

Administrative Policy and Procedure Manual

Pain Management
Scope: Organizationwide

Effective Date: 3/28/2001
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I. Purpose

To assure that all patients cared for at Children's Hospital of Chicago Medical Center (the "Medical Center") have access to safe and appropriate pain relief.

II. Definitions

Licensed Independent Practitioner (LIP): An individual permitted by law and by the organization to provide care, treatment and services without direct supervision. A LIP operates within the scope of his/her license, consistent with individually granted clinical privileges.

Range Orders: Orders in which the dose varies over a prescribed range, depending on the patient's status. ^{4E}

Therapeutic Duplication: The practice of prescribing multiple medications of the same class for the same indication ^{17R}

Multimodal analgesia: The use of more than one method of treating pain (e.g., drugs from two or more classes and non-drug treatment) to obtain additive beneficial effects, reduce side effects or both. ^{17R}

III. Policy Statements

A. Organizational Philosophy for Pain Management

1. The Medical Center acknowledges the impact that entering the healthcare system has on the child and the family. Although we cannot eliminate all pain and anxiety associated with medical treatment, our commitment to our families is be sensitive to their pain and discomfort and to partner with them to minimize pain and unpleasant experience to the best of our ability. We promise our families a consistent organizational approach to the management of pain throughout the continuum of care. ^{18L}

B. Self/Caretaker Reporting

Pain is what the experiencing child says it is. The child's self-report is the single most reliable indicator of the existence and intensity of pain. Children who may have difficulty communicating their pain because of developmental level, cognitive impairment, and/or language barrier require particular attention with careful assessment

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and a high degree of suspicion for pain. The parent's or caretaker's impression of the child's level of distress should also be considered.^{6E}

C. Patient/Family Rights and Responsibilities

The patient and their family have the right to a quick, respectful response to reports of pain and the responsibility to notify the healthcare provider when the patient feels any pain. The patient and their family also have the right to discuss concerns and preferences regarding pain treatment with the healthcare team.^{18L}

I. Procedures

A. Pre-procedural/pre-intervention pain assessment and management:

Proactive assessment and planning for pain control should occur *before* procedures or interventions that may be painful. Treatment should be tailored to the expected intensity and duration of the pain as well as the general medical condition of the patient.^{7E}

B. **Screening** patients for pain:

1. Staff screens patients for pain^{18L}

- a) All hospitalized patients will be screened for pain upon admission and with every full patient assessment as defined by specific unit-based assessment policies, but **at a minimum** of every 12 hours.^{18L}
- b) All ambulatory surgical and emergency department patients will be screened for pain to determine if pain should be assessed and addressed during the visit. If the patient reports pain that is unrelated to the current illness or reason for the visit, a referral plan should be documented (e.g., referral to primary care provider or another subspecialist).^{8E, 18L}
- c) Patients in Ambulatory Clinics will be screened and assessed, as appropriate to the patient's diagnosis/condition.
- d) Screening procedure:

Screen patient for presence of pain "ARE YOU HAVING PAIN?" **OR** when appropriate due to the patient's developmental level or cognitive impairment, the parent/GUARDIAN should be asked "IS YOUR CHILD

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HAVING PAIN?" OR "is this visit because of pain or to address your child's pain?"^{18L}

If the answer is "no", document this. If the answer is "yes", document this and proceed with the following Pain Assessment questions.

C. Pain **Assessment**:

1. Staff will use valid, reliable and developmentally appropriate tools to assess patient experiencing pain^{18L} (see attachments 1A, 1B & 1C)
2. For patients for whom valid and reliable pain assessment tools do NOT exist (i.e. nonverbal patients with lower limb paralysis or intubated and sedated patients) suspicion for pain must remain a high priority of care.^{6E}
3. PQRST Assessment Questions

P: Pain (Y/N) – See pain screen

Quality^{5E} – Ask the child if there are words to describe his/her pain.

Note: Quality cannot be inferred from patients unable to give self-report.

R: Radiation/Location^{5E} – Ask the child to identify each place he/she is hurting and if the pain radiates to other locations. Note: Location cannot be inferred from patients unable to give self-report; but suspicion must remain high that sites of disease, trauma, and/or invasive procedures results in pain at the affected site.

S: Severity^{5E} – Review with the patient and family the pain severity scale which is appropriate to the patient's developmental level. Note specific indications of pain identified by parents and other consistent caregivers.

T: Timing/Triggers/Treatment^{5E} - Ask patient or parent "When did the pain start?", "Is it constant or intermittent", "What makes the pain worse and what makes it better?"

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4. Pain Scales: (see attachments at end of policy)

Scale	Type:	Appropriate developmental level
Faces Pain Scale-Revised (FPS-R) ^{9S}	S	Most developmentally appropriate children \geq 4 years who can self-report pain (includes adults)
Numeric Rating Scale (NRS) ^{10D, 11D}	S	Most developmentally appropriate children \geq 8 years who can self-report pain (includes adults). Determine patient preference for FPS-R or NRS.
Faces Legs Activity Cry Consolability (FLACC) ^{6E}	HOT	Most developmentally appropriate children < 3 years of age; and < 7 years in PACU
Revised-FLACC ^{6E,S} (rFLACC)	HOT	Developmentally nonverbal >3 years of age. Includes individual patient behaviors
Neonatal Pain, Agitation, and Sedation Scale (N-PASS) ^{6E,S, 12C}	HOT	NICU infants < 1 year of age

HOT=Healthcare provider objective scoring tool S= Patient self-report

B. Treatment and Reassessment

1. If assessment indicates that intervention is warranted, pharmacologic and/or non-pharmacologic strategies will be utilized and documented.^{18L}
2. After patient has received treatment for pain, reassess to determine the effectiveness of that treatment. ^{18L} Document reassessment intervention as:
 - o treatment effective,
 - o treatment not effective – no further intervention indicated
 - o treatment not effective – see documented intervention (intervention may include notifying prescriber and/or primary service, and/or obtaining an Anesthesia Pain Management Team or Palliative Medicine consult.)
 Patients do not need to be awakened for pain reassessment unless there is concern the patient is over-sedated by the pain management intervention.^{11E, 13E,S}
3. Utilize the Chain of Responsibility Policy (Medical and Dental Staff Policy-018) if unable to resolve pain management issues through the usual methods.

D. Pain Management Orders

1. The patient's primary service will assume responsibility for pain management orders unless an Anesthesia Pain Management Team or Palliative Care consult is ordered.

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The Anesthesia Pain Management Team is also available for informal verbal or telephone consultation at the request of any member of the patient's care team.^{18L}

Notify the patient's LIP or, as appropriate, the Anesthesia Pain Management Team or Palliative Care Team if pain medications, as ordered, are not effective in relieving the patient's pain.

2. PRN orders and range orders, are acceptable and are directed by the Administrative Policy "Medication Prescribing, Processing/Dispensing, Administration and Monitoring."^{4E}

The nurse will contact the prescriber for clarification of concerns, issues or questions prior to administering a drug if an order is unclear given the patients current clinical status.

3. No pain medications will be ordered to be administered by the intramuscular (IM) route unless all other options fail and it is in the best interest of the patient to provide pain relief.^{13E, S}
4. Pharmacists can make necessary changes in medication orders after consulting with the LIP ordering the medication. If the pharmacist clarifies the order, the pharmacist will record the change as a verbal/telephone order (as appropriate to the situation).

D. Non-Pharmacologic (Bio behavioral) Interventions

We strive to promote non-pharmacologic interventions which can enhance the patient's and family's sense of control for coping and managing pain and pain-related distress. Resources such as Child Life, Music Therapy, Art Therapy, Psychology and/or acupuncture can be used to assist in non-pharmacologic pain treatment strategies. The nurse caring for the patient will be responsible for assessing the use of non-pharmacologic interventions and making suggestions for additions.^{14S}

Some non-pharmacologic interventions for coping and managing pain and pain-related distress include:		
Heat	Cold	TENS
Comfort Holds	Positions of Comfort	Favorite item from home
Breathing Exercises	Relaxation Exercises	Guided Imagery or Self-Hypnosis
Acupuncture	Massage	Distraction

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Distraction techniques include:				
Singing	Music	Videos	Games	Handheld video games
Books	Bubbles	Toys	Hand puppets	Virtual Reality
Many of these items are readily available in patient care areas (in Comfort Carts, Comfort Kits or Comfort Cabinets).				

E. Specialized Pain Management Modalities

1. Patient Controlled Analgesia (PCA) ^{13E,S, 15E, 17R}

PCA is managed by members of the Anesthesia Pain Management Team with the following exceptions:

- a. PCA may be managed by the Palliative Care Team for patients under their care.
 - b. PCA may be managed by Cardiovascular Surgery for all post-operative intubated patients under their care. When the patient is extubated, the Anesthesia Pain Management Team will assume care at 08:00 following extubation.
 - c. PCAs in non-surgical patients may be managed by Pediatric Intensive Care Unit (PICU) team while patient remains in the PICU. Upon transfer to an in-patient floor, PCA management will be assumed by the Anesthesia Pain Management team after handoff from the PICU team. PCAs in post-surgical/post-anesthesia PICU patients will be managed by the Pain Management Team.
2. Epidural Analgesia and Continuous Nerve Block Analgesia (CNBA) may only be managed by the Anesthesia Pain Management Team. ^{13E, S}
 3. Continuous Wound Infiltration (CWI) is managed by Surgical Services. The Anesthesia Pain Management Team will provide assistance upon request of the Surgical Services Providers. ^{13E, S}
 4. Sub-anesthetic ketamine infusions, with or without loading/bolus dosing, oral ketamine, and/or intranasal ketamine may be managed by the Anesthesia Pain Management Team, Palliative Care Team, or the appropriate Critical Care Team. ^{13E, S}

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5. Specialized order sets are utilized for PCA, Epidural, CNBA, CWI infusions and sub-anesthetic ketamine infusions. In addition to nursing orders outlining required levels of patient monitoring and care, these order sets outline suggested weight-based dosing ranges, commonly prescribed adjuvants and suggested medications for side-effect management.^{15E}
 - a. Refer to Sub-anesthetic Ketamine for Pain Management Guideline for dosing suggestions, parameters, monitoring and other nursing concerns,
6. Education of patients/families regarding use of Specialized Pain Management Modalities^{15E}
 - a. Patients/families will receive education regarding the use of Specialized Pain Management Modalities.
 - b. All education is to be documented in the patient's medical record.

F. Monitoring of Patients Receiving Opioids^{11L}

Patients receiving opioids have the potential for sedation and change in respiratory status and must be monitored in the period immediately following medication administration.^{14E}

1. Procedure

Equipment/Safety: Patients who are receiving opioids will have the following items placed in their room:

- a. Resuscitation bag with appropriate-sized mask
- b. Standard Oxygen set up
- c. Suction set up with Yankauer suction catheter (or appropriate alternative)
- d. Continuous pulse oximetry **or**
- e. Cardio-respiratory monitor

2. Monitoring

Patients receiving opioids by any route or epidural medications:

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- a. Obtain baseline vital signs (HR, RR, BP, T), oxygen saturation and Level of Consciousness (using the Pasero Opioid Sedation Scale, see attachment 2) or N-PASS, see attachment 1C).^{11L, 13 E,S}
- b. Patient must be monitored by continuous pulse oximetry when in bed and/or asleep.
- c. The following vital signs will be assessed and documented after each initial dose and each increased dose at the expected opioid peak time (approximately 5-10 minutes after IV administration and 30-60 minutes after oral administration):^{11L, 13E,S}
 - 1) Respiratory Rate (RR)
 - 2) Level of consciousness
 - 3) Oxygen Saturation
 - 4) Pain score (based on appropriate pain scale).

If opioids are administered, use Pasero Opioid-Induced Sedation Scale (POSS) (See Scale attachment 2) or N-PASS (see attachment 1C).
- d. Notify MD/APRN if:
 - patient reaches score of 3 or greater (POSS)
 - patient outside of goal sedation range (N-PASS).
 - Deep sedation score -10 to -5
 - Light sedation score -5 to -2
- d. Exceptions to these monitoring guidelines must be ordered and documented in the Medical record by the patient's LIP.

G. Addressing Patient/Family Expectations

1. Current treatment modalities make pain reduction to acceptable levels a realistic goal; however, patients and their families should be made aware that it is not always possible to eliminate all of the stated pain.^{18L}
2. Patients and their families will also be made aware that some type of intervention, either pharmacologic or non-pharmacologic, will be made if unacceptable levels of pain are communicated or assessed.^{18L}

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H. Continuity of Care

1. Specific information regarding each patient's current level of pain and recent treatment/intervention will be communicated between care providers as the patient is transitioned from one area of care to another (e.g. post-anesthesia care unit to the floor). See Administrative Policy and Procedure entitled: "Patient Care Hand-Off Communication"

I. Discharge Preparation

1. Before discharge, staff will provide specific discharge instructions to the patient and their family regarding pain assessment and its management.
2. If discharge plan includes the use of opioids at home; patient and family will be instructed that the opioids are exclusively for the prescribed use for the prescribed patient and it is illegal to share opioids. Parents will be instructed in opioid securement, monitoring, and disposal.^{18L}

IV. Cross References/Related Policies

The following Administrative Policies, Nursing Protocols and Patient/Family Education Materials also guide the safe, effective, and consistent care of patients and management of their pain. Some of these materials are available on the Pain Management Share Point Site.

Administrative Policy: "Sedation"

Administrative Policy: "Medication Prescribing, Administering, and Monitoring"

Administrative Policy: "Patient Care Hand-Off Communication"

Administrative Policy: "Patient Assessment"

Medical and Dental Staff Policy MS018: "Chain of Responsibility"

Nursing PCA Management Protocol

Nursing Epidural Analgesia Management Protocol

Nursing Continuous Nerve Block/Continuous Wound Infiltration Analgesia Protocol

Procedural Pain Algorithms

Sub-anesthetic Ketamine for Pain Management Guideline

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Patient Education Materials:

About Epidural Analgesia Information Sheet
About PCA Information Sheet
Children Experiencing Pain
Comfort holds (for use by patients and for healthcare providers)
Continuous Wound Infiltration
Epidural Steroid Injections
Outpatient Surgery: Pain Handout
Pain Management Following Surgery
Pain Management Following Spinal Fusion Surgery
Supporting Patients through Procedural Hurts (located on cmh.org)
Your Child is going Home with a Nerve Catheter and Pain Relief Pump
Your Child had a Nerve Block Completed in the Operating Room
Pain Management Education on the Get Well Network

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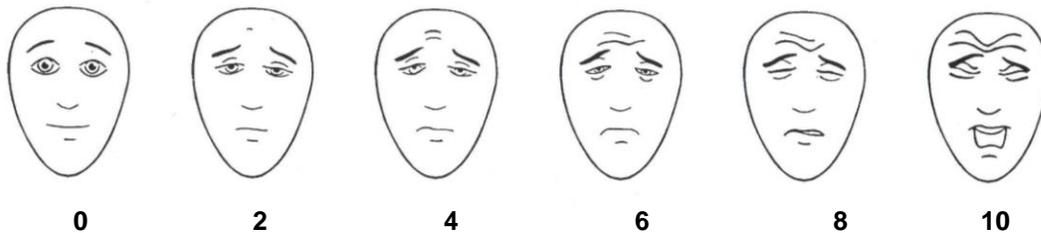
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Attachment 1A

PAIN SCALES

Faces Pain Scale – Revised (FPS-R)



“These faces show how much something can hurt. This face [*point to left-most face*] shows no pain. The faces show more and more pain [*point to each from left to right*] up to this one [*point to right-most face*] – it shows very much pain. Point to the face that shows how much you hurt [*right now*].”

Hicks CL, von Baeyer CL, Spafford P, von Kortaar I, Goodenough B, The Faces Pain Scale – Revised: Toward a common metric in pediatric pain measurement. *Pain* 2001, 93:173-183.

From the *Pediatric Pain Sourcebook*. Original copyright ©2001. Used with permission of the International Association for the Study of Pain and the Pain Research Unit, Sydney Children's Hospital, Randwick NSW 2031, Australia. Version : 24 Sep 2001

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FLACC*/Revised FLACC (rFLACC) Pain Scale**

***FLACC Pain Scale incorporates the non-bolded choices**rFLACC includes both the non-bolded and bolded choices**

Categories	Scoring		
	0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested. Appears sad or worried	Frequent to constant frown, clenched jaw, quivering chin, distressed looking face; expression of fright or panic
Legs	Normal position or relaxed, usual tone and motion to limbs.	Uneasy, restless, tense; occasional tremors	Kicking or legs drawn up, marked increase in spasticity, constant tremors or jerking
Activity	Lying quietly, normal position, moves easily regular, rhythmic respirations.	Squirming, shifting back and forth, tense/guarded movements, mildly agitated, shallow/splinting respirations, intermittent sighs	Arched, rigid, or jerking, severe agitation, head banging, shivering, breath holding, gasping, severe splinting.
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint, occasional verbal outburst or grunt	Crying steadily, screams, sobs, frequent complaints, Repeated outbursts, constant grunting
Consolability	Calm, relaxed	Reassured by occasional touching, hugging, or 'talking to', distractible	Difficult to console or comfort, pushing away caregiver, resisting care or comfort measures

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 0 and 10

The FLACC Pain Scale can be used with patients less than 3 years of age or with patients unable to verbalize a pain score

- ❖ In a paralyzed or deeply sedated patient, do not assign a FLACC or rFLACC score. Assess adequacy of pain/agitation management via vital signs. Resume rFLACC scoring when no longer paralyzed/deeply sedated.

A critically ill patient may score low because he/she is too ill to amount a behavioral response to pain/agitation. Whenever feasible, behavioral measurement of pain should be used in conjunction with self-report. When self-report is not possible, interpretation of pain behaviors and decision-making regarding treatment of pain requires careful consideration of the context in which the pain behaviors were observed.

Each category is scored on the 0-2 scale which results in a total score of 0-10

NEONATAL PAIN, ANXIETY, AND SEDATION SCALE (N-PASS)

Assessment Criteria	Sedation		Sedation/Pain	Pain/Agitation	
	-2	-1	0/0	1	2
Crying/Irritability	No cry with painful stimuli	Moans or cries minimally with painful stimuli	No sedation/ No pain signs	Irritable or crying at intervals Consolable	High-pitched or silent-continuous cry Inconsolable
Behavior State	No arousal to any stimuli No spontaneous movement	Arouses minimally to stimuli Little spontaneous movement	No sedation/ No pain signs	Restless, squirming Awakens frequently	Arching, kicking Constantly awake or arouses minimally/ no movement (not sedated)
Facial Expression	Mouth is lax No expression	Minimal expression with stimuli	No sedation/ No pain signs	Any pain expression intermittent	Any pain expression continual
Extremities Tone	No grasp reflex Flaccid tone	Weak grasp reflex ↓ muscle tone	No sedation/ No pain signs	Intermittent clenched toes, fists, or finger splay Body is not tense	Continual clenched toes, fists, or finger splay Body is tense
Vital Signs: HR, RR, BP, SaO ₂	No variability with stimuli Hypoventilation or apnea	< 10% variability from baseline with stimuli	No sedation/ No pain signs	↑ 10% to 20% from baseline SaO ₂ 76% to 85% with stimulation – quick ↑	↑ > 20% from baseline SaO ₂ ≤ 75% with stimulation – slow [arrow up] Out of sync/fighting vent

Note: Premature Pain Assessment: +1 if less than 30 weeks gestation/corrected age.

Hummel P, Puchalski M, Creech SD, Weiss MG. (2008). Clinical reliability and validity of the N-PASS: neonatal pain, agitation and sedation scale with prolonged pain. *Journal of Perinatology*, 28, 55-60.

KEY POINTS

ASSESSMENT OF PAIN/AGITATION

- Pain assessment should be included in every vital sign assessment
- Pain is scored from 0 → +2 for each assessment criteria
- Total pain score is documented as a positive number (0 → +10) (add +1 if < 30 weeks age)
- **More frequent pain assessment indications:**
 - Indwelling tubes or lines which may cause pain, esp with movement (e.g. chest tubes) → at least every 2-4 hours
 - Receiving analgesics and/or sedatives → at least every 2-4 hours
 - Post-operative → at least every 2 hours for 24-48 hours, then every 4 hours until off medications

ASSESSMENT OF SEDATION

- Sedation is scored in addition to pain for each assessment criteria to assess the infant's response to stimuli
- Sedation is scored from 0 → -2 for each assessment criteria, then summed and noted as a negative score (0 → -10)
- A score of 0 is given if the infant's response to stimuli is normal for their gestational age
- "Deep sedation" → score of -10 to -5 as goal
- "Light sedation" → score of -5 to -2 as goal

Negative sedation scores without the administration of opioids/sedatives by the RN may mean:

- The premature infant is having a negative response the prolonged stress and activity
- Septic status, CNS depression or some other underlying condition that needs further investigation

A critically ill infant or a paralyzed infant may score low because are unable to mount a behavioral response to pain/agitation. Assess adequacy of pain/agitation management via vital signs (i.e., HR, O2sats, BP from baseline) Select Neuromuscular Block, NMB, in EPIC as applicable.

Pasero Opioid-induced Sedation Scale (POSS)

- S = Sleep, easy to arouse
Acceptable; no action necessary; may increase opioid dose if needed
- 1 = Awake and alert
Acceptable; no action necessary; may increase opioid dose if needed
- 2 = Slightly drowsy; easily aroused
Acceptable; no action necessary; may increase opioid dose if needed
- 3 = Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50% or notify prescriber or anesthesiologist for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated.
- 4 = Somnolent, minimal or no response to verbal and physical stimulation
Unacceptable; stop opioid; consider administering naloxone; notify prescriber or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

Evidence Based Grades			
S	Meta-analysis or Systematic Review	F	Basic laboratory research
A	Randomized controlled trial: large sample	L	Legal or Regulatory requirement
B	Randomized controlled trial: small sample	M	Manufacturer Recommendation
C	Prospective trial or large case series	Q	Decision analysis
D	Retrospective analysis	R	Review article
E	Expert opinion or consensus	O	Other evidence

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