Providence SWEDISH

Providence Regional Medical Center Everett (PRMCE)

Pain Management Policy

The following are excerpts from employed caregiver policy provided to students and learners for onboarding compliance

Updated 4.1.2025

Scope

Pain management care impacts all patient care areas and departments.
This policy includes care of:

- Neonate/Infant patient (0-1 year of age)
- Pediatric patients (1 year – 17 years of age)
- Adult patients (18 years or older)

Policy

The organization supports the patient's right to the appropriate assessment and management of pain. Our goal is to achieve adequate pain control so that the patient is functional and can participate in their recovery and/or experience the least amount of discomfort related to their situation. We recognize that non-treatment, undertreatment and overtreatment of pain and continued use of ineffective treatment results in physiological, psychological and spiritual distress that can negatively impact recovery from an illness and/or lead to chronic pain. All safe and effective treatment options available are discussed with the patient. Decisions should consider the patient's clinical situation, functioning and life context, as well as the benefits and risks of treatment options.

Pain management is part of quality medical practices for all patients with pain including acute, perioperative, subacute, and chronic pain.

Age specific knowledge and pain assessment skills are used to anticipate and alleviate pain through skilled intervention, achieving as much patient comfort and activity level as possible while still being functional. PRMCE uses evidence-based tools to assess pain that are consistent with the patient's age, condition and ability to understand.

Policy (contd.)

A comprehensive approach to pain management involves an initial pain screening, comprehensive pain assessments, pre pain management assessments to establish a baseline pain level, post pain management assessment to determine effectiveness of the medication/intervention; and developing an interdisciplinary pain management plan of care with an education plan on how to manage pain, medication side effects, etc. The hospital provides non-pharmacologic modalities when appropriate to provide a complementary approach for pain management which may potentially reduce the need for opioid medications for some patients in some clinical situations.

We accept and respect the patient's report of pain. Caregiver beliefs and value systems will not influence the care provided. Cultural, spirituality, and personal beliefs of the patient and family will always be considered. Treatment comes from a holistic, interdisciplinary approach, treating each patient with respect, dignity and supports using trauma informed care guiding principles. Patients are included in the development of their pain management plan of care.

Definitions

Acute Pain: A type of pain typically lasting less than 3-6 months or pain directly related to soft tissue injury/damage and may be relatively more severe or sharp. Gradually resolves as injured tissue heals. (Examples: surgery, childbirth, burns, fractures).

Chronic pain: A pain or discomfort that persists or progresses over a long period of time and may be unrelated to specific tissue injury. May be difficult to treat and may increase with psychological and/or environmental factors. (Examples: cancer pain, frequent headaches, arthritis, back pain).

Screening

Complete an Initial Pain Screening using appropriate verbal and non-verbal cues

within 4 hours of inpatient admission and in the Emergency Department as soon as feasible.

1. Use Age Appropriate and Condition Appropriate Pain Tools/Scales to assess pain. Document the tool/scale and corresponding pain level accordingly.

- Infants less than 3 months of age and all infants in NICU and FMC use the N-PASS Neonatal Pain, Agitation, and Sedation Scale
- The choice of N-PASS or FLACC . FLACC (Face, Legs, Activity, Cry, Consolability) may be used on infant older than 3 month, but the choice must be used consistently for that patient throughout the hospitalization or until the condition changes to warrant a change in the scale
- Children, younger pediatrics use the Wong-Baker Faces
- Older adolescents and adults use the 0-10 Numeric scale
- Any cognitively impaired or dementia patients use the PAINAD

2. Outpatients are screened for pain as appropriate to the care, treatment, and services.

Comprehensive Pain Assessment

If pain is identified at any level, complete a comprehensive pain assessment if possible and document in EPIC. Include the following as appropriate for the patient's condition and ability to communicate

- ✓ patient's goal for pain relief
- ✓ effects of pain on life, and
- ✓ current treatment regimen
- ✓ duration
- ✓ onset
- ✓ quality
- ✓ location
- ✓ intensity

Pain Assessment Before an Intervention

1. Document patient's pain, using age-appropriate pain tool assessments, within 60minutes, before any PRN or SCHEDULED pain intervention (either non-pharmacological or pharmacological) and a minimum of once each shift (whether patient has pain or not).

2. Document on Vital Signs flowsheet in the Pain/Comfort section in EPIC

Interventions: Non-Pharmacological & Pharmacological

Identify and utilize Non-pharmacological Intervention as appropriate, either in isolation or complementary to a pharmacological intervention. These interventions may potentially reduce the need for opioid medications in some circumstances.

•MD/APC order required:

- Occupational Therapy such as body mechanics, splints
- Physical Therapy such as Ultrasound, electrical stimulation, joint mobilization, stretching, strengthening, myofascial release, relaxation, positioning, orthotics

•Emotional/spiritual support: listening, Spiritual Care Consultation

•Repositioning

•Heat and cold applications (only use in pediatrics if patient is able to self-report)

•Meditation

•Massage

•Music therapy

•Humor

•Distraction

•Guided imagery

•Relaxation techniques

•Cognitive Behavioral Therapy

•Collaborate with physician for referrals, if the patient requests, to acupuncture therapy, chiropractic therapy, osteopathic manipulation, and massage therapy, etc. if these are unavailable at the hospital,

Interventions: Non-Pharmacological & Pharmacological (contd.)

Identify and utilize Pharmacological Interventions as appropriate (Must be ordered by the MD/APC). Match analgesia to severity and type of pain, consider multi-modal approach (Non-opioid, opioid, and adjuvants) Non-opioids

•Opioids

•Infants under 6 months who receive opioids are to have continuous oximetry and cardiorespiratory monitoring (CRM). Neonatal opioid withdrawal syndrome patients in the pediatric unit may have the CRM discontinued once they have shown to be stable and not over sedated, the pulse oximetry will remain.

•Adjuvants may be considered alone or in combination with one another

•When using pharmacological interventions consider the following and discuss with MD/APC as appropriate

- Use of scheduled times for routine pain medications for constant pain
- Use of non-opioid first as appropriate
- Alternating opioid and non-opioid therapy
- Combining long and short acting opioid treatment
- Use of medications for opioid use disorder, See "Opioid Use Stabilization" order set

Reassessment (contd.)

(for neonates see Neonatal Pain, Agitation and Sedation NPASS Guideline N-PASS Scale)

1.REASSESS and document pain using age/condition appropriate tool within appropriate time frame (see below) after the pain management intervention to determine effectiveness of the intervention/medication and if care plan needs to be updated

- Document on Vital Signs flowsheet in the Pain/Comfort section in EPIC

2.Notify MD/APC of unrelieved pain greater than 7 (or greater than 3 on NPASS) or intolerable pain despite interventions and/or unrelieved side effects

3.PRN or SCHEDULED pain management/non-pharmacological reassessment timing:

1. IV or Sublingual medication: **reassess within 30 minutes**
2. Oral/topical/rectal/SQ: **reassess within 60 minutes**
3. Non-pharmacologic intervention: **reassess in 30 to 60 minutes**

Reassessment (contd.)

4. If the patient is asleep at the time of reassessment, do not awaken; document "asleep" for the reassessment. Upon awakening, document the patient's specific pain level.
Note: *per CPG Acute Pain Overview: Lack of physiological responses or absence of pain behaviors (quiet, withdrawn, sleeping) should not be interpreted as absence of pain. Documentation of the patient's pain level may be pended until patient is awake, if "asleep" is documented at the time of the reassessment. Additional indicators of pain to consider documenting include respiratory rate, blood pressure, heart rate, sedation level, non-verbal cues, and duration of sleep.*

5. When reassessing patients following an intervention, observe for possible medication side effects:

a) Constipation: Assess patient if s/he is receiving frequent opioids and attempt to establish a routine bowel pattern
b) Nausea/vomiting: Treat on a prn basis following MD/APC orders. If analgesia is satisfactory, consider discussing with LIP reduction of opioid dose by 10-25%, and/or add an adjuvant
c) Pruritus: Contact MD/APC to treat on a prn basis and to consider reducing or switching opioids if pruritus persists
d) Sedation/over-sedation/respiratory depression: Determine if cause is from opioids or the need to sleep now that pain is relieved.

    i. May use Pasero Opioid-Induced Sedation Scale (POSS) or Richmond Agitation-Sedation Scale (RASS) as indicated to assess for respiratory depression
    ii. Note respiratory rate, depth, rhythm/pattern, quality, breath sounds and level of arousal.
    iii. Consult MD/APC to eliminate other CNS depressant drugs if analgesia is satisfactory, to reduce opioids by 10-25%, to consider a lower dose with increased frequency, or to add a non-opioid or adjuvant

6. Documentation of the timely reassessment may occur following the reassessment, even up to the end of the shift. The reassessment may be documented in the end of shift note. If further pain intervention is required at the time of reassessment, pain reassessment documentation will occur concurrent with reassessment

Initiate a Pain Management Plan of Care

Initiate a pain management plan of care based on the patient's condition, past medical history and pain management goals.

If pain management is determined as necessary during hospitalization, a multi-disciplinary collaborative pain management plan of care that includes age specific interventions is developed with patient and/or family involvement.

1.In Epic, initiate the Pain Acute (Adult or Pediatric) or Pain Chronic (Persistent) Adult or Pediatric as appropriate for patient's condition

2.View CPG: Pain Acute or Pain Chronic (persistent) as appropriate for patient's condition and age

3.Involve the patient in the pain management treatment planning process. Collaborate and assist patient in the following:

a) Developing realistic expectations and measurable goals

b) Discussing and identifying criteria to evaluate and monitor treatment progress

c) Awareness and understanding of the pain management plan, reviewing treatment options; and the safe use of opioid and non-opioid pain medication.

Interventions: Non-Pharmacological & Pharmacological

1.Document all patient, family, and caregiver education in EPIC

a) Education on medications is found in the MAR using the Lexicomp link

b) More general education is available via Krames

c) Education maybe documented in the Care Plan section of EPIC

2. Inform patient/caregiver that pain management/comfort is an important part of treatment and encourage reporting of pain

3. Instruct patient/caregiver regarding pain assessment measures and use of age-appropriate and condition-appropriate pain scale

4. Educate patient/caregiver about the need to request pain medications to intercept pain before it becomes severe

5. Inform patient/caregiver about pain medication name, dosage, route, schedule and any potential side effects

6. Elicit from patient/caregiver their beliefs about pain and any beliefs/misconceptions regarding fear of addiction

7. Encourage use of comfort measures

8. Utilize Epic for patient, family, and caregiver educational material

9. Educates patient and family on the pain management plan for after discharge.

This includes:

- The aftercare pain management plan
- Any potential side effects of pain management treatment
- Changes in activity level at home, including what might make the pain worse and what might diminish the pain
- Safe storage of the pain medication, especially addressing children and pets
- Safe disposal of the pain medication

Consultation and Resources

1. Collaborate with provider to discuss need for pain management if pain is unrelieved.
2. Collaborate with provider to discuss need for Substance Use Disorder/Chemical Dependency or Psychiatric Consult if deemed necessary.
3. Clarify with provider if patient is listed in the prescription drug monitoring program database for Washington.

SPECIAL SITUATIONS

I. End of Life care will be in accordance with age-appropriate policies
   - Neonates: See NICU Perinatal Loss
   - Pediatrics/Adults: See PSJH-Clin-1207 Policy of Care Through the End of Life: Responding to Requests for Provider-Hastened Death
   - Address possible impact of unresolved psychosocial or spiritual issues on pain management
     - Recognize most end-of-life pain can be adequately controlled
     - Identify that acute or escalating pain in end-of-life patients as a medical emergency requiring prompt attention.
     - Monitor for under medicating for pain relief and address concern.

Consultation and Resources (contd.)

Opioid tolerant patients with pain may or may not have an opioid use disorder

- Promote non-pharmacological pain interventions in addition to pain management medications
- Discuss medication for opioid use disorder with MD/APC and patient as appropriate. Consider opioids and opioid withdrawal symptom management medications. Reference the "Opioid Use Stabilization" order set
- Tell the patient and family, if indicated, the next time the pain medication is due and write it on the white board in the room.
- Consider a Substance Use Disorder/Chemical Dependency Consult. Discuss with MD/APC as appropriate
- Consider a Psychiatric Consult. Discuss with MD/APC as appropriate
- Discuss with MD/APC use of scheduled long acting opioid medications around the clock and PRN short acting opioids for breakthrough pain or use of the standard of care medications for an opioid use disorder i.e. Suboxone or Methadone (Reference order set "Opioid Use Stabilization")
- Recognize the opioid tolerant patient may require higher doses of pain medications.
- Discuss with MD/APC the possibility of initiating the Substance Misuse Plan of Care /Substance Use Disorder Pathway (see policy "Management of the Patient with a Substance Misuse History Admitted to the Hospital").
- Recognize the need to manage opiate withdrawal symptoms is different than the pain management needs.

Consultation and Resources (contd.)

Neonates

- Current evidence shows that neonates do experience pain. If a procedure is painful for an adult, it is considered painful in newborn infants, even if they are preterm.
- Adequate treatment of pain is associated with decreased clinical complications and decreased mortality
- The use of environmental, behavioral, and pharmacological interventions can prevent, reduce, or eliminate neonatal pain in many clinical situations.

Dementia

- Use the PAINAD (Pain in Advance Dementia) scale in Epic
- Consider that agitation, increasing confusion, and restlessness may be signs of increasing pain

Pediatrics

- See "Comfort Promise for Pediatric Patients" policy which provides caregiver guidelines and resources to implement the "Comfort Promise" in order to minimize or eliminate needless pain, anxiety and discomfort at PRMCE for all pediatric patients.
- The "Comfort Promise" is a practice methodology which reduces or eliminates discomfort and anxiety associated with painful procedures which includes, but is not limited to topical skin numbing, sucrose or breast feeding, comfort positioning and distraction.

Placebos

- The use of placebos for pain treatment is prohibited without a written informed consent by the patient.

Referenced Documents

- ❑ Aromatherapy policy
- ❑ Comfort Promise for Pediatric Patients policy
- ❑ Multiple PRN Medication, Duplication, and Range Order Clarification policy and Guideline: PRN Analgesics - Order of Use and Opioid Range Orders
- ❑ Inpatient Standards of Nursing Care policy
- ❑ Eat, Sleep and Console Pharmacological and Non-Pharmacological Management policy
- ❑ Care of Patients With Substance Use policy