PAIN ASSESSMENT AND MANAGEMENT



Objectives The Participant will be able to:

- 1. Verbalize that patients have a right to pain management.
- 2. Verbalize how to establish patient centered goals for pain management.
- 3. Identify and use the pain tools used at ETCH.
- 4. Identify the required elements for appropriate pain assessment and reassessment.
- 5. Verbalize how we define mild, moderate and severe pain.
- 6. Provide pain management by assessing and reassessing the patient.
- 7. Identify facts about non-pharmacological and pharmacological interventions for pain management.
- 8. Verbalize documentation requirements for discharge plans.

Organizational Principles and Beliefs

- Every patient has the right to effective pain management.
- Pain assessment and pain management, including safe opioid prescribing, is an organizational priority for ETCH.



Commitment to comfort

ETCH is committed to sustaining an environment where patients and families are supported throughout the continuum of care and comfort is maximized.

Our goal is to unite our institution on a shared mission of pain prevention. By continually re-committing to do no harm, we demonstrate our organization's core values to excellence and respect.

Why is Pain Management Important?

- Pain can be complex to identify and treat.
- The misidentification and under-treatment of pain continues to occur. Screening patients for pain or the risk of pain at the time of admission will help to improve pain identification and treatment.
- The patient's right to pain management is an essential aspect of quality and safety.



Scope of the problem

- Children's pain experience
 - 25-45% experience pain </= 3months duration
 - O Up to 30% experience chronic or recurrent pain severe enough to interfere with daily functioning
- •Effect of pain on quality of life





What Types of Pain Do We See?

- Acute Pain: An unpleasant sensory or emotional experience associated with actual or potential damage, or described in terms of such damage.
- **Chronic Pain:** Pain extending beyond three (3) months on an almost daily basis. May be more challenging to treat than acute pain. Patients may have physical dependency.
- End of Life Pain: Pain experienced as an individual nears end of life, in certain instances can be complex and challenging to treat.

Harmful Affects of Unrelieved Pain

- A significant affect of unrelieved pain is the inability to functionally progress towards treatment goals
- Unrelieved pain can cause these effects:
 - Cardiovascular & respiratory dysfunction
 - GI distress
 - Confusion
 - Muscle spasm or immobility
 - Decreased immune response
 - Future pain- chronic neuropathic
 - Anxiety or depression

Results of untreated pain

- Long term effects in sensory and pain processing
- Anticipatory fear: "Am I getting a shot today"?
- Decreased effectiveness of analgesics
- Difficulty completing needed interventions
- Needle phobia
 - Up to 25% of adults with considerable fear of needles interfering with obtaining preventative and necessary health care



Patient Pain Assessment

- Perform a pain assessment and utilize appropriate techniques based on age, condition, and comprehension level.
- Obtain pain history.
- Patients are screened for pain during emergency department visits, at time of admission, and routinely thereafter.
- Identified pain is treated promptly.
- The clinical team assesses for pain.
 - At least once every shift
 - At every focused assessment a patients' pain is addressed
 - Prior to administration of PRN medication for pain
 - Whenever the patient's level of care or location changes
 - Whenever the patient undergoes a potentially painful procedure



- Elements of Pain Assessment: The clinical team will assess pain using the following minimum elements.
 - Location(s) of pain
 - Description of pain
 - Intensity of pain using the appropriate age specific and evidence-based pain scale.
- Interventions
 - Non-pharmacologic and pharmacologic pain treatment modalities.
 - All interventions are documented in the patient's medical record.
 - Provide non-pharmacological pain relief measures using developmentally appropriate intervention(s).
 - Consider referrals to Child Life, Social Work, Rehabilitation , and Pain/Palliative Care Service



- Nurses in the Emergency Department can initiate ED specific standing orders by physician direction.
 - Pain >6 months of age
 - Extremity/Clavicle injury
 - Burn Injury
 - Sickle Cell with Pain
 - Eye irrigation for chemical injury





- Individualized pain management goals set in collaboration with patient, family and team.
- Utilizes evidence based practices.
- Based on patients current clinical condition and past medical history.





Pain Treatment Care Plan

- Realistic, measurable goals for degree, duration and reduction of pain.
- Discuss measures for evaluation of progress focused on patient functionality.
- Provide education on specifics of pain management plan.



A Word on Pain Scales

- Pain scales are "Valid and Reliable"
- Pain as the "Fifth Vital Sign"
- Self report as "Gold Standard"



- An accurate screening and assessment is required for satisfactory pain management
- The tools required to adequately assess pain may differ depending on a patient's age, condition, and ability to understand.
- Using numerical pain scales alone to monitor patients' pain is inadequate.
- Assess pain effect on functionality.
 - Ability to take a deep breath
 - Ability to move in bed
 - Ability to walk
 - Ability to play

How Do We Define Pain Intensity?

- The experience of pain is unique for every patient.
- Pain scales are useful tools that can help quantify the intensity of pain.
 - Each pain scale uses a numeric system to calculate the intensity of pain.
 - Mild pain is numerically defined as a 1-3 intensity.
 - Moderate pain is numerically defined as a 4-6 intensity.
 - Severe pain is numerically defined as a 7-10 intensity.
- At ETCH, we have identified four evidence-based pain scales that are age specific and take into account non-verbal patients.

ETCH Evidence-Based Pain Scales

Table1. Evidence-Based Pain Scales Used by the Hospital		
Pain Scale	Appropriate Age	Organization Specific Criteria
NPASS- Neonatal Pain, Agitation, Sedation Scale	0-2 Months	Adjust score for prematurity with the following criteria: +3 if < 28 weeks gestation/corrected age +2 if 28-31 gestation/corrected age +1 if 32-35 weeks gestation/corrected age
FLACC- Behavioral Pain Assessment Scale	2 months-3 years	This scale is also used for all non-verbal or developmentally delayed patients.
WONG-Baker Faces Pain Scale	3-7 Years	
Numeric Pain Scale	>7 years	
Score Calculations for Intensity	Scores 1 to 3, mild pain. 4-6, moderate pain. 7-10, severe pain.	
Reference	Lippincott Procedures, Pain Assessment, Pediatric (Nov.11, 2016).	

NPASS- Neonatal Pain Agitation Sedation Scale

- Pain scale is appropriate for specific age 0 to 2 months.
- We adjust score to gestational prematurity.

Adjust score for prematurity with the following criteria:

- +3 if < 28 weeks gestation/corrected age
- +2 if 28-31 gestation/corrected age
- +1 if 32-35 weeks gestation/corrected age

N-PASS: NEONATAL PAIN AGITATION AND SEDATION SCALE

The N-PASS is a tool that measures not only pain but also sedation level.^[21] Developed for nurses in neonatal intensive care settings, it can be used for preterm and full-term neonates. Each section of the scale (sedation and pain/agitation) has five parameters. The total sedation score ranges from 0 to minus 10. The total pain/agitation score ranges from 0 to 10.

Premature pain assessment: +1 if less than 30 weeks gestation/corrected age.

Assessment criteria	Sedation		Sedation/Pai n	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 spontanecus movement	Arouses minimally to stimuli Little spontaneous movement	No sedation No pain signs	Restless, squirming Awakens frequently	Arching, kicking Constantly avake 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	Less than 10% variability from baseline with stimuli	No sedation No pain signs	↑ 10% to 20% from baseline SaO ₂ 76% to 85% with stimulation, quick recovery	↑ greater than 20% from baseline SaO ₂ 75% or less with stimulation, slow recovery Out of sync with vent

sedation scale with prolonged pain. *Journal of <u>Recinatology</u>, 28*, 55–60.

FLACC- Behavioral Pain Scale LAC **Observational Pain Scale** F - Face L - Legs A - Activity C - Cry **C** - Consolability

FLACC- Behavioral Pain Scale

- Pain scale is appropriate for age specific 2 months to 3 years.
- Is the pain scale to be used for non-verbal patients.

FLACC Behavioral Pain Assessment Scale¹⁹

The FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain.

Scoring				
0	1	2		
No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin		
Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up		
Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking		
No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints		
Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort		
	Scoring 0 No particular expression or smile Normal position or relaxed Lying quietly, normal position, moves easily No cry (awake or asleep) Content, relaxed	Scoring01No particular expression or smileOccasional grimace or frown, withdrawn, disinterestedNormal position or relaxedUneasy, restless, tenseLying quietly, normal position, moves easilySquirming, shifting back and forth, tenseNo cry (awake or asleep)Moans or whimpers, occasional complaintContent, relaxedReassured by occasional touching, hugging, or being talked to, distractible		

FLACC- Behavioral Pain Scale Meditech Documentation Screen

Face	$\bigcirc 0 \bigcirc 1 \bigcirc 2$
	(0) No particular expression or smile
	(1) Occasional grimace or frown, withdrawn, disinterested
	(2) Frequent to constant frown, clenched jaw, guivering chin
Leas	
3-	(0) Normal position or relaxed
	(1) Uneasy, restless, tense
	(2) Kicking, or legs drawn up
Activity	$\bigcirc 0 \bigcirc 1 \bigcirc 2$
	(0) Lying quietly, normal position, moves easily
	(1) Souirming, shifting back and forth, tense
	(2) Arched, rigid, or terking
Crv	$\bigcirc 0 \bigcirc 1 \bigcirc 2$
	(0) No cry (awake or asleep)
	(1) Moans or whimpers, occasional complaint
	(2) Crying steadily, screams or sobs, frequent complaints
Consolability	$\bigcirc 0 \bigcirc 1 \bigcirc 2$
	(0) Content, relaxed
	(1) Reassured by occasional touching, hugging, or being talked to, distractible
	(2) Difficult to console or comfort
FLACC - Total Score	
	Each category is scored on the 0-2 scale, which results in a total score of 0-10.
	0 = Relaxed and comfortable
	1-3 = Mild discomfort
	4-6 = Moderate pain
	7-10 = Severe discomfort or pain or both

When the FLACC scale is documented in Meditech, the screen will total the score for the user.

FLACC- Behavioral Pain Scale MediTech Documentation Screen

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		Reason for Intervention	Acute disease process Developmental Post-op Procedure/ Post procedure Traumatic
Pain Assessment Note		Pain Assessment Note	

The FLACC Scale has replaced the Non-Verbal/Preverbal Scale





HOW TO USE THE FLACC SCALE WITH NON-VERBAL PATIENTS

- **Scenario:** The mother of a developmentally delayed 4 year old is frantic because she does not think her child's pain is relieved. When you assess the child she is grimacing, stiffening, and fussy. She had surgery the day before. Since she has cerebral palsy you cannot tell if her behavior is different from before. You know that vital signs are not a reliable indicator for this child.
- To solve this problem, you sit down with the mother for a few minutes and go over the FLACC Behavioral-Physiological Pain Scale with her. Pick out the behaviors that she recognizes as pain indicators for her child.
- If the child is always stiff, throw that one out.
- Ask the mother to just use the indicators she identified to rate her child's pain. If she is not available, then the nurses will also know which ones to use.

Wong-Baker FACES Pain Scale

Wong-Baker FACES Pain Rating Scale

The Wong-Baker FACES Pain Rating Scale can be used with children age 3 and older. It's a self-report tool in which the child points to the face that corresponds to his pain intensity. It can be used with a 0 to 5 or a 0 to 10 scale. Explain to the child what each face means before having him rate his pain.

To use the FACES scale, explain to the child that each face represents a person who feels happy because he has no pain (hurt) or is sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the child to choose the face that best describes how he is feeling.



- Pain scale is appropriate for specific age of 3 years - 7 years.
- Self reporting tool in which the child point to the face that best represents their pain.

Numerical Pain Scale

Numeric pain scale

A numeric pain scale is a self-report tool that can be used with children as young as 5 years old. To use this scale, the child must be able to count and have a concept of numbers and their relationship to each other. The scale can be used vertically or horizontally. The numbers range from 0 to 10, with 0 representing no pain and 10 representing the worst possible pain. Ask the child to pick which number corresponds to his pain level.



- Pain scale is appropriate for specific age greater than 7 years.
- Self reporting tool in which the child can pick which level represents their pain.
- To use this scale, the child must be able to count and have a concept of number and their relationship to each other.

Patient is at Risk For Adverse Events

- What kind of patient would be at risk for an adverse event?
 - A patient who already has respiratory compromise and who requires treatment with opioids.
 - A patient with sleep apnea and who requires treatment with opioids.
 - A patient whose pain management needs exceed the expertise of the patient's licensed independent practitioner.
- Access to pain specialists by consultation or referral reflects the best practice in addressing patients with complex pain management needs.

Pain Management and Challenging Populations

• Assessing Pain in the Neonate



Chronic Pain



A Crying Baby Does Not Always = PAIN

- Babies cry for LOTS of different reasons
 - -Hunger
 - -Wet diaper
 - -Wanting to be held
 - -Needing a pacifier
 - -For no reason whatsoever



Assessment: More Than Tears

- Utilize FLACC scale
- Consider ALL sources of discomfort (pain, vs hunger, vs wanting to be held)
- Review all physiological (vital signs) and behavioral signs (body, face, vocalization)
- Ask the caregiver
- Optimize non-pharmacologic interventions
- Caution when using opioids—watch for respiratory depression

Infant Comfort Strategies

- Avoid use of medicines:
 - Sucrose
 - Swaddle
 - Rock & Hold
 - Pacifier



When Medicines are a Must in Neonates

- Know the infant weight & medications
- Consider Tylenol/Motrin first
- Beware of dose accumulation in infants when using morphine or another opioid
- If using medication, also use integrative approaches such as music, massage, etc.

A Word about Chronic Pain...

- It is not always desirable to use opioids in patients with chronic pain. These patients who may or may not have an organic reason for their pain are better served with enhancement therapies or non-opioids.
- Heat pads, ice packs, imagery, distraction or other methods may be used.
 - Physical therapy can provide TENS units and possible biofeedback.
 - Social work can offer counseling.
- The patient should be instructed that he/she may have life-long pain and coping techniques are very powerful allies.
- Do not always assume the physician is wrong, if they do not order pain medication for these patients.



Pain Reassessment

- Complete reassessment within 60 minutes of intervention.
- Assess patient's response to intervention.
- Assess for side effects of intervention.
- Assess for risk factors for adverse events from intervention.
- Assess for progress toward established goals for functionality.

Range Orders

- Start at lower end of dose range
- Reassess and elevate to higher dose if needed
- Offer non-pharmacological interventions to supplement medication
- Document assessment leading to use of higher dose
- Contact provider if current order not effectively treating patient's pain.
- Chart and Advocate!

Patient and Family Education

Education Plan Includes:

- **Pain scales**-patient assists in setting goals that include functional ability.
- **Drug information**-use computer drug sheets
- Side effects-especially for long-term use and at home
- Safety-side rails and assistance to bathroom
- **Discharge planning**-drug information, side effects, how to get help if pain not relieved

Special Consideration for Education

- Some patients may experience pain that is better controlled using pain control devices such as:
 - PCA (Patient Controlled Analgesic) Pump
 - Continuous Epidural
- Education should be focused on:
 - What the device is and how does it work?
 - How to use the device?
 - Safeguards and precautions

Pain Management Plan Discharge Education

- Review pain management plan of care.
- Educate on potential side effects of pain treatments.
- Discuss activities of daily living at home and potential impact on pain management plan.
- Discuss strategies to maximize effectiveness of pain management at home as activities increase.
- Educate on safety, storage and disposal of opioids if prescribed







- Non-drug approaches to pain management are never a substitute for appropriate analgesia.
- Benefits:
 - diminish the emotional components of pain
 - strengthen coping abilities
 - reduce perceived threat
 - give the patient and family a sense of control
 - change expectations & enhance comfort
 - decrease fatigue & promote sleep
 - restore hope and improve the quality of life.



Cutaneous Stimulation

• **Heat**-decubitus, boils, hematoma, musculoskeletal pain, itching, rectal pain, spasms

Precautions-stop if pain increases, think warm not hot, cover heat source with towel, moisture increases intensity of heat, do not use over menthol ointment, do not use over area which has been bleeding recently

• **Cold**-acute trauma, bleeding, swelling, headache, muscle aches or spasms, joint pain, itching, surgical incision

Precautions-do not use over area with poor circulation, stop if pain increases, cover cold pack with towel, moisture increases intensity of cold, remove if skin becomes numb, do not freeze skin.

• **Other**-TENS, vibration



NON-PHARMACOLOGICAL APPROACHES TO PAIN

- Child Life
- Age Appropriate Distraction
- Therapeutic Play
- Therapeutic Positioning
- Guided imagery
- Deep Breathing
- Art Therapy
- Aromatherapy
- Massage Therapy
- Music Therapy
- Acupuncture/Acupressure



There are 3 main groups of analgesics: non-opioids, opioids, and adjuvants. It is useful to know the difference because each group relieves pain in different ways. Therefore it is sometimes possible to combine analgesics from different groups to address different types of pain in the same person.



- 1. Non-opioids: acetaminophen & NSAIDS
- 2. Opioids: Mu agonists and Agonist-antagonists
 - If drugs in either of these sub-types bind on the opioid receptor sites in the CNS, pain relief occurs.
 - Naloxone (Narcan) is a well known opioid antagonist which blocks the effects of all opioids.
- 3. Adjuvant analgesics: diverse classes of drugs that relieve pain by a variety of mechanisms.
 - Antidepressants, benzodiazepines, antihistamines, neuroleptics

(McCaffery, 1999, p. 108-114)







- In opioid-naïve patients, common opioid side effects include constipation, nausea and vomiting, sedation, respiratory depression, pruritis, and mental confusion and clouding.
- As the patient becomes opioid tolerant, these side effects, **except for constipation, tend** to subside.

Preferred Routes of Administration

Route	Considerations and Precautions
Oral	Always the First (1 st) Choice. Use Whenever Possible
IV	Always the Second (2 nd) Choice if oral not possible. For post-operative pain around the clock dosing is more effective than PRN for the first few days. Pain is an antidote for respiratory depression.
IM	Only if no other choice-consider the use EMLA or ELA-MAX
Rectal	Absorption less predictable.
Transdermal	Difficult to regulate dosage, slow onset. Use for chronic pain.
Other	PCA, epidural, blocks



- Nurses in the Emergency Department can initiate ED specific standing orders by physician direction.
 - Pain >6 months of age
 - Extremity/Clavicle injury
 - Burn Injury (one order on paper; broken down into mild, moderate, and severe as separate orders in Meditech)
 - Sickle Cell with Pain
 - Eye irrigation for chemical injury (tetracaine eye drops)



- Nurses can utilize the pain management protocol for topical anesthetics with a physician order.
- EMLA: lidocaine 2.5% and prilocaine 2.5% cream
- L.M.X.: lidocaine 4% cream
- Gebauer's Pain Ease[®] (No order required)
- Review and follow instructions for use within the TOPICAL ANESTHETIC PROTOCOL: PROCEDURAL PAIN MANAGEMENT FOR NEEDLE PUNCTURES



- Sucrose (Sweet Ease)may be used without an order and is obtained through Purchasing.
- It may be used for neonates and infants less than 6 months old.
- The nurse may give up to 2 ml. by mouth, two minutes before a painful procedure, and may be repeated once in the hour.
- Sucrose comes in individual packets and may only be used for an hour after opened.

REFERENCES

- Frederiskson, TW, et al. (2015). Reducing the adverse drug events related to opioids implementation guide. Philadelphia: Society of hospital medicine, 2015.
- Glowacki, D. (2015). Effective pain management and improvements in patients' outcomes and satisfaction. *Critical Care Nurse*, 2015;35(3):33-43.
- Jarzyna D, et al. (2011). American society for pain management guidelines on monitoring for opioid-induced sedation and respiratory depression. *Pain Management Nursing. Official Journal of the American Society of Pain Management Nurses*. American Society of Pain Management Nursing, 2011;12(3):118-45.The Joint Commission (2017). PC.01.02.07, *Comprehensive Accreditation Manual for Hospitals*: Provision of Care, Treatment, and Services Chapter. January 2018.
- The Joint Commission (2017). RI.01.02.01 *Comprehensive Accreditation Manual for Hospitals*: Patient Rights Chapter. January 2017.
- The Joint Commission (2012). Safe use of opioids in hospitals. *Sentinel Event Alert*; 2013; 49.





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