



Pain Management

Educate patient and/or family

- Teach them to rate pain intensity by using the appropriate Pain Scale
- Set a comfort goal

Assess your patients pain:

- On admission/or clinic visit
- After any pain producing event
- Every hour (inpatient)
- After each pain management intervention

DOES YOUR PATIENT HAVE PAIN?

NO

Continue to assess and document pain minimally every 8 hours inpatient and each clinic visit outpatient.

YES

If unable to verbalize or unsure then evaluate:

- situation/condition
- behaviors
- family proxy
- vital signs

OR Assume Pain Present if there is a reason to suspect pain

Assess pain history and intensity, location, onset, duration, quality, character, ameliorating and provoking factors.

Analgesic Interventions

Severe (7-10)
Opioid +/- Non-opioid +/- adjuvant

Moderate (4-6)
Opioid +/- Non-opioid +/- adjuvant

Mild (1-3)
Non-opioid +/- adjuvant

Complementary Therapies

- Heat/Cold
- Repositioning
- Diversional activities (TV-relaxation channel 35, visitors, reading, music)
- MD order for physical or occupational therapy
- Behavioral Medicine consultation for non-pharmacologic approaches (MD to call 327-2133 or page 11043)

Reassess pain management and medication side effects after every intervention

- 15-30 minutes after IV medications
- 1 hour after all other interventions
- Each clinic visit or sooner as appropriate

Side Effects:

- Sedation
- Nausea/vomiting
- Pruritis
- Constipation (order bowel program or stool softener/stimulant)

Document pain management in Medical Record

INTERVENTIONS

- Prevent or palliate
- Give pain medication around the clock NOT PRN
- Treat breakthrough pain
- Opioids of choice Morphine, Dilaudid, Fentanyl
- Avoid Demerol
- Give IV or PO; NO IM
- Use a multi-modal approach as appropriate

Pain Management

Educate patient and family. The patient and family should be actively involved when possible regarding their pain management.

- Ideally education should occur pre-hospitalization or pre-operatively, in clinic or preadmission testing. Patients and family should be given verbal and written instructions, with clear expectations (i.e. a certain amount of pain or “discomfort” is expected after surgery)
- Patient education materials can be found on the patient education web site
- Teach the *pain talking points*

Pain rating at Loyola – Go to EMR-Protocols

- Pain Rating Scale for Adults in English, Italian, Spanish, and Polish. Reverse side addresses assessment of nonverbal adults.
- FLACC for infants and preverbal children
- NPASS for neonates and newborns

Other Resources

- *Pain: Clinical Manual* by Margo McCaffery – located on each unit
- Unit Pain Resource Nurse

Comfort Goal- The pain intensity level at which one is able to carry out activities (ADL’s) or those directed to recovery (cough, deep breath, ambulate). ABOVE that level which they would want something done to relieve pain or the side effects of pain medication.

Pain Assessment

- Pain assessment is incorporated with the Positive Patient Encounter hourly rounding initiative
- Identify if pain is acute or chronic (lasting longer than 3 months)
- Identify mechanism of pain

Types of Pain: Nociceptive, somatic or visceral is defined as the normal processing of stimuli that damages tissue or has the potential to do so; usually responsive to non-opioids and/or opioids. Somatic arises from bone, joint, muscle, skin. It is usually aching or throbbing and well localized. Visceral arises from organs (i.e. pancreas); pain can be a result of a tumor or obstruction. Pain resulting from a tumor is often aching and localized where as an obstruction is cramp-like and poorly localized. Neuropathic pain is abnormal processing of sensory input by the peripheral or central nervous system. Treatment usually includes adjuncts (SSRI, anticonvulsants and tricyclic antidepressants) (McCaffrey, 2000)

Pain History: Assess if the patient is currently having pain and taking pain medication (why, for what and how)

Complementary Therapy: Guidelines for heat and cold. Cold can be effective for acute and chronic pain, recommended 20 minutes intervals for 48 hours (Can be effective for more than 48 hours in chronic pain). Warm compresses can be applied to ease stiffness and relax muscles, apply at 20 minute intervals.

Analgesic Interventions: See pain orders in the EMR for adult and pediatric dosing

Equianalgesia = approximately equal analgesia dose comparing routes and medications

Agent	Route	Equianalgesic Dose (mg)	Onset (Minutes)	Duration (Hours)
Fentanyl	IM, IV	0.1-0.2mg	5-15	0.5-2
Hydromorphone	IM, SQ, IV	1.3-1.5	Variable	4-5
	PO	7.5	15-30	3-4
Methadone	IM, SQ	10	30-60	4-5 (acute)
	PO	10-20	30-60	> 8 (chronic)
Morphine	IM, SQ, IV	10	5-10	4-5
	PO	30-60	60	4-5
Oxycodone	PO	20-30	10-15	3-6
Hydrocodone	PO	30	10-20	4-8
Meriperidne	IM, SQ	75-100	10-45	3-4
	PO	50-300	10-45	3-4
Codeine	IN, IV, SQ	120 (starting dose lower)	10-30	4-6
	PO	200 (starting doses 15-60)	30-60	4-6
Tramadol	PO	Not available	30-60	4-6

Baumann, T. (2005) Pharmacotherapy: A physiologic approach.