County of Los Angeles **Department of Health Services**

OLIVE VIEW-UCLA MEDICAL CENTER
POLICY & PROCEDURE

NUMBER: 1011
VERSION: 4

SUBJECT/TITLE: **PAIN ASSESSMENT AND MANAGEMENT POLICY (ADULT)**

POLICY: The hospital assesses and manages the patient's pain

PURPOSE: To provide guidelines for the health care provider to ensure optimal patient comfort through a proactive pain control plan which is mutually established with the patient, family members and members of the health care team.

DEPARTMENTS: **ALL**

DEFINITIONS: **Pain** as defined by the International Association for the study of Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (Merskey & Bugduk, 1994).

Pain Tool A clinical instrument used for pain assessment that has been empirically and widely tested and shown to demonstrate reliability and validity.

FACES Scale: Consists of an ascending numerical score and facial expressions correlated to increase pain intensity. Used in patients five years and older.

Numerical Rating Scale (NRS): Rates pain from "0", meaning no pain, to "10", meaning the worst possible pain.

0 1 2 3 4 5 6 7 8 9 10

0	No pain
1-3	Mild pain
4-6	Moderate pain
7-10	Severe pain

Critical Care Pain Observation (CPOT) – Adult cognitively impaired: Rates pain from "0", meaning no pain to "8", meaning the worst possible pain. Presences of pain are suspected when the CPOT score is greater than 2 or when the CPOT score increases by 2 or more. This tool is used for adult patients that are unable to communicate.

Assumed Pain Present (APP) – Adult Unresponsive: Pain is assumed to be present in patients, e.g., during procedures that would cause pain, movement that would elicit pain, etc. Used for patients who are unresponsive to traumatic brain injury, pharmacologically induced coma, or neuromuscular blockade.

Face, Legs, Activity, Cry and Consolability (FLACC) - Pediatric: A behavioral scale using five categories. Each category is scored on 0-2 which results in a total score of 0-10, with zero being no pain and ten being the worst possible pain. Used in patients under 5 years of age. Can be used in patients greater than 5 years who are developmentally delayed, unable to verbalize, or are non-communicative.

Neonatal Pain, Agitation, and Sedation Scale (N-PASS): Used for neonates/infants in the Neonatal Intensive Care Unit (NICU). Pain should be presumed in neonates/infants in all situations that are usually painful for adults. Pain scale is documented as 0-10, 0 being no pain and 10 being the worst possible pain.

PROCEDURE: **Assessment/Reassessment:**

1. All patients will be assessed for the presence or absence of pain upon admission, point of entry to the Department of Emergency Medicine (Triage) or Behavioral Health area, and clinic visits. This assessment will be documented in the Electronic Health Record (EHR).

2. Pain assessment and reassessment will continue while pain is being treated and with any new patient complaint of pain.
    - This includes the evaluation of patient's satisfaction with pain management.

3. The health care professional will assess the patient's pain utilizing the patient's self-report (0-10 or faces) or the assessment tool for non-verbal patients.

4. The initial patient assessment will be comprehensive based on patient's self-reported pain score. Factors can include, but are not limited to, the following parameters:
    - Location
    - Laterality
    - Quality
    - Pattern

NOTE: Use behavioral indicators only when patient is unable to self-report.

5. The patient's acceptable level of pain will be documented in the medical record (if applicable).

6. Pain assessment/reassessment will be conducted before, during, and after each potentially painful event or procedure and to evaluate efficacy of behavioral, environmental and pharmacological interventions.

7. Timing of pain reassessment, after intervention, will be appropriate for the modality or medication and route of administration, not to exceed two (2) hours. IV/IM pain medication reassessment within 30 minutes.

8. In the Department of Emergency Medicine (DEM), pain will be assessed/reassessed as follows:
    - At triage, or initial nursing assessment if patient does not go through triage.
    - Reassessed minimum every 8 hours from the original pain assessment, or as needed if there is a change in patient condition.
    - During and after a painful event or procedure, to evaluate efficacy of behavioral, environmental, and pharmacological or nursing interventions.

INTERVENTION:

1. Pharmacological management of pain should be provided as appropriate for each patient, as ordered, for "Mild," "Moderate" and "Severe" pain. If the patient's pain is not relieved, the nurse shall notify the provider for reassessment and evaluation.

2. Non-pharmacological management of pain should always be considered for each patient.

3. Special learning needs of patients will be addressed following assessment of barriers to learning.

Examples of Non-Pharmacological Management of Pain:

Non-Physician Ordered Interventions *(including, but not limited to)*
- Determining/meeting patient's ADL needs
- Breathing techniques
- Cold
- Decrease environmental stimulation
- Distraction
- Heat
- Music therapy
- Positioning
- Relaxation/meditation
- Pastoral care

PHYSICIAN ORDERED INTERVENTIONS *(including, but not limited to)*

- Physical Therapy
  - E.g. for assessment and treatment for musculoskeletal pain.
- Psychotherapy

4. When appropriate, non-pharmacologic and non-opiate options should be first line in the treatment of pain. For moderate to severe pain that is unrelieved by those measures, then morphine or oxycodone are both options for moderate and severe pain, unless the patient has an allergy to morphine or other specific clinical contraindications.
   Acute severe pain conditions seen in the Emergency Department, such as a long bone fracture, may require opiate medication as the first line medication. Meperidine is generally NOT recommended for use in acute or chronic pain or for pain in the geriatric population because of the risk of accumulation of toxic metabolites. If Meperidine is used, careful assessment is required to assure that appropriate doses are given and adverse effects are not apparent.

5. Upon initiation of regular opioid regime, orders for management of constipation are recommended.

6. The equal-analgesic chart should be utilized when converting between analgesic selections, routes and dosages.

DOCUMENTATION:

All pain complaints, assessments, interventions, reassessments, plan of care, and medication will be documented in the Electronic Health Record.

PATIENT AND FAMILY TEACHING:

1. Health care professionals will collaborate with patients and/or family members to develop a patient specific pain management plan based on their stated acceptable level of pain.

2. Patients and their family members will be informed regarding the importance of effective pain management.

The healthcare professional is responsible for teaching the patient/family about pain management and expectations, the pain rating scale, and assisting the patient with utilizing the scale for self- report (if appropriate).

For Pediatric and Neonatal patients, see policy:

- 2329, Pain Management Policy (Pediatric)
- 3312, Neonatal Pain Assessment/Management

References:

Health Services Los Angeles County. DHS Pain Assessment Tool Policy (06/13). Policy NO: 311.102

Merskey, H. & Bugduk, N. (1994). Classification of Chronic Pain. Descriptions of Chronic Pain Syndromes and Definitions of Pain Terms. 2nd ed. Seattle, WA: IASP Press.

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