



# The Patient Care Manual

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## Pain Assessment and Monitoring

Site	All BCH
Setting/Population	All Settings/All Populations
Clinician	All Clinicians

### Policy

- Obtain a Pain History and an Initial Pain Assessment for every patient admitted to gain knowledge about the patient's personal, cultural, spiritual and/or ethnic beliefs and practices.
- Identify and document pain intensity using the standardized pain assessment tools appropriate to the age, medical condition and level of cognitive development of the child in conjunction with the child's self-report, family member's and health professional's assessment of pain.
- Follow the **Acute Pain Management Communication Guide** to notify the appropriate clinician if the patient's pain is NOT consistent with illness or surgery or significant and unrelenting.
- Use cardio-respiratory and oxygen saturation monitoring for:
  - Patients on epidural analgesia (with or without opioids).
  - Full term infants 0 to 3 months on opioids via any route (PO, IV, etc).
  - Full term infants 0 to 6 months on IV opioids.
  - Former premature infants with a post-conceptual age less than 60 weeks
  - on any opioids (PO, IV, etc).
  - Patients on opioids-scheduled or PRN for less than 72 hours (opioid naïve) with continuous opioid infusions.
  - Any patient with increased risk of respiratory depression. See list **below** for more conditions that increase risk. For more information on respiratory depression see **Critical Alert** below.

**Note: Exception to monitoring requirement:** Cardio-respiratory monitoring may be discontinued intermittently while patient is awake and alert and when a responsible adult is present.
- Assess and reassess and document pain intensity using a valid and reliable tool:
  - on admission, in the inpatient and ambulatory setting
  - before and after analgesic administration or any interventions to decrease or alleviate pain
  - at a minimum of every shift, typically pain is assessed every 4 hours with vital signs when awake and /or at risk for experiencing pain

## Purpose

To decrease pain as much as possible while ensuring patient safety.

## Critical Alerts

### Pain NOT Consistent with Illness or Surgery

Unexpected intense pain, particularly if sudden or associated with altered vital signs such as respiratory distress, hypotension, tachycardia or fever must be evaluated by the primary service and new diagnoses such as wound dehiscence, bladder distension, ileus, compartment syndrome, tight cast or dressing, bleeding or infection should be considered. The first priority in caring for a patient with significant pain not consistent with illness or surgery is to stabilize and treat the primary cause of the pain especially if associated with altered vital signs. For additional information, refer to the [Acute Pain Management Communication Guide](#).

### Respiratory Depression

The least common, but most serious, side effect of opioids is respiratory depression. Monitoring of the patient's responsiveness can alert the clinician to early signs of problems. For patients with significant cognitive/developmental impairment, refer to the Nursing Inpatient Assessment History for the patient's cognitive/developmental baseline.

### Increased Risk of Respiratory Depression

Selected patients with increased risk of respiratory depression may require cardio-respiratory monitoring. This includes but is not limited to the following conditions:

- Compromised airway
- Significant kidney disease
- History of respiratory depression with opioid use
- Large opioid doses for patient's weight and/or condition
- Neurological impairment
- Opioid naïve (use of opioids-scheduled or PRN for less than 72 hours) and concurrent use of other medication capable of
- central nervous system depression (e.g. benzodiazepines)
- Significant lung disease in patients who are not ventilated
- Somnolence
- Significant liver disease
- Morbid obesity
- Muscle weakness

### Responsiveness Assessment

- Awake and alert.
- Easily aroused but drowsy.
- Drowsy but opens eyes when name is called several times.
- Hard to arouse – needs tactile stimulus in addition to loud voice.
- Responds to pain only.
- No response.

## Emergency Response

Opioid related respiratory depression and serious complications requiring ventilatory support are treated by emergency response (anesthesia STAT or Code Blue), and with Naloxone (Narcan) as needed. For detailed information about Naloxone (Narcan) refer to:

- Boston Children's Hospital Formulary: Narcan
- Patient Care Manual: The Parenteral Naloxone (Narcan) Administration by Rapid Intravenous Administration
- Emergency equipment (at bedside):
  - ❖ oxygen
  - ❖ ambu bag
  - ❖ proper size mask for patient
  - ❖ suction equipment
  - ❖ Naloxone (Narcan) stocked in PYXIS

## Placebos

**Placebos (i.e. saline injections for analgesia) are NOT administered as a method for assessment or treatment** of pain except with informed consent or in clinical trials. A placebo is defined as any medication or procedure that produces an effect in a patient because of its implicit or explicit intent and not because of its specific physical or chemical properties. Placebo use deprives the patient of appropriate treatment or diagnostic measures.

## Procedure

## Resources

- Pain Treatment Service (page # 7246 [PAIN])
- Patient's Pain History and an Initial Pain Assessment
- Laminated Pain Assessment tools  
(Non-English versions of the Wong-Baker FACES tool are available from the Family Education Home Care Instructions area in the e-library)
- Pain Management Module [NetLearning]
- Ordersets for specific medications
- Coping Kit (located in unit treatment rooms)
- Child Life Therapists
- Pain Management Website

## Planning

Administer therapeutic interventions per level of patient's pain and as condition warrants. Interventions may include:

- Patient and/or parent/caregiver teaching:
- Administering analgesics as ordered;
- Behavioral distraction techniques; and/or
- Other pharmacologic and non-pharmacologic interventions, including needle pain interventions per the needle pain protocol, (inpatient and non-inpatient)

## Assessment

1. Obtain a **Pain History** for every patient **within 24 hours** of admission. Document an **Initial Pain Assessment on the Flowsheet** when clinically indicated. In the **Ambulatory setting**, ask the patient if they are having any pain. If the patient reports any pain, the nurse completes a pain assessment. For non-verbal patients, assess for non-verbal cues indicating pain or discomfort and discuss with parent/guardian.
2. Select a **pain assessment tool** based on the developmental level, medical condition, patient's language preference, past experience, and patient and family choice of tool. Use a self-report tool whenever possible. Instruct patient and family on its use.
3. Complete the pain assessment tool to assess, reassess and document the patient's pain intensity. Document the results. Follow these frequency criteria:
  - On admission.
  - Before and after analgesic administration or any intervention to decrease or alleviate pain. Refer to Formulary for peak and duration of specific drugs.
  - At a minimum of every shift. Typically pain is assessed every 4 hours with vital signs while the patient is awake and/or at risk for experiencing pain. More frequent assessment is necessary in patients in whom pain has not been well controlled. For example, pain assessment after surgery or an invasive procedure may require assessment as frequently as every 15-30 minutes.
4. Assess patient receiving opioids or other sedating medications for **respiratory depression**; assess **Responsiveness Assessment**.
  - When you obtain vital signs; and
  - Before and after administering sedating medications. Refer to the **Formulary** and the Patient Care Manual: **Patient Controlled (PCA)/Nurse Controlled (NCA) Analgesia** or **Epidural Analgesia**.
5. Consider interventions such as analgesics, topical local anesthetics, sucrose, or opioids, as clinically indicated.
6. Reassess pain and document if interventions performed do not produce the intended effect.
7. Document the **Responsiveness Assessment** when you obtain vital signs and before and after administering sedating medications.
8. Manage side effects of opioids.
9. Use cardio-respiratory and oxygen saturation monitoring as indicated.
10. Use the **Acute Pain Management Communication Guide** to communicate inadequate pain relief, unacceptable physiological measures and uncontrolled side effects to the appropriate team members.

## Assessment of a Sleeping Patient

In the case of the sleeping patient, the frequency of pain assessment is based upon:

- Patient's medical condition
- Past reports of pain
- Analgesics orders

- Consult with the family whenever possible

Pain cannot be assessed when the patient is asleep. By definition pain is awareness of an unpleasant sensory experience at the cortex level (i.e. consciousness). Therefore, when the patient is asleep, pain intensity cannot be documented, rather document observations of the patient such as vital signs. It is not always necessary to wake the sleeping patient for a pain assessment.

## Patient/Family Education Regarding Pain Management

- Teach pt/ family how to use the appropriate pain assessment tool
- Effective pain relief is an important part of treatment.
- Communication of unrelieved pain to the clinical staff is essential so they may respond promptly
- A total absence of pain may not be a realistic goal.
- Pain is assessed at regular intervals through the use of self-report pain tools and/or behavioral observation tools.
- Communication of suspected side effects of pain interventions is important.
- Teach patient/family about pain medications prescribed upon discharge: usage, dosage, potential side effects, safe handling and disposal of medication.

## Evaluation

Evaluate effectiveness of the procedure and patient outcomes.

Remember the AIR Cycle: Assessment, Intervention and Reassessment when treating pain.

## Documentation

Complete patient care documentation as described in the Patient Care Manual. In addition, document specific Pain Assessment and Management Information as follows:

<b>Pain History and Initial Assessment form</b>	<ul style="list-style-type: none"> <li>• Obtain a <u>pain history</u> for every patient from the patient and/or family/caregivers upon admission and an Initial Pain Assessment when clinically indicated.</li> </ul>
<b>Patient Care Flow Sheet/ Electronic Documentation</b>	<ul style="list-style-type: none"> <li>• Document the selected pain tool.</li> <li>• Record the <u>Responsiveness Assessment</u> as indicated.</li> <li>• Record the pain assessment <b>every shift</b> for all patients.</li> <li>• Record all changes in pain management plan, and communication of unexpected outcomes (unsatisfactory pain relief, significant side effects, dose changes, etc.) along with response to changes.</li> </ul>

## Related Content

### Website

- Pain Management Website
- Formulary (for specific drug information)

#### Family Education Materials/ Family Education Sheets

- Patient-Controlled Analgesia for Pain Relief
- Nurse-Controlled Analgesia (NCA) for Pain Relief
- Epidural Catheter for Pain Relief
- Nursing Competency
- Pain Management Modules [NetLearning]

#### Patient Care Manual

- Patient Controlled (PCA)/Nurse Controlled (NCA) Analgesia
- Controlled Substances
- Local Anesthetics Infusions via Wound and Peripheral Nerve Catheters
- Intrathecal Analgesics
- Parenteral Naloxone (Narcan) Administration by Rapid Intravenous Administration
- Epidural Analgesia

#### Reference Tools

- Pain Assessment Tools
- Individualized Numeric Rating Scale
- Pain History and an Initial Pain Assessment
- Management Plan: Pain
- Behavioral Distraction Techniques
- Pressure Ulcer Staging Guidelines: Assessment and Treatment
- Acute Pain Management Communication Guide

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