scale (see attachment: Assessment)* of children less than 5 years of age, elderly who are cognitively impaired or patients who cannot verbally communicate pain may involve non-verbal behavioral observations or patients with learning barriers, may have difficulty communicating pain and assessment may have to be performed using behavioral observation tools.

D. Pain is considered the “fifth vital sign” and is to be evaluated each time the nursing staff takes the patient’s vital signs.

E. Initial pain assessment is documented on the Progress note by nursing staff. The patient is asked to identify and state a personal comfort goal.

F. The primary means of pain assessment is through patient self-reporting. The patient should not be told he/she does not have pain.

G. Every patient must receive both initial and ongoing evaluation and assessment of pain. Assessment includes but is not limited to:

1. Quality/ Description of the pain (as described by the patient): Ask the patient to verbalize characteristics of the pain: is it sharp, dull, burning, stabbing?
2. Region/Location: where is the pain?
3. Severity/ Intensity: Patient’s pain score.
4. Timing/ Duration: Is the pain intermittent or constant?
5. Aggravating and relieving factors.

H. Pain reassessment will continue while pain is being treated, including evaluation of patient’s satisfaction with pain management.

I. Each patient’s response to pain will be evaluated after administration of pain medication for response and when vital signs are obtained throughout the patient’s admission to the PACU and when deemed necessary.

HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: VI-108 PAIN MANAGEMENT	**POLICY #**: 1145
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J. Observe non-verbal behaviors for patients who are unable to self-report pain relief:
   1. Quiet, Relaxed
   2. Absence of facial grimace
   3. Non-crying
   4. Sleeping
   5. Stable vital signs

K. Assess/reassess for adverse effects of medication:
   1. Nausea/Vomiting
   2. Allergic reaction
   3. Respiratory depression
   4. Dizziness
   5. Risk for fall

II. INTERVENTION

A. Postoperative pain management can be initiated in the operating room. The surgeon's decision to infiltrate the operative area with local anesthesia prior to making the incision may effectively reduces the patient's need for narcotic analgesia following surgery.

B. Treatment of pain in the immediate postoperative period begins with a pain assessment by the PACU nurse. Results of that pain assessment determine and/or trigger the administration of pain medication, which has been or will be ordered by anesthesia providers.

C. Patients cannot be discharged from PACU with persistent pain. Persistent pain that is not managed or controlled by pain medication should be discussed with the anesthesia provider.

D. Pain assessment is to be included in the discharge criteria from the POHA. When applicable, discharge information will include medication usage, side effects, signs and symptoms to report and when to contact the ASC for additional assistance.

HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

SUBJECT: VI-108 PAIN MANAGEMENT	**POLICY #**: 1145
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E. Intervention should be initiated when the pain is unacceptable to the patient. This can be demonstrated through verbal and non-verbal behavioral communication.

F. Interventions may include analgesics (opioids, non-opioids) as prescribed for the individual patient.

G. There will be no intramuscular injections of opioid analgesics in ASC.

H. Non-pharmacological interventions to assist in pain reduction may include:

1. Heat/cold packs (physicians order)
2. Positioning for comfort
3. Simple relaxation
4. Imagery
5. Breathing exercise, anxiety reduction measures
6. Distraction
7. Tactile stimulation

I. Patients/caregiver/surrogate decision maker should receive timely education about “how to” communicate pain, including the use of the pain intensity scale. This should be in a language and at a level they can easily understand.

III. DOCUMENTATION

A. All pain complaints, assessments, interventions, reassessments and education/instructions will be documented on the appropriate perioperative flow sheet in the medical record.

B. All medications administered for pain control will be documented in the medical record including drug name, dose, route, time administered and patient’s response to the medication.

IV. PATIENT AND FAMILY EDUCATION

A. The ASC nursing staff is responsible for teaching the patient/family about pain management and the pain rating scale. ASC staff will assist the patient with utilizing he scale for self-reporting.

HIGH DESERT HEALTH SYSTEM
AMBULATORY SURGICAL CENTER

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	VERSION: 1

B. All patients requiring pain management and/or their family members will be educated regarding their specific pain medication regime by the assigned nurse.

C. Patients will receive ongoing education on pain management throughout the stay in the ASC. Knowledge of pain management includes:

1. Recognition/assessment of pain
2. Use of Pain Intensity Rating Scales
3. Reporting of pain
4. Cultural barriers to pain management
5. Pharmacological and non-pharmacological pain interventions
6. Common misconceptions about risks of addiction
7. Discharge planning for pain management including symptom management, medication usage

REFERENCES:

DHS Pain Assessment Tool Policy, # 311.102, 6/2013

American Pain Society, 2012; American Society for Pain Management Nursing, 2012

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