THE MOUNT SINAI HOSPITAL, NEW YORK STANDARD: PROCEDURE	SUBJECT NO. NU-505
DEPARTMENT: Nursing SUBJECT: Pain Screening, Assessment, and Reassessment	

CROSS-REFERENCE:
GPP-321 MSH-MSQ Pain Assessment and Management - Institutional Policy
NU- 514: Patient Controlled Analgesia (PCA)
NU-506: Epidural Analgesia Administration
ICCM-2 MSH-MSQ The Critical-Care Pain Observation Tool (CPOT) - In Critical Care Units for Patients Under Sedation
WCS-PICU-29 MSH-MSQ PAIN MANAGEMENT IN CHILDREN,
WCS-NICU-45 MSH-MSQ Pain and Sedation, Assessment and Nursing Management

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Revised:	5/05	7/06	9/06	6/08	4/09	11/09	2/18	5/18	11/18

Performed by:
Registered nurses (RN) and licensed practical nurses (LPN) under the supervision of RN's

Equipment:
Numerical Rating Scale (NRS), Faces Pain Scale – Revised, or other scales appropriate for intubated or pediatric patients as referenced below

Standard of care:
Patient self-report is the gold standard for the assessment of pain in all cognitively intact patients when developmentally appropriate. Acute and chronic pain management begins with the affirmation that pain is anything that the patient reports as such, and that the patient should have access to the optimal level of pain relief that may safely be provided. Pain can exist even when no physical cause can be found. The goal is to assess and manage the patient's pain, side effects and minimize the risks associated with treatment

Screening, assessment, and reassessment are essential components of any pain management plan. Pain is subjective and multidimensional, so multiple aspects (sensory, affective, cognitive) must be considered. The nature of the assessment varies with multiple factors (e.g., purpose of the assessment, the setting, patient population, age, condition and ability to understand and clinician), thus, no single approach is appropriate for all patients or settings

Screening for pain:

- the first step in successfully managing pain;
- is intended to detect the presence of pain;
- is performed and documented in the initial admission assessment (including ED visits);
- may be performed by ancillary staff (PCA); and
- require further assessment by an RN if the initial screening is positive and for any screening that discovers a change in pain.

Example language for screening for pain: "Do you currently have any pain or discomfort?"

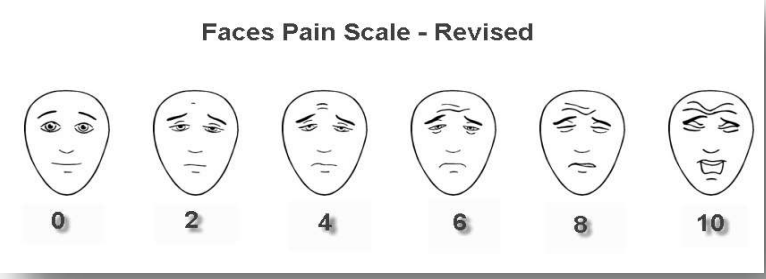
Assessment of pain:

Whenever possible, involve patients in their pain management treatment planning process through:

- Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain
- Discussing the objectives used to evaluate treatment progress (for example, relief of pain or improved physical or psychosocial function)
- Providing education on pain management, treatment options, and safe use of prescribed opioid and non-opioid medications

To measure and document pain intensity, use one of the following tools, as appropriate for the patient:

Pain intensity assessment tools:	
Numerical Rating Scale (NRS)	most commonly used, patients rate their pain on a 0 to 10 scale, with 0 representing "no pain at all" and 10 representing "the worst imaginable pain." 0 no pain, 1-4 mild, 5-6 moderate, 7-10 severe
Faces Pain Scale - Revised	adults with cognitive impairment 0 = no pain 2-4 = mild pain 6 = moderate pain 8-10 = severe pain
For pain assessment in non-verbal patients, refer to policy # ICCM – 2 The Critical Care Pain Observation Tool (CPOT)	
For pediatric patients refer to policy # WCS-P-20 Pain Management in Children and #WCS-NICU-45 Pain and Sedation, Assessment and Nursing Management	



Information that may be elicited and documented during the initial assessment for patients who screen positively for having pain may include the following characteristics:

Characteristics of the pain	**Example language for assessment**
Pain Level	If using NRS: "On a scale of 0 to 10, with 0 meaning no pain at all and 10 meaning the worst imaginable pain, how strong is your pain right now?" (may use other scales as appropriate for clinical situation)
Level of Consciousness	0 = wide awake 1 = drowsy 2 = dozing 3 = sleeping, responds to commands 4 = responds only to tactile stimuli 5 = no response to tactile stimuli 6 = unresponsive [selected areas (e.g. ICUs), use the Richmond Agitation-Sedation Scale (RASS) as an alternative]
Affected Area	Where does it hurt? The location of pain may be verified by having patients "point to where it hurts with one finger." Choose body part from dropdown list.
Pain Location	Choose further description of location (Right, Left, Anterior, etc.) from dropdown list.
Pain Type	Choose type (Acute, Chronic, Neuropathic, etc.) from dropdown list.
Pain Description	What does the pain feel like? Is it sharp or dull? Aching or throbbing? Does it feel like tingling, burning, or electric shocks? Choose description from dropdown list.
Pain Onset	How did your pain start? Was is gradual, sudden, or something else? Is this a new pain for you? Choose onset type from dropdown list.
Pain Frequency	Is your pain present all of the time or does it come and go? Choose frequency (Continuous, Intermittent, or Other) from the dropdown list.
Pain Intervention(s)	What interventions have you tried in the past to minimize your pain? (Medication, Repositioned, MD notified, etc.). Choose from dropdown list.
Pain Level Acceptable	Is your current level of comfort acceptable? Choose Yes or No from the dropdown list.

Reassessment of pain:

Pain is assessed after pain medication has been administered or after non-pharmacological therapies. Reassessment after non-pharmacological therapies should occur within one hour of application of the therapy

Pain reassessment after opioid administration includes:

- Level of Consciousness (LOC)
- Respiratory Rate (RR)
- Pain level
- Evaluation and documentation of response to pain interventions

The timeframe for safety and therapeutic effectiveness is based on opioid pharmacokinetics:

Route of opioid medication	**Therapeutic effectiveness**
Oral or rectal opioid analgesics	60 minutes
IV opioid analgesics	30 minutes
Subcutaneous or Intramuscular opioid analgesics	60 minutes
Ongoing continuous opioid infusions via epidural or PCA - Evaluate as per Policy NU- 514: Patient Controlled Analgesia, NU- 506 Epidural Analgesia Administration	

- For non-opioid analgesics (ibuprofen, acetaminophen, ketorolac, etc.) Patients should see therapeutic effectiveness within 60 minutes
- For nonpharmacological pain treatments (heat or cold, repositioning, massage, guided imagery, etc.), patients should see therapeutic effectiveness within 60 minutes following completion of treatment
- Re-assessment of pain for patients following medication administration for pain, who have changed location, will be assessed upon arrival to the designated nursing unit

Documentation:

For documenting medications refer to policy # NU-239 Medication Administration with Mobile Carts and Barcode Scanning (EPIC). Documentation of the screening, assessment, and reassessment is completed in the Electronic Medical Record (EMR) (flow sheet and nursing note)

Patient Education:

The hospital educates the patient and family on

- Discharge plans related to pain management including the following:
- Pain management plan of care
- Side effects of pain management treatment
- Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues
- Safe use, storage, and disposal of prescribed opioids
- Document education in the EMR as per policy #NU- 511 Interdisciplinary Patient and Family Educational Needs Assessment And Teaching Record

Escalation:

Uncontrolled pain is an urgent condition and warrants evaluation by a Licensed Independent Provider (LIP). The LIP may choose to order a Palliative Care or Pain Service consult. If a consultant has been following the patient for pain management, the LIP may discuss the pain treatment plan with the consultant. RNs are responsible for immediate escalation to a LIP in the following situations:

- Patient report of a new or different pain
- Pain level that continues to be unacceptable to the patient after the RN has implemented the pain treatment plan
- New side effects of pain management treatment including but not limited to sedation, confusion, decreased LOC, or RR < 10

References:

1. Berry, PhD, RN, CHPN, CS, Covington, MD, Dahl, PhD, Katz, MD, Miaskowski, RN, PhD, FAAN. 2017. American Pain Society. Pain: Current Understanding of Assessment, Management and Treatments
2. E. Chai, J. R. Horton, Managing Pain in the Elderly Population: Pearls and Pitfalls. Curr Pain Headache Rep (2010) 14:409–417. DOI 10.1007/s11916-010-0148-0
3. Herr K: Pain in the older adult: An imperative across all health care settings. Pain Manag Nurs 2010, 11(2 Suppl):S1–S10.
4. Joint Commission on Accreditation of Healthcare Organizations. Comprehensive accreditation manual for hospitals. Oakbrook Terrace: Joint Commission on Accreditation of Healthcare Organizations; 2018. Standards Revisions Related to Pain Assessment and Management
5. Voepel-Lewis T, Zanotti J, Dammeyer JA, Merkel S (2010). "Reliability and validity of the face, legs, activity, cry, consolability behavioral tool in assessing acute pain in critically ill patients". Am. J. Crit. Care. 19 (1): 55–61. doi:10.4037/ajcc2010624. PMID 20045849.